STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185482	A. BUILDING _____ B. WING _____	R 05/09/2025

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

(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 000}	INITIAL COMMENTS An off-site Revisit Survey was initiated and concluded on 05/09/2025. It was determined the facility had achieved substantial compliance on 05/07/2025 as alleged. Based upon the implementation of the acceptable Plan of Correction, the facility was deemed to be in compliance on 05/07/2025, as alleged.	{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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0000	INITIAL COMMENTS A Recertification and Abbreviated Survey was concluded on 04/04/2025. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. A deficiency was issued related to KY00045384 at F584. No deficiencies were issued related to KY00039662, KY00039851, KY00040970, KY00043928, and KY00045226. Survey Dates: 04/01/2025 to 04/04/2025 Survey Census: 45 Sample Size: 14 Supplemental Residents: 7	F0000		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents	F0578	F 578 It is and was on the days of survey the policy of the facility to ensure the right to refuse, request, and /or stop treatment to take part in or refuse in experimental research and to formulate an Advance Directive. Per the statement of deficiencies, the facility did not inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and at the resident s option, formulate an advance directive for 3 of 5 residents reviewed for advance directives. 1.Resident 5 was admitted on 12/18/24. This resident was notified regarding the facilities responsibility to make the necessary provisions to inform and provide written information to all residents and/or responsible parties if applicable concerning the right to accept or refuse medical or surgical treatment, and at the time formulate an Advance Directive. Advance Directives were received and scanned into the residents medical record on 4-27-2025.	05/07/2025

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0578 SS = D	Continued from page 1 concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive for 3 of 6 residents reviewed for advance directives, Resident (R) 5, R36, and R42. The findings include: Review of the facility's policy titled, "Guidelines for Advance Directives," revised 09/26/2024, revealed its purpose was to ensure the facility's staff obtained and followed residents' advance directives regarding end-of-life care. Further review revealed if a resident had a living will and a durable power of attorney (POA) for health care, these documents would be scanned into the medical record by the admissions representative or designee. 1. Review of R5's "Face Sheet" revealed the facility admitted the resident on 12/18/2024 with diagnoses including dementia and atherosclerotic heart disease.	F0578	Continued from page 1 Resident 36 was admitted 02/24/24. This resident was notified regarding the facilities responsibility to make the necessary provisions to inform and provide written information to all residents and/or responsible parties if applicable concerning the right to accept or refuse medical or surgical treatment, and at the time formulate an Advance Directive. The resident had a living will which was prepared prior to admission. A copy of the living will was requested and provided by the resident s responsible party (family member 5) on 04/28/25 and was scanned into the resident s medical record on 04/28/25. Resident 42 was admitted 02/21/25. This resident was notified regarding the facilities responsibility to make the necessary provisions to inform and provide written information to all residents and/or responsible parties if applicable concerning the right to accept or refuse medical or surgical treatment, and at the time formulate an Advance Directive. Family member was contacted on 4/27/25 and states that resident does not have an Advance Directive or POA as she is her own responsible party. 2.All residents have the potential to be affected by the deficient practice. A one-time audit of current residents residing at The Willows at Fritz Farms was completed on current residents residing at the campus to ensure residents and/or their responsible party if applicable, have documented evidence that the facility is in compliance with requirements 489 483.10(g)(12) as specified in 42 CFR part 489, subpart I (Advanced Directives) regarding the facilities responsibility to make the necessary provisions to inform and provide written information to all residents and/or responsible parties if applicable concerning the right to accept or refuse medical or surgical treatment , and at the time formulate an advance Directive on 04/27/25. 3. The Trilogy Health Services Campus Clinical Support provided re-education to the Executive Director, Director of Health Services, Assistant Director of Health Services, and the campus Director of Sales about Trilogy s policy and procedure Guidelines for Advanced Directives on 04/18/25. Once trained, the Director of Health Services and the Assistant Director of Health Services provided training to the licensed nursing staff about Trilogy s policy and procedure Guidelines for Advanced Directives beginning 4/18/2025 and concluded on 4/28/2025. Any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0578 SS = D	Continued from page 2 Further review revealed Family (F) 4 was listed as R5's POA. Review of R5's admission "Minimum Data Set [MDS]," with an Assessment Reference Date (ARD) of 12/27/2024, revealed the the facility assessed the resident to have a "Brief Interview for Mental Status [BIMS]" score of one out of 15, indicating the resident was severely cognitively impaired. Review of R5's Electronic Health Record (EHR) revealed documentation of code status only. There was no evidence in the resident's chart the facility had requested and/or received a copy of R5's legal POA document. Also, the facility was unable to provide a copy of R5's legal POA document. In an interview with F4 on 04/03/2025 at 3:49 PM, she stated she was the legal POA for R5. 