DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185470	A. BUILDING _____ B. WING _____	R-C 08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT HAMBURG	2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509

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{F 000}	INITIAL COMMENTS Based on the acceptable Plan of Correction (POC) and the on-site revisit survey conducted on 08/13/2024, it was determined the facility was in substantial compliance on 07/11/2024.	{F 000}		

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.

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F 000	INITIAL COMMENTS	F 000		

An Abbreviated/Partial Extended Survey concluded on 07/03/2024. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.

Immediate Jeopardy (IJ) and Substandard Quality of Care were identified on 06/21/2024 and was determined to exist on 06/07/2024 in the area of 42 CFR 483.12.

Deficiencies were cited related to complaint KY00042719 at F600 and F607. No deficiencies were issued related to complaints KY00042045, KY00042197, KY00042412, KY00042568, and KY00042615.

On 06/21/2024 at 5:35 PM, the Administrator and Director of Health Services (DHS) were provided a copy of the CMS Immediate Jeopardy (IJ) Template and notified of the facility's failure to ensure residents were protected from verbal and physical abuse constituted Immediate Jeopardy (IJ) at F600 and F607 with a scope and severity (S/S) of a "J."

On 06/07/2024 Certified Resident Care Aide #6 (CRCA6), CRCA10, and Licensed Practical Nurse #2 (LPN2) witnessed Certified Registered Medication Aide #7 (CRMA7) in a verbal and physical altercation with Resident #7 (R7). R7 was attempting to leave the building, with a wheelchair-bound resident, through a door located by the 700 Hall nurses' station. CRMA7 and CRCA10 responded initially with CRMA7 trying to divert R7 from the area. R7 became resistant and began to yell and hit CRMA7, which knocked her glasses from her face. CRMA7 was

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Electronically Signed | 07/26/2024

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F 000	Continued From page 1 observed cornering R7, yelling at her, and smacking the resident in the face with her hand. The facility provided an acceptable removal plan for the immediate jeopardy on 06/28/2024. The State Survey Agency (SSA) validated the immediate jeopardy was removed on 06/15/2024 following the facility's implementation of the removal plan. The deficient practice remained at a S/S of a "D" following the removal of the immediate jeopardy. Survey Dates: 06/18/2024-07/03/2024 Survey Census: 61 Sample Size: 8	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the	F 600	1. (Corrective actions for identified	7/11/24

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F 600	Continued From page 2 facility's investigation report, and review of the facility's policies, the facility failed to protect 1 of 8 sampled residents (Resident 7 (R7)) from physical and verbal abuse by Certified Registered Medication Aide (CRMA) 7. Review of the facility's initial "Investigation Report" and the witness statements from Certified Registered Care Aide 6 (CRCA6), CRCA10, and Licensed Practical Nurse (LPN) 2, revealed that on 06/07/2024 at 5:50 PM, CRCA6 and CRNA10 observed CRMA7 smack R7 across the face, after R7 had knocked CRMA7's glassess off her face. CRCA6's and CRCA10's statements revealed they both heard what sounded like R7's head hitting the wall at the same time as the smack; however, no visible marks were reported or documented. The facility's failure to have an effective system to ensure residents were protected from verbal and physical abuse was likely to cause serious injury, impairment, or death. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on 06/21/2024 and determined to exist on 06/07/2024 at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F600) at the highest Scope and Severity (S/S) of a "J." The facility was notified of the IJ on 06/21/2024. An acceptable "Immediate Jeopardy Removal Plan" was received on 06/28/2024 and validated before exiting on 07/03/2024. The IJ removal was on 06/15/2024. The deficient practice remained at a S/S of a "D" following the removal of the immediate jeopardy.	F 600	resident(s) affected by the deficient practice.) a. LPN(2) immediately intervened and separated CRMA(7) and R(7) when observing the incident at approximately 5:50 pm according to LPN(2), CRNA(6), and CRNA(10) interviews. b. (R)7 was immediately removed from the incident by LPN(2) to ensure the safety of (R)7 in accordance with our abuse protocol. RN performed a head-to-toe assessment on (R)7 with no acute signs of injury. The RN assessment found the resident had old fading bruising that was determined to be contributed to lab draws. The bruising was described as old and fading in anatomical locations prone to venous blood draws. This was also later confirmed by the phlebotomy documentation and Bruise Event opened on 5/27/24. c. CRMA(7) was immediately escorted from the patient care area to the corner of the nurse□s station and seated in a chair within visual sight of the RN. CRMA(7) remained under 1:1 staff supervision while CRMA(7) and RN completed narcotic shift count and giving report. The Director of Health Services (DHS) was notified of the incident at 6:20 pm by CRNA(6). The Executive Director (ED) was then made aware of the incident by the DHS at 6:23 pm. (CRMA)7 was then asked to leave the premises after the narcotic shift count and report was given to the RN. (CRMA) 7 had a documented punch out time of 6:39 pm. The ED contacted (CRMA) 7 at 6:50 pm and informed her that she was suspended pending investigation until	

