| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **185482** | A. BUILDING _____ B. WING _____ | **08/05/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **THE WILLOWS AT FRITZ FARM** | **2710 MAN O' WAR BOULEVARD LEXINGTON, KY 40515** |

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 0609<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, record review, review of Kentucky Revised Statutes (KRS), and review of the facility's policy, it was determined the facility failed to ensure all alleged violations involving abuse or neglect were reported immediately 1) to the facility's supervisors and 2) to State Agencies (SA) for one (1) of three (3) sampled residents (Resident #1). On 07/23/2020, State Registered Nurse Aide (SRNA) #2 reported to Licensed Practical Nurse (LPN) #1, approximately a month before, she witnessed Resident #1 strike SRNA #1 in the face, knocking his glasses to the floor. SRNA #2 stated after Resident #1 did this, SRNA #1 hit Resident #1 on the left shoulder and told the resident he/she could not be hitting staff, and his glasses would cost over five (5) hundred dollars to replace. SRNA #2 stated she waited until she and SRNA #1 had an argument, on 07/23/2020, to report the incident she alleged had happened a month earlier. The Director of Nursing (DON) and Administrator were not notified of the allegation until 07/23/2020. Therefore, State Agencies were not notified of the allegation until 07/23/2020, approximately a month after the incident occurred. The findings include: Review of KRS Chapter 209.030, revealed an oral or written report was to be made immediately to State Agencies upon knowledge of suspected abuse, neglect, or exploitation of an adult. Review of the facility's policy, Alleged Abuse/Potential Neglect/Exploitation Reporting/Investigation, dated 08/29/2019, revealed allegations of abuse were to be reported to the supervisor and the resident's charge nurse. Per the policy, persons' receiving the report were to immediately inform the Administrator. Continued review revealed allegations of abuse would be reported to the appropriate regulatory and investigative agencies in accordance with state requirements. Review of the Long Term Care Facility-Self Reported Incident Form/ Initial Report, faxed to the Office of Inspector General (OIG), on 07/23/2020, revealed an incident had occurred, approximately one month prior to 07/23/2020 and witnessed by staff, which alleged SRNA #1 hit Resident #1 on the arm. Review of the facility's Long Term Care Facility-Self Reported Incident Form/ Five-Day Report for Resident #1, dated 07/28/2020 at 2:50 PM, signed by the DON, revealed SRNA #2 alerted LPN #1 approximately a month from 07/23/2020, she witnessed Resident #1 strike SRNA #1 in his face, knocking his glasses to the floor. This caused an earpiece to break off his glasses. Further, this form revealed SRNA #2 stated SRNA #1 struck back at the resident by hitting him/her on the left shoulder. SRNA #1 stated he laid his hand on the resident's left shoulder asking him/her not to strike at staff. Per interview, SRNA #1 denied striking the resident. Additionally, the report stated Resident #1 had no injuries observed at the time of the alleged incident reported on 07/23/2020. Review of Resident #1's medical record revealed the facility admitted the resident on 11/06/2019 with [DIAGNOSES REDACTED]. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 05/02/2020, revealed the facility assessed the resident had a Brief Interview for Mental Status (BIMS) score of two (2) out of fifteen (15), indicating severe cognitive impairment. Additional review of the Quarterly MDS Assessment, Section E - Behavior, revealed the facility assessed aggressive/combative behaviors exhibited by Resident #1. Observation of Resident #1, on 08/04/2020 at 10:00 AM, revealed the resident lying in bed with his/her eyes closed. Resident #1 was non-interviewable related to cognitive deficits. Review of Resident Interviews conducted by staff, on 07/23/2020 and 07/24/2020, revealed residents denied being abused by anyone. Phone Interview with SRNA #1, on 08/04/2020 at 11:40 AM, revealed he had worked at the facility for three (3) years. He stated, on the evening of 07/23/2020 at approximately 6:30 PM, SRNA #2 was upset about assignments, and he and she got into a verbal argument. Per interview, later that evening he was sent home pending an investigation of an incident that had occurred about a month prior regarding Resident #1. Per interview, he recalled the incident happened during the evening, he could not recall the date, when SRNA #2 was assisting him with providing care to Resident #1. He stated it took two (2) to three (3) staff to provide care related to Resident #1 being resistive and combative with care. SRNA #1 stated Resident #1 struck him in the face, knocking his glasses to the floor. He stated it upset him. He stated he picked up his glasses and laid one (1) of his hands on Residents #1's left shoulder in an attempt to redirect and explain to him/her it was not appropriate to hit staff or knock his glasses to the floor because it cost money for repair. He stated he never hit the resident and had never abused any resident. Continued interview revealed he was suspended pending the investigation and was later terminated, on 07/23/2020, for continuing to argue with SRNA #2. Further, he stated Administration told him they could not verify abuse had occurred, and he again denied abusing Resident #1. Phone interview with SRNA #2, on 08/04/ 2020 at 4:15 PM, revealed, on 07/23/2020 at approximately 6:00 PM, she and SRNA #1 had a disagreement related to their assignments for the evening. She stated she told SRNA #1 to leave her alone, but he kept bothering her. SRNA #2 stated, approximately a month before the disagreement on 07/23/2020, she was assisting SRNA #1 in caring for Resident #1. She stated she witnessed Resident #1 strike SRNA #1 in the face which knocked his glasses to the floor. She stated SRNA #1 was mad, and she witnessed him hit Resident #1 on the left shoulder. She stated Resident #1 did not appear to be injured. SRNA #2 stated she was in shock because she had never witnessed SRNA #1 behave like that before. Per interview, she stated SRNA #1 told the resident it would cost him hundreds of dollars to replace his glasses and hitting staff was not appropriate. Per interview, she reported this incident to another aide; however, she did not report the incident to her supervisor. She further stated not reporting the incident between SRNA #1 and Resident #1 had been bothering her for a while; and, after the incident, on 07/23/2020 with SRNA #1, she then decided to report the previous incident, involving Resident #1 and SRNA #1, to LPN #1. Per interview, SRNA #2 stated she had received abuse training upon hire, annually, and as needed. She further stated she should have reported it immediately when the alleged abuse occurred. Interview with LPN #1, on 08/04/2020 at 4:30 PM, revealed SRNA #2 told SRNA #3, on 07/23/2020, of an incident, approximately a month ago, of SRNA #1 hitting Resident #1 on the shoulder. She stated she reported this to the DON and was instructed to send SRNA #1 home pending investigation and perform a skin assessment of Resident #1 immediately. She further stated she had never had any residents report any allegations of abuse by SRNA #1. LPN #1 stated she had never witnessed any form of abuse committed by SRNA #1. LPN #1 stated abuse should be reported immediately to the supervisor. Interview with the DON, on 08/04/2020 at 2:37 PM, revealed she was notified by LPN #1, on 07/23/2020 via a telephone call, that SRNA #2 alleged she witnessed Resident #1 strike SRNA #1 on the face and knock his glasses to the floor; and, this had happened a few weeks ago. Continued interview revealed the DON instructed LPN #1 to send SRNA #1 home pending investigation and to perform a skin assessment on Resident #1 immediately. She further stated she drove to the facility, on 07/24/2020 around 4:30 AM, to interview SRNA #2 regarding the alleged abuse of Resident #1 by SRNA #1. The DON stated she spoke with the Administrator, after they both had interviewed SRNA #1 and SRNA #2, to discuss the occurrence. She stated, at that time, they did not feel abuse could be substantiated. However, she further stated SRNA #1 was terminated, on 07/23/2020, related to continued arguments with SRNA #2 after LPN #1 had told him to leave her alone. The DON further stated the allegation was not reported to the state when it supposedly happened because SRNA #2 did not report the incident until 07/23/2020. She stated as soon as she and the Administrator were notified, they investigated and reported it to State Agencies. Further, |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **185482** | A. BUILDING _____ B. WING _____ | **08/05/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **THE WILLOWS AT FRITZ FARM** | **2710 MAN O' WAR BOULEVARD LEXINGTON, KY 40515** |

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 0609<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>she stated if there was an allegation of abuse, she expected staff to report the allegation immediately so State Agencies could be notified timely as per facility policy. Interview with the Administrator, on 08/04/2020 at 3:07 PM, revealed SRNA #2 should have reported the alleged abuse immediately. Per interview, she expected staff to report any allegation of abuse immediately, and because this was not reported immediately, staff did not follow their policy. The Administrator stated she expected the residents to be cared for and free from any forms of abuse. |