2. Review of R36's "Face Sheet" revealed the facility admitted the resident on 02/24/2024 with diagnoses including metabolic encephalopathy, pulmonary fibrosis, and need for assistance with personal care. Review of R36's annual "MDS," with an ARD of 02/27/2025, revealed the resident had a BIMS score of 10 out of 15, indicating the resident was moderately cognitively impaired. Review of R36's EHR revealed documentation of code status only. There was no evidence of a living will documented or located in the resident's chart. In an interview with R36 on 04/03/2025 at 9:53 AM, she stated all of her decisions would be made by her daughter, but her husband had taken care of their end-of-life paperwork. In an interview with F5, R36's family member, on 04/03/2025 at 11:55 AM, he stated R36 had a living will, and he remembered going over it with the facility when she was admitted.	F0578	Continued from page 2 licensed nursing staff member who had not completed the required education and post test in person was educated and post tested by the Director of Health Services and/or Assistant Director of Health Services by phone prior to returning to work. A post test requiring 100% accuracy was completed to ensure educational information was retained. If 100% was not achieved, the staff member was educated until 100% was achieved. The facility does not employ agency staff. Education was completed on 4/28/25. Any newly hired admissions and licensed nursing staff will be provided the above-mentioned education as a part of their facility Onboarding. A post test requiring 100% accuracy will be completed to ensure educational material is retained. If 100% is not achieved, the staff member will be educated until 100% is achieved. It will be the responsibility of the Sales Director and/or the Admissions Coordinator at the time of admission to review Advanced Directives with the resident and responsible party. A member of the Interdisciplinary Team which includes the Director of Health Services, Assistant Director of Health Services, Director of Social Services, and MDS Coordinator will review and update quarterly and as needed according to policy and procedures beginning 5/6/2025. 4.A Quality Assurance meeting was held on 04/08/25 with the Medical Director regarding the above referenced findings from the cited deficiency as well as our process for ensuring residents Advanced Directives are reviewed by the Admissions Coordinator at time of admission regarding making the necessary provisions to inform and provide written information to all residents and/or responsible parties concerning the right to accept or refuse medical or surgical treatment, and at the time formulate an Advance Directive. A member of the IDT will review and update quarterly, and as needed, according to the policy and procedures. Members of the IDT include the Director of Health Services, Assistant Director of Health Services, Director of Social Services, and MDS Coordinator. Starting on 04/29/25 as part of the facility s ongoing quality improvement plan, the Director of Health Services and Assistant Director of Health Services will review a cumulative total of three resident records for evidence of documented Advanced Directives weekly x 4 weeks, then monthly x 5 months to ensure compliance with the above referenced regulation. The Director of Health Services and/or Assistant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0578 SS = D	Continued from page 3 3. Review of R42's "Face Sheet" revealed the facility admitted the resident on 02/21/2025 with diagnoses including paralysis of left side following a stroke, osteoarthritis, and personal history of breast cancer. Review of R42's admission "MDS," with an ARD of 02/25/2025, revealed the resident had a BIMS score of 13 out of 15, indicating the resident was cognitively intact. Review of R42's EHR revealed documentation of code status only. There was no evidence of a living will or evidence the facility presented living will information to the resident documented in her chart. In an interview with R42 on 04/03/2025 at 11:33 AM, she stated she had a living will but was not sure what it specified. She further stated her son took care of information like that, and he should have provided it. When shown a "Living Will Packet," the resident stated it looked familiar. In an interview with the Admissions Coordinator on 04/03/2025 at 2:30 PM, he stated as soon as residents came in to the facility, he obtained their code status, introduced them to staff, and went over each paper in the admission agreement in a way they understood. The Admissions Coordinator stated he asked the resident and/or their POA if they had an advance directive in place, and if they did, he requested a copy so it could be placed in the resident's EHR. He further stated he completed a progress note in the resident's EHR that stated the resident had some type of Advance Directive, and it had been requested. The Admissions Coordinator stated the previous admissions person completed R42's admission, and he did not recall that