

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185470	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER The Willows at Hamburg		STREET ADDRESS, CITY, STATE, ZIP CODE 2531 Old Rosebud Road Lexington, KY 40509	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to promptly inform the resident's representative following a fall for 1 of 5 residents sampled for falls, Resident (R) 93. The findings include: Review of the facility's policy titled, Notification of Change in Condition, revised 05/10/2024, revealed the resident representative/provider should be notified of change in condition or diagnostic testing results in a timely manner, and notification attempts should be recorded in the resident's electronic health record (EHR). Review of R93's Face Sheet revealed the facility admitted the resident on 05/21/2026 with diagnoses including intracerebral hemorrhage, disorientation, and atrial fibrillation. Further review revealed R93's primary contact person as Family (F) 1 with a notation she should be contacted at any time and notified of any changes. Review of R93's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 05/25/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of four out of 15, which indicated the resident was severely cognitively impaired. Review of Progress Notes, dated 05/23/2026 at 3:13 AM and written by Licensed Practical Nurse (LPN) 4, revealed R93 experienced an unwitnessed fall on 05/22/2026 at approximately 9:18 PM. However, the resident's representative was not notified until the following morning, 05/23/2026 at approximately 6:35 AM. R93 was no longer present for observation or interview. During an interview with family (F) 1 on 07/08/2026 at 1:09 PM, she stated R93 was admitted to the facility on [DATE] for rehab after she was hospitalized following a stroke. F1 stated on Saturday after R93's admission [DATE], F1's husband received a phone call at approximately 6:45 AM from LPN4 at the facility who reported R93 was found on the floor, had a suspected fall, but was not injured. F1 stated she was R93's power of attorney (POA) and was listed as the primary contact, but she had not received any calls, her phone showed no missed calls, and there were no recent voicemail messages. F1 further stated her husband handed her the phone, and LPN4 repeated the information that R93 was found on the floor in her room but was not injured. F1 stated she asked the nurse for more details and learned R93 was found on the floor the following evening at around 9:30 PM, but because she was not injured and it was a busy night, notifications were not made until the following morning. F1 stated at that point she drove to the facility, and while she was there, LPN4 came into R93's room, and when she saw F1, she cried and apologized for not calling timely. F1 additionally stated the weekend supervisor, Registered Nurse (RN) 4 directly apologized because she was not notified in a timely manner after R93's fall at the facility. During an interview with LPN1 on 07/09/2026 at 11:21 AM, she stated after an unwitnessed fall, the resident was not left alone and was placed on 15-minute neurological checks because of a potential head injury. LPN1 stated once the resident was stabilized, an Occurrence Note was opened in the electronic health record (EHR), and the representative and provider were notified. When asked if there (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to implement their admissions policy for 1 of 5 residents sampled for admissions, Resident (R) 93. The findings include: Review of the facility's policy titled, admission Policy, revised 07/03/2025, revealed the facility would maintain an admissions policy governing admissions to the facility to ensure fair and impartial admission practices to best serve inquiring customers. Review of Resident (R) 93's Face Sheet revealed the facility admitted the resident on 05/21/2026 with diagnoses including intracerebral hemorrhage, disorientation, and atrial fibrillation. Review of R93's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 05/25/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of four out of 15, which indicated the resident was severely cognitively impaired. Review of R93's admission Observation documentation revealed the resident was admitted on [DATE] at 5:18 PM. Review of R93's electronic health record (EHR) revealed the facility admitted the resident on 05/21/2026 and discharged the resident on 05/27/2026. However, there was no evidence of signed admission paperwork for R93 documented anywhere in the resident's EHR. Resident 93 was no longer present for observation or interview. During an interview with R93's family (F) 1 on 07/08/2026 at 1:09 PM, she stated R93 was admitted to the facility on [DATE] for rehab after she was hospitalized for a stroke. F1 stated she was with the resident at admission and signed two forms, one was a consent to treat, and one was a designated code status. F1 additionally stated she asked at that time about additional admission paperwork but was told not to worry because it would get done. F1 stated she visited her aunt each day at the facility, and each day she asked someone about admission paperwork that should have been signed. She stated after several days, she eventually received the paperwork via email followed by a phone call from the facility that requested the paperwork be signed and returned as soon as possible. F1 stated she informed the caller that she wanted the opportunity to review the admission paperwork before she signed. F1 stated on Tuesday, 05/27/2026, she met with staff at the facility for R93's first resident meeting that discussed care, goals, finances, and other concerns that needed to be addressed. F1 stated the Social Services Director (SSD) was present at the meeting and immediately notified her there was a problem with R93's insurance, her stay was not covered, and there was a balance owed of \$6,000. F1 stated she was obviously upset and displayed that in the meeting. F1 further stated the Executive Director (ED) attended the meeting, and after discussions among them all, the ED stated the facility would cover the cost, and R93 was not responsible. F1 stated R93 was discharged home with her that day, but she never signed admission paperwork. During an interview with the Admissions Director (AD) on 07/10/2026 at 9:31 AM, she stated once an admission was known, it was announced to all staff. She stated when the new admission resident arrived, the consent to treat and code status forms were signed immediately. She further stated if a new admission arrived after hours or on a weekend day, someone from nursing obtained signatures for the consent to treat and code status forms. The AD stated the entire admission packet paperwork was completed and signed the day of or the day following admission. She further stated the expectation was that within 48 hours of admission, all admission paperwork was completed and signed. When asked what happened with R93's admission process, she stated the team that processed insurance for new admissions worked remotely and made a mistake when they verified her insurance. The AD stated R93's primary insurance was inactive, and the resident discharged home (continued on next page)		

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	before admission paperwork was signed. The AD stated she was not sure why R93's paperwork was not presented for signature prior to 05/27/2026. During an interview with the SSD on 07/10/2026 at 9:56 AM, she stated R93 came to the facility for rehab after she suffered a stroke, and the resident's niece was her power of attorney (POA) and responsible party. The SSD stated the facility held R93's initial meeting and discharge at the same time, and the ED, Director of Health Services (DHS), AD, SSD, and F1 were present at the meeting. She stated they discussed insurance status and concerns because there was a co-pay on day one. The SSD stated R93 was discharged home on [DATE], medications were sent to the resident's pharmacy, and F1 told the SSD she would ensure R93's medical appointments were made and home care arranged. During an interview with the Director of Health Services (DHS) on 07/10/2026 at 11:08 AM, she stated if a resident was admitted after hours or on the weekend, nursing ensured a consent to treat form and a code status form were reviewed and signed by the resident or their representative. She additionally stated other than the two forms and reviewing referrals, she was not involved in the admission process. During an interview with the Executive Director on 07/10/2026 at 4:15 PM, he stated it was his expectation admission paperwork was completed, signed, and documented in the resident's chart. He further stated the facility was unsuccessful from a customer service standpoint with R93 from the beginning, and therefore, the facility absorbed the cost, and the resident was not charged.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of the facility's policy, the facility failed to store food in a safe manner for 1 of 3 nourishment refrigerators. Observation on 07/10/2026 at 12:00 PM revealed staff stored personal food items in the 200-unit nourishment refrigerator. The findings include: Review of the facility's policy titled, Food Brought Into Facility, dated 11/27/2017, revealed the purpose is to store foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Food or beverage items are to be stored in such a manner that they are either separate or easily distinguishable from facility food. Observation of the 200-unit nourishment refrigerator on 07/10/2026 at 12:30 PM revealed a large pink lunch bag with no identification, and a salad in a restaurant lunch bag with no name or date. During an interview with Licensed Practical Nurse (LPN) 5 on 07/10/2026 at 1:36 PM, she stated the resident food was labeled with name and date. She stated the staff food was not to be stored in the nourishment refrigerator to prevent possible infection control issues between staff and resident food. During an interview with Registered Nurse (RN) 3 on 07/10/2026 at 1:37 PM, she stated staff food was in the 200-unit refrigerator. She stated staff kept their food in the staff lounge refrigerator to prevent the potential for infection control issues with staff and resident food in the same refrigerator. During an interview with the Director of Health Services on 07/10/2026 at 3:41 PM, she stated that staff should put their food in the break room refrigerator with their name and the date. She stated there would be a potential risk for cross contamination if stored in the nourishment refrigerator because that was for residents only. During an interview with the Executive Director on 07/10/2026 at 4:15 PM, he stated staff were to keep their food in the break room refrigerator to prevent cross contamination.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's documents and policy, the facility failed to maintain essential equipment in safe operating condition, including crash cart supplies and a lock on the storage closet containing oxygen tanks. Observations on [DATE] revealed 1 of 1 crash carts located in the Legacy Memory Care Unit contained an empty oxygen tank, and the Legacy Memory Care Unit oxygen supply room could not be immediately accessed by the Director of the unit due to a faulty keypad lock and the absence of a key to the room on the unit. The findings include: Review of the facility's policy titled, Guidelines for Crash Cart Contents, last review date [DATE], revealed the crash cart should be restocked after use and examined for expired products, a functional suction machine, and that the oxygen tank is full. Review of code status Orders for the current memory care residents revealed that one of the 11 residents was designated as a full code. Review of the facility's document Crash Cart Checklist, undated and electronically signed by LPN2, revealed the night shift was expected to document crash cart audits for supplies and replace them as needed. Review of the initialed Crash Cart Checklist revealed on [DATE] and [DATE], initials did not match the night shift nurse on duty but that of Licensed Practical Nurse (LPN) 2. 1. Observation on [DATE] at 10:27 AM revealed the only crash cart available in the Legacy Memory Care Unit contained an empty oxygen tank. During an immediate interview with LPN2/Assistant Director of Health Services of the Legacy Memory Care Unit, she stated the night shift was responsible for the crash cart check, and she was not sure why it was empty, and she checked it herself. She stated she felt a resident could have turned it on, which would have allowed it to leak out. She stated, if she worked in the evenings, sometimes she would go ahead and check the crash cart. She stated part of her duties included an audit to ensure the crash cart check was done. During an interview with the Director of the Legacy Memory Care Unit on [DATE] at 11:17 AM, she stated she expected staff to monitor and maintain the crash cart, and it included ensuring the oxygen tank was full. She stated she did not feel, however, the empty oxygen tank placed the residents at risk because there were several tanks in the oxygen supply room, also located in the same unit. 2. Observation on [DATE] at 11:17 AM with the Director of the Legacy Memory Care Unit, revealed she attempted to show the unit's oxygen supply room. However, a faulty keypad-style lock prevented access. She stated she would have to call maintenance to fix the lock. A keyhole was observed as part of the keypad lock, but the Director stated the key was kept by the maintenance department, and she did not have access to it. During continued interview with the Director of the Legacy Memory Care Unit on [DATE] at 11:17 AM, she stated again she did not feel residents would be in danger because there was a crash cart in the main part of the campus, located in the adjacent building. In addition, she stated she was unaware of any occasion the crash cart had been used in her unit, but in an emergency, the situation of an empty oxygen tank could cause a delay of care that increased the potential for harm. During an interview with the Director of Health Services (DHS) on [DATE] at 4:03 PM, she stated she covered all portions of the campus, including the Legacy Memory Care Unit. She stated she expected the crash carts would be stocked with all necessary supplies, including oxygen. She stated it was the responsibility of the night shift to do this and/or the nurse at the time it was used. She stated the crash cart on the memory care unit was audited by the Assistant Director of the Legacy Memory Care Unit/LPN2. She stated the risk of not having supplies available in the event of an emergency could result in a delay of care and potentially cause harm to a resident. During an interview with the Maintenance Director on [DATE] at 2:58 PM, he stated it was not practical to do a monthly check of the battery-operated (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	locks because it could be checked on Monday and die on Tuesday. He stated a staff member would let him know when the battery was dead, and he would replace the battery as needed. He stated he was notified of this particular lock immediately after the observation by the State Survey Agency (SSA) Surveyor, and the battery was replaced and confirmed to be in working order. He stated he was the one who kept the keys to access these locks, although laundry services had the same type of lock, and the whole unit had to be replaced. He stated, when that happened, the laundry service was provided a key until the replacement was made. During an interview with the Executive Director (ED) on [DATE] at 4:17 PM, he stated he expected all of the crash carts to be checked for appropriate supplies, including a full oxygen tank. He stated he felt a confused resident might have had access to the tank, and the oxygen could have leaked out. As a result of this potential risk, he stated, some changes would be made to decrease accessibility to those residents, such as removing the regulator from the tank so nursing could control its access, and a red pouch with a key would be made available at the Legacy Memory Care Unit so, in the event of an emergent need, the room could be accessed with a key. He stated he felt Cardio-Pulmonary Resuscitation (CPR) would have been the first step, and a patent airway would have to be ensured before application of oxygen would be an issue. He stated, even though the oxygen supply closet was an issue on this occasion, there was another crash cart available in the main building.		