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F 600	Continued From page 3 The findings include: Review of the facility's policy titled, "Abuse Neglect Procedural Guidelines," revised 08/29/2019, stated, "Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. . . irrespective of mental or physical condition." Further review revealed two forms of abuse could be verbal or physical. Per the policy, verbal abuse included the use of oral communication or sounds within hearing distance of the resident, regardless of the resident's age, ability to comprehend, or disability. The policy also stated physical abuse could be with or without injury. Review of the facility's policy titled, "Resident Rights Guidelines," revised 05/11/2017, revealed residents had the right to be free from physical and verbal abuse from staff, family, and other residents. Review of R7's "Facesheet" revealed the facility admitted the resident on 01/05/2024 with diagnoses that included unspecified dementia, pain, and abnormalities in gait and mobility. Review of R7's quarterly "Minimum Data Set (MDS)," with an assessment reference date (ARD) of 04/05/2024, revealed the facility assessed the resident to have a "Brief Interview for Mental Status" (BIMS) score of three (3) of fifteen, indicating severe cognitive impairment. Review of the "Long Term Care Facility - Self Reporting Incident Form Facility Reported," dated 06/07/2024, revealed the incident between R7 and CRMA7 occurred at 5:50 PM on 06/07/2024.	F 600	further notice. The Legacy Coordinator confirmed on 6/8/24 the department leader contact information including the DHS and ED was on a laminated posting at the nurses station. d. R(7) was interviewed on 6/7/24 at approximately 8:59 pm by RN post incident to ensure R(7) was not psychosocially affected by the incident. The resident indicated she had no recollection of the event. RN performed a head-to-toe assessment on (R)7 with no acute signs of injury. Based on the RN assessment, it was determined R(7) had no evidence of changes from her baseline. According to RN, R(7) clinically appeared to be in her normal, pleasant mood. e. The ED initiated our internal abuse investigation on 6/7/24, and reported the incident to appropriate state agencies, local authorities, and applicable parties. f. R(7) still resides at our facility and has shown no adverse effects from the incident. The resident□s psychosocial status remains at baseline. R(7) was observed by APRN on 6/10/24 with no signs of any emotional distress related to the recent event. g. R(7) was seen by psych services prior to the incident on 6/5/24 due to pre-existing history of anxiety and periods of tearfulness. Psych recommendations to increase resident□s Lexapro from 10 mg daily to 20 mg daily. The recommendations were reviewed with ARNP on 06/09/24 and she agreed to the recommendations. h. Upon concluding the investigation,	

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F 600	Continued From page 4 The report revealed this form was submitted to the Office of Inspector General/State Survey Agency (OIG/SSA) on 06/07/2024 at 7:55 PM. Review of the facility's initial "Investigation Report," dated 06/07/2024 at 7:55 PM and the witness statements from CRCA6, CRCA 10, and LPN2, revealed that on 06/07/2024 at 5:50 PM, CRCA6 and CRNA10 observed CRMA7 argue and yell at R7 while preventing her from leaving an area at the end of a hall. CRMA7 was observed restraining R7 until she got loose and swung at CRMA7, knocking CRMA7's glasses from her face. CRMA7 smacked R7 across the face, with her hand. CRCA6's and CRCA10's statements revealed they both heard what sounded like R7's head hitting the wall at the same time as the smack. CRCA 6, CRCA 10, and LPN2 stated R7 exhibited increased anxiety and uncontrollable crying but no visible marks were reported or documented. Review of the skin assessment performed by LPN2, dated 06/07/2024, after the incident, revealed the bruising present on R7 could be correlated with labs recently drawn in the anti-cubital area of her left arm, and an old bruise on her right forearm could also be associated to scheduled labs. Review of CRMA7's 06/07/2024 timesheet revealed she clocked out at 6:39 PM, 50 minutes after the facility's report and witness statements indicate the incident occurred. Review of CRMA7's employee file revealed upon hire date in 2014, a previous reprimand was on file regarding her tone when talking to residents. The file revealed CRMA7 was suspended on	F 600	CRMA(7) was terminated by the ED on 6/12/24 due to findings of misconduct. 2. (Identification of other residents who may be affected by the deficient practice and corrective actions that will be put in place to ensure the deficient practice does not reoccur.) a. All residents residing on the Memory Care Unit at The Willows at Hamburg have the potential to be affected by the deficient practice. b. LPN(2) and RN completed a one-time head to toe skin assessment of all residents residing on the Legacy Neighborhood on 6/7/24 to determine if there was any other residents who exhibited any suspicious bruising and/or evidence of possible abuse. There were no other findings based off campuses assessment. c. Beginning 6/8/24, the ED initiated interviews to alert and oriented residents. The ED completed 3% of alert and oriented resident interviews as the CRMA (7) had not recently worked on the Health Center. d. Beginning on 6/8/24, residents that reside on the Health Center received a weekly skin assessment by their assigned perspective nurse with no new skin issues or signs of abuse. This was completed on 6/14/24. e. CRMA(7) has not worked on the Health Center since 5/20/24. f. A resident council meeting was held on the Health Center and Assisted Living on 6/4/24 with no concerns voiced of	

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F 600	Continued From page 5 06/07/2024 pending an internal investigation of the incident with R7 and was terminated on 06/12/2024. Review of the statement documented by the Administrator and dictated by the Director of Health Services (DHS), dated 06/07/2024, revealed the witnesses CRCA6 and CRCA10 did not see but "thought" CRMA7 hit R7, and when asked, they stated, "I'm not sure" and CRMA7 "may have" hit R7 back. Per the statement, CRCA6 reported she saw CRMA7 get slapped by R7 and "possibly" saw CRMA7 restrain R7 against the wall. Review of the final "Investigation Report," dated 06/12/2024 at 2:05 PM, revealed its findings were inconclusive and stated the written versus oral versions of these events were not the same, and there was no "willful" infliction of injury resulting in physical or emotional harm. The facility did, however, terminate CRMA 7 based on "not following company service standards." Review of a written statement by CRMA7, dated 06/07/2024 at 7:37 PM, revealed R7 was agitated because she wanted to go out, and R7 proceeded to hit, pinch, and knee CRMA7 in the stomach area. She reported that she had R7 in the corner so she would not hurt a resident. CRMA7 reported R7 had her by the wrists, and when R7 let go of them, she knocked the glasses off CRMA7's face. CRMA7 stated, "I did not retaliate by hitting her on purpose but if my arm hit her when it raised up to keep her from getting my face. . . .I wasn't going to let her hit me." During an interview on 06/18/2024 at 1:34 PM with R7 and her husband, R7 denied memory of	F 600	abuse, neglect, or exploitation. g. A one-time audit of the grievance log was reviewed on 6/14/24 to ensure no concerns were raised regarding abuse with no findings. 3. (Measures put in place and systemic changes you will make to ensure that the deficient practice does not reoccur.) a. The Trilogy Health Services Campus Clinical Support Nurse provided re-education to the DHS, ED, and Assistant Director of Health Services (ADHS) via phone post event on 6/7/24 regarding Trilogy policy and procedures on abuse, identification, appropriate interventions, protection, identification of others at risk, residents with aggressive behaviors, immediate notification and reporting with suspension and removal of any employee once allegations of abuse are made against them, and prevention of abuse by recognizing burnout and stress. b. Once the DHS, ED, and ADHS were provided re-education, then beginning on 6/7/24 the above referenced education was provided to 100% of staff (nursing staff, housekeeping, laundry, dietary, department leaders, therapy, and plant operations) with a follow-up posttest to ensure knowledge of information provided. Education was provided through in person, verbal over the phone, and/or via Trilogy Wordrede app. Education was completed on 6/14/24. After 6/14/24, any newly hired staff will be educated through orientation by the SDC or DHS. The	

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F 600	Continued From page 6 any events where someone had been mean with her, and she was not afraid. R7's spouse stated he recalled hearing about the incident on 06/07/02024, but he had no current concerns. He stated he was glad CRMA7 was no longer at the facility, and he was otherwise happy with his wife's care. During an interview on 06/19/2024 at 10:00 AM with CRMA7, she stated it was near the end of the shift on 06/07/2024 at 5:15 PM to 5:30 PM, when staff heard the door alarm go off. She stated R7 was wandering around and pushing another resident in a wheelchair. She stated R7 told staff they were going "home." CRMA7 stated she observed R7 attempting to get a chair-ridden resident out of her wheelchair and push on the exit door, which set off the door alarm. She stated CRCA10 redirected the resident in the wheelchair and she attempted to redirect R7. She stated R7 was already agitated because she was stopped from going out the door. She stated R7 became so agitated that she became physically aggressive toward CRMA7. CRMA7 stated she felt the only way to control the situation was to manually hold R7 off. She stated R7 then got loose and smacked the glasses off her. CRMA7 stated she did not smack R7 in return, but with R7 trying to hit her, it was possible her arms went up to defend herself and she accidentally hit her. CRMA7 could not confirm or deny that she remembered any contact, stating, "It all just happened so fast, I don't know." She stated she later saw R7 in the courtyard with other residents. She denied any previous disciplinary action related to staff and patient interaction. CRMA7 stated she received regular, yearly training on abuse.	F 600	campus does not utilize agency staff. c. On 7/2/24, According to the surveyor□s request, Trilogy Health Services Policy on Abuse was updated to include the following verbiage from the State Operations Manual- Appendix PP (VIII), how staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program under ¿483.75. The new policy is attached, see page 3, g) Reporting/Response, i □ Campus staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program. d. On 7/2/24, addendum education was initiated to 100% of staff (nursing staff, housekeeping, laundry, dietary, department leaders, therapy, and plant operations) by the Executive Director, Administrator and Director of Health Services. Education was provided through in person, verbal over the phone, and/or via Trilogy Wordrede app. Education was completed on 7/4/24. After 7/4/24, any newly hired staff will be educated through orientation by the ED, DHS or SDC. The campus does not utilize agency staff. 4. Describe the Quality Assurance & Process Improvement Program that will be put into place (track and trend data over time to ensure action plan met the initially identified goal). a. An Ad Hoc Quality Assurance meeting was held on 6/10/24 with the following, Medical Director, Administrator, Social	

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F 600	Continued From page 7 During an interview on 06/18/2024 at 1:11 PM, CRCA10 stated R7 had been pushing another resident around in a wheelchair, but at some point, the residents decided they wanted to go home. She stated R7 went toward the 700 Hall exit door. She stated she heard the door alarm, and she went to the door. CRCA10 stated R7 attempted to exit with the resident she was pushing in the wheelchair. She stated she and CRMA7 attempted to re-direct the residents. CRCA10 stated she got the wheelchair-bound resident out of the immediate area and turned back to R7 and CRMA7. CRCA10 stated she observed CRMA7 holding R7's arms firmly, but then R7 got loose and smacked the glasses off CRMA7's face. She stated then CRMA7 smacked R7's face, and she heard her head make contact with the wall. CRCA10 stated she reinforced verbally for CRMA7 to let R7 go, and CRCA6 went to get the nurse. During an interview on 06/19/2024 at 9:29 AM with CRCA6, she stated she was picking up dishes at the end of dinner and was working with another resident, when CRCA10 went around the corner toward the 700 Hall exit door, near the nurses' station. She stated CRNA10 reported to CRCA6 that she could see CRMA7, in the corner, physically holding R7's arms. She stated, by this time, she had joined CRCA10. She stated R7 got loose and hit the glasses off CRMA7's face. She stated she then saw CRMA7 slap R7 in response and heard R7's head hit the wall. When asked if it might have been a defensive move and the slap was accidental, CRCA6 stated, "No, it all happened too fast and there was no time for R7 to have attempted to hit CRMA7 before the slap to R7." CRCA6 was asked about the statement provided by the weekend supervisor and her	F 600	Services (SSD), MDS, Legacy Neighborhood Director (LND), Assistant Director of Health Services (ADHS, Director of Health Services (DHS), Business Office Manager (BOM) regarding recent incident from 6/7/24 of failing to ensure Trilogy abuse policy was followed to prevent, protect, report, and removing the alleged perpetrator with initiation of campus abuse investigation checklist. b. Starting on 6/14/24, as part of the facility□s ongoing quality improvement plan the DHS, ADHS, ED, Administrator, SDC, and Clinical Support will interview a total of three staff members weekly until the immediacy was lifted on 6/15/24, and then weekly x 4 weeks, then monthly x 5 months by asking questions related to our abuse protocol. This will ensure staff members have retained the education provided on Trilogy□s abuse policy and procedure. c. The monthly QAPI meeting was held on 7/10/24 where the audits, POC, and abuse policy was discussed, as all unusual occurrences and facility reported incidents are discussed monthly. The Executive Director, Administrator, or Director of Health Services will present the findings of this audit to the Quality Assurance and Performance Improvement Committee (QAPI) consisting of Executive Director, Administrator, Director of Health Services, Assist Director of Health Services, Medical Director weekly until the immediacy is lifted then monthly. The QAPI meetings will determine when	

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F 600	Continued From page 8	F 600		

report that CRCA6 did not have a direct vision of events. CRCA6 stated that was not true. She stated, "They have their reasons." CRCA6 stated she and CRCA10 verbally tried to get CRMA7 to "just let her go." She stated CRCA10 separated R7 and CRMA7, while CRCA6 got LPN2.

During a phone interview on 06/20/2024 at 8:50 AM, LPN2 stated she was at the 700 Hall nurses' station, and R7 was ambulating and pushing another resident around in a wheelchair. She stated the 700 Hall's exit door alarm sounded, and CRMA7 and CRCA10 went to it. She stated R7 became more agitated with CRMA7 as manifested by the raised voices of both R7 and CRMA7. She stated CRCA6 arrived, and CRCA10 took the wheelchair resident away from the area. She stated she could see through a glass window that CRMA7 had her arms extended out and was yelling at R7, and R7 was yelling back. She stated she and CRCA6 separated CRMA7 and R7. She stated she took R7 outside and told CRCA6 to call the DHS, which CRCA6 did at 6:20 PM. She stated R7 was very upset and hard to console for a little while, although R7 could not express why she was upset. She stated the nursing shift ended at 6:30 PM, and LPN2 observed CRMA7 counting her medications on her cart and giving a report to the oncoming shift. LPN2 stated CRMA7 clocked out but remained at the nurses' station desk, on her phone watching a video, after her shift. She stated CRMA7 did leave before LPN2, who clocked out at 7:00 PM (this was verified by LPN2's timesheet).

During an interview on 06/21/2024 at 9:25 AM with the DHS and the Corporate Clinical Support present, she stated residents were allowed to

compliance is achieved or if ongoing monitoring is required.

Attachment #1: Abuse and Neglect Procedural Guidelines

Date of Compliance 7/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185470	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT HAMBURG	2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9 wander because staff knew them and tried to anticipate their actions. About the incident on 06/07/2024, she stated she was contacted by CRCA6 at 6:20 PM, and she immediately reported this to the Executive Director. The DHS stated the determining factor in deciding this was not a substantiated case were the witness comments that they "thought" or "didn't hear." The DHS stated she would expect to be notified immediately if there was a concern about abuse. She stated she was content with the chain of events and the timeline as they occurred. During an interview on 06/19/2024 at 9:48 AM with the Executive Director (ED), he stated he was not sure CRMA7 hit R7, or with intent, because he was hearing inconsistencies with the stories from the staff involved. He stated CRMA7 was terminated because she did not rise to the facility's standards. He stated that CRMA7 had received previous disciplinary action related to her tone with other residents.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607		7/11/24

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F 607	Continued From page 10 §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's investigation reports, and review of the facility's policy, the facility failed to ensure its staff implemented the facility's abuse policy regarding immediately providing for the safety of the resident after her allegations of physical and verbal abuse by staff for 1 of 8 sampled residents (Resident #7(R7)). Additionally, review of the facility's policy revealed the policy failed to include guidance to equip staff with the knowledge to be able to communicate and coordinate situations of abuse with the facility's Quality Assurance and Performance Improvement (QAPI) program. On 06/07/2024 at approximately 5:50 PM Certified Resident Care Aide (CRCA) 6 and CRCA10 observed Certified Resident Medication Aide (CRMA) 7 become argumentative and physically aggressive with R7 including, but not limited to, a slap on R7's face. They both could hear what sounded like R7's head hitting the wall	F 607	1. (Corrective actions for identified resident(s) affected by the deficient practice.) a. LPN(2) immediately intervened and separated CRMA(7) and R(7) when observing the incident at approximately 5:50 pm according to LPN(2), CRNA(6), and CRNA(10) interviews. b. (R)7 was immediately removed from the incident by LPN(2) to ensure the safety of (R)7 in accordance with our abuse protocol. RN performed a head-to-toe assessment on (R)7 with no acute signs of injury. The RN assessment found the resident had old fading bruising that was determined to be contributed to lab draws. The bruising was described as old and fading in anatomical locations prone to venous blood draws. This was also later confirmed by the phlebotomy documentation and Bruise Event opened	

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F 607	Continued From page 11	F 607		

at the same time as the smack. CRCA6 contacted the Director of Health Services (DHS) at 6:20 PM. Per review of CRMA7's timesheet, she did not clock out until 6:39 PM. Therefore, CRMA7 was not sent home immediately but remained in the facility approximately 50 minutes after the incident occurred.

The facility's failure to have an effective system to ensure residents were protected from verbal and physical abuse by immediately securing the safety of the resident from the alleged perpetrator was likely to cause serious injury, impairment, or death.

Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on 06/21/2024 at CFR 42 483.12 Develop/Implement Abuse/Neglect Policies (F607) at the highest Scope and Severity (S/S) of a "J." The IJ was determined to exist on 06/07/2024. The facility was notified of the Immediate Jeopardy on 06/21/2024.

An acceptable "Immediate Jeopardy Removal Plan" was received on 06/28/2024 and validated before exit on 07/03/2024. The IJ removal was on 06/15/2024. The deficient practice remained at a S/S of a "D" following the removal of the immediate jeopardy so the facility could develop their abuse policy to define how staff would communicate and coordinate situations of abuse with the QAPI program.

Refer to F600

The findings include:

Review of the facility's policy titled, "Abuse,

on 5/27/24.

c. CRMA(7) was immediately escorted from the patient care area to the corner of the nurse□s station and seated in a chair within visual sight of the RN. CRMA(7) remained under 1:1 staff supervision while CRMA(7) and RN completed narcotic shift count and giving report. The Director of Health Services (DHS) was notified of the incident at 6:20 pm by CRNA(6). The Executive Director (ED) was then made aware of the incident by the DHS at 6:23 pm. (CRMA)7 was then asked to leave the premises after the narcotic shift count and report was given to the RN. (CRMA) 7 had a documented punch out time of 6:39 pm. The ED contacted (CRMA) 7 at 6:50 pm and informed her that she was suspended pending investigation until further notice. The Legacy Coordinator confirmed on 6/8/24 the department leader contact information including the DHS and ED was on a laminated posting at the nurses station.

d. R(7) was interviewed on 6/7/24 at approximately 8:59 pm by RN post incident to ensure R(7) was not psychosocially affected by the incident. The resident indicated she had no recollection of the event. RN performed a head-to-toe assessment on (R)7 with no acute signs of injury. Based on the RN assessment, it was determined R(7) had no evidence of changes from her baseline. According to RN, R(7) clinically appeared to be in her normal, pleasant mood.

e. The ED initiated our internal abuse investigation on 6/7/24, and reported the

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F 607	Continued From page 12	F 607		

Neglect - Procedural Guidelines," dated 08/29/2019, revealed that for the protection of the resident, upon identifying suspected abuse or neglect, immediately provide for the safety of the resident. This action might include, but was not limited to, suspending the suspected employee pending the outcome of an investigation. Further review revealed the policy failed to address how staff would communicate and coordinate situations of abuse with the QAPI program.

Review of the same policy, "Abuse, Neglect - Procedural Guidelines," updated 06/19/2024, revealed this version of the policy also failed to address how staff would communicate and coordinate situations of abuse with the QAPI program.

Review of the Centers for Medicare and Medicaid (CMS) State Operations Manual (SOM), Appendix PP, 42 CFR 483.12 (b)(4), dated 02/03/2023, revealed the facility's abuse policy should define how staff would communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program.

Review of the facility's "Long Term Care Facility - Self Reporting Incident Form Facility Reported," dated 06/07/2024, revealed the incident between R7 and CRMA7 occurred at 5:50 PM on 06/07/2024. Further review of the report revealed it was submitted to the State Survey Agency (SSA) on 06/07/2024 at 7:55 PM.

Review of the facility's initial "Investigation Report," dated 06/07/2024 at 7:55 PM, indicated CRMA7 had contact with R7's head after R7 struck her. There was no indication via skin

incident to appropriate state agencies, local authorities, and applicable parties.
f. R(7) still resides at our facility and has shown no adverse effects from the incident. The resident□s psychosocial status remains at baseline. R(7) was observed by APRN on 6/10/24 with no signs of any emotional distress related to the recent event.
g. R(7) was seen by psych services prior to the incident on 6/5/24 due to pre-existing history of anxiety and periods of tearfulness. Psych recommendations to increase resident□s Lexapro from 10 mg daily to 20 mg daily. The recommendations were reviewed with ARNP on 06/09/24 and she agreed to the recommendations.
h. Upon concluding the investigation, CRMA(7) was terminated by the ED on 6/12/24 due to findings of misconduct.

2. (Identification of other residents who may be affected by the deficient practice and corrective actions that will be put in place to ensure the deficient practice does not reoccur.)
a. All residents residing on the Memory Care Unit at The Willows at Hamburg have the potential to be affected by the deficient practice.
b. LPN(2) and RN completed a one-time head to toe skin assessment of all residents residing on the Legacy Neighborhood on 6/7/24 to determine if there was any other residents who exhibited any suspicious bruising and/or evidence of possible abuse. There were

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F 607	Continued From page 13 assessment that there was physical injury other than an old bruise on the left bicep. Per the report, the resident was taken for a walk by Licensed Practical Nurse (LPN) 2. The report stated R7 did not recall the event when interviewed by facility staff, immediately after and in the days to follow. Per the report, the Executive Director called the facility to suspend the staff member (on 06/07/2024, no time given), but CRMA7 had already left. Review of CRMA7's 06/07/2024 timesheet, revealed she clocked out at 6:39 PM in the memory care building. During an interview on 06/19/2024 at 9:29 AM with CRCA6, she stated she was picking up dishes at the end of dinner and was working with another resident, when CRCA10 went around the corner toward the 700 Hall exit door, near the nurses' station. She stated CRNA10 reported to CRCA6 that she could see CRMA7, in the corner, physically holding R7's arms. She stated, by this time, she had joined CRCA10. She stated R7 got loose and hit the glasses off CRMA7's face. She stated she then saw CRMA7 slap R7 in response and heard R7's head hit the wall. When asked if it might have been a defensive move and the slap was accidental, CRCA6 stated, "No, it all happened too fast and there was no time for R7 to have attempted to hit CRMA7 before the slap to R7." CRCA6 stated she and CRCA10 verbally tried to get CRMA7 to "just let her go." She stated CRCA10 separated R7 and CRMA7, while CRCA6 got LPN2. During a phone interview on 06/20/2024 at 8:50 AM, LPN2 stated she was at the 700 Hall nurses' station, and R7 was ambulating and pushing	F 607	no other findings based off campuses assessment. c. Beginning 6/8/24, the ED initiated interviews to alert and oriented residents. The ED completed 3% of alert and oriented resident interviews as the CRMA (7) had not recently worked on the Health Center. d. Beginning on 6/8/24, residents that reside on the Health Center received a weekly skin assessment by their assigned perspective nurse with no new skin issues or signs of abuse. This was completed on 6/14/24. e. CRMA(7) has not worked on the Health Center since 5/20/24. f. A resident council meeting was held on the Health Center and Assisted Living on 6/4/24 with no concerns voiced of abuse, neglect, or exploitation. g. A one-time audit of the grievance log was reviewed on 6/14/24 to ensure no concerns were raised regarding abuse with no findings. 3. (Measures put in place and systemic changes you will make to ensure that the deficient practice does not reoccur.) a. The Trilogy Health Services Campus Clinical Support Nurse provided re-education to the DHS, ED, and Assistant Director of Health Services (ADHS) via phone post event on 6/7/24 regarding Trilogy policy and procedures on abuse, identification, appropriate interventions, protection, identification of others at risk, residents with aggressive	

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F 607	Continued From page 14 another resident around in a wheelchair. She stated the 700 Hall's exit door alarm sounded, and CRMA7 and CRCA10 went to it. She stated R7 became more agitated with CRMA7 as manifested by the raised voices of both R7 and CRMA7. She stated CRCA6 arrived, and CRCA10 took the wheelchair resident away from the area. She stated she could see through a glass window that CRMA7 had her arms extended out and was yelling at R7, and R7 was yelling back. She stated she and CRCA6 separated CRMA7 and R7. She stated she took R7 outside and told CRCA6 to call the DHS, which CRCA6 did at 6:20 PM. She stated R7 was very upset and hard to console for a little while, although R7 could not express why she was upset. She stated the nursing shift ended at 6:30 PM, and LPN2 observed CRMA7 counting her medications on her cart and giving a report to the oncoming shift. LPN2 stated CRMA7 clocked out but remained at the nurses' station desk, on her phone watching a video, after her shift. She stated CRMA7 did leave before LPN2, who clocked out at 7:00 PM (this was verified by LPN2's timesheet). During an interview with the DHS on 06/21/2024 at 9:25 AM, she stated in the event of any type of abuse, she would expect to be notified immediately if there was a concern about abuse. She stated she was notified at 6:20 PM by CRCA6, approximately 30 minutes after the incident occurred. She stated she was satisfied with the timing of events, and she felt staff contacted her as fast as they were able. The DHS stated she reported the incident to the Executive Director immediately. During an interview with the Corporate Clinical	F 607	behaviors, immediate notification and reporting with suspension and removal of any employee once allegations of abuse are made against them, and prevention of abuse by recognizing burnout and stress. b. Once the DHS, ED, and ADHS were provided re-education, then beginning on 6/7/24 the above referenced education was provided to 100% of staff (nursing staff, housekeeping, laundry, dietary, department leaders, therapy, and plant operations) with a follow-up posttest to ensure knowledge of information provided. Education was provided through in person, verbal over the phone, and/or via Trilogy Wordrede app. Education was completed on 6/14/24. After 6/14/24, any newly hired staff will be educated through orientation by the SDC or DHS. The campus does not utilize agency staff. c. On 7/2/24, According to the surveyor□s request, Trilogy Health Services Policy on Abuse was updated to include the following verbiage from the State Operations Manual- Appendix PP (VIII), how staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program under ¿483.75. The new policy is attached, see page 3, g) Reporting/Response, i □ Campus staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program. d. On 7/2/24, addendum education was initiated to 100% of staff (nursing staff, housekeeping, laundry, dietary,	

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F 607	Continued From page 15 Support Nurse on 07/03/2024 at 11:16 AM, she stated, after an abuse allegation or observation, her expectation was for staff to take action to ensure the resident's safety, separate the alleged perpetrator from the resident, escort the alleged perpetrator out of the building, and immediately report the abuse to the supervisor and/or the Executive Director. She also stated she felt the facility incorporated the components of the QAPI requirement in their abuse investigations. She stated the abuse policy might not detail the exact verbiage of the QAPI requirement but thought other tools that were used facilitated meeting that requirement.	F 607	department leaders, therapy, and plant operations) by the Executive Director, Administrator and Director of Health Services. Education was provided through in person, verbal over the phone, and/or via Trilogy Wordrede app. Education was completed on 7/4/24. After 7/4/24, any newly hired staff will be educated through orientation by the ED, DHS or SDC. The campus does not utilize agency staff. 4. Describe the Quality Assurance & Process Improvement Program that will be put into place (track and trend data over time to ensure action plan met the initially identified goal). a. An Ad Hoc Quality Assurance meeting was held on 6/10/24 with the following, Medical Director, Administrator, Social Services (SSD), MDS, Legacy Neighborhood Director (LND), Assistant Director of Health Services (ADHS, Director of Health Services (DHS), Business Office Manager (BOM) regarding recent incident from 6/7/24 of failing to ensure Trilogy abuse policy was followed to prevent, protect, report, and removing the alleged perpetrator with initiation of campus abuse investigation checklist. b. Starting on 6/14/24, as part of the facility□s ongoing quality improvement plan the DHS, ADHS, ED, Administrator, SDC, and Clinical Support will interview a total of three staff members weekly until the immediacy was lifted on 6/15/24, and then weekly x 4 weeks, then monthly x 5 months by asking questions related to our abuse protocol. This will ensure staff	

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F 607	Continued From page 16	F 607	members have retained the education provided on Trilogy□s abuse policy and procedure. c. The monthly QAPI meeting was held on 7/10/24 where the audits, POC, and abuse policy was discussed, as all unusual occurrences and facility reported incidents are discussed monthly. The Executive Director, Administrator, or Director of Health Services will present the findings of this audit to the Quality Assurance and Performance Improvement Committee (QAPI) consisting of Executive Director, Administrator, Director of Health Services, Assist Director of Health Services, Medical Director weekly until the immediacy is lifted then monthly. The QAPI meetings will determine when compliance is achieved or if ongoing monitoring is required. Attachment #1: Abuse and Neglect Procedural Guidelines Date of Compliance 7/11/24	