R36 informed him of an advance directive. The Admissions Coordinator stated they periodically followed up with residents they knew had a living will or POA and just had not brought in a copy. The Admissions Coordinator was unable to be more specific than periodically. In an interview with the Director of Nursing (DON) on 04/04/2025 at 10:14 AM, she stated Admissions completed advance directive paperwork. She further stated if a resident's code status was not signed when they came in, nursing obtained the signature and scanned the	F0578	Continued from page 3 Director of Health Services will present the findings from the audits at the monthly QAPI Committee on 5-6-2025. The QAPI Committee will decide as to the frequency of the monitoring plan based on the findings from the above-mentioned ongoing audits. The Executive Director has the oversight to ensure an effective plan is in place to meet the residents wellbeing as well as an effective plan to find any facility concerns and implement a plan of correction. The QA Committee consists of the Executive Director, Director of Health Services, Assistant Director of Health Services, Director of Food Services, Director of Environmental Services, Life Enrichment Director, Director of Social Services, MDS Coordinator, Director of Plant Operations and the Medical Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0578 SS = D	Continued from page 4 documentation into the resident's EHR. The DON stated living will and POA documentation were completed and obtained by the Admission's office. The DON stated they had resident "first meetings" upon admission where code status and advance directives were discussed. She further stated that information was also discussed at quarterly care plan meetings, where the care plans were reviewed and discussed with staff/family/resident. The DON stated if the resident wanted to change their status that included palliative or hospice care, the doctor became involved, and their living will was addressed at that time as well. In an interview on 04/04/2025 at 11:15 AM, the Executive Director stated residents were given the opportunity upon admission, to make an advance directive if they had not already done so. She further stated they tried to get copies of existing living wills and/or POAs for the residents' medical records. The Executive Director stated if a resident stated they had an advance directive in place, the resident and family should be interviewed about their wishes at admission, so that information was known and documented until the legal documentation had been received. The Executive Director stated a "resident first" meeting was held right after admission and advance directives were addressed at that meeting. She further stated the subject was addressed again in quarterly care plan meetings. The Executive Director stated it was important they had regular conversations with the family, especially when a resident's health had declined. The Executive Director stated she talked with F5, and he stated R36's advance directive information was probably in some drawer at home. Additionally, the Executive Director stated communication and follow-up between the facility and the families related to advance directive documentation needed improvement.	F0578		
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike	F0584	F 584 It is and was the policy of The Willows at Fritz Farm to provide a safe, clean, comfortable, and homelike environment, allowing the residents to use his or her personal belongings to the extent possible. Per the statement of deficiencies, the facility did not provide a clean, sanitary, comfortable, and homelike environment for 1 resident. 1. The resident who lived in room 110 expired on 03/31/25 at 21:29. The carpet was replaced on 04/24/2025. 2. All residents who have an indwelling foley catheter	05/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0584 SS = E	Continued from page 5 environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of the facility's document and policy, the facility failed to provide a clean, sanitary, comfortable, and homelike environment for 1 of 4 hallways, the 100 Hall. The findings include: Review of the facility's document "Trilogy - Kentucky HC Admission Packet 10.28.24_Combined," undated, revealed under the Resident Rights section, the resident had the right to a dignified existence, self-determination, and communication with and access	F0584	Continued from page 5 have the potential to be affected by leaking which causes significant odors. The rooms of the three residents identified as having Foley catheters have been reviewed during room rounds performed by the Director of Health Services on 04/26/25 to ensure their catheters are not leaking and there are no foul odors in their room thus providing a safe, clean, comfortable, and homelike environment. There were no other findings. The Environmental services conducted room rounds throughout the campus for odors on 04/28/25. There were no other concerns found at the time of the rounds. 3. The Trilogy Health Services Campus Clinical Support provided re-education to the Executive Director, Director of Health Services, and Assistant Director of Health Services regarding Trilogy s policy and procedure Preserving Dignity with Indwelling Catheter and regulation F584 483.10(I)(1) A Safe, Clean, Comfortable, Homelike Environment on 04/18/25. The Executive Director provided re-education to the Director of Environmental Services about Trilogy s policy and procedures SOP Cleaning Health Care Rooms and regulation F584 483.10(i)(1) A Safe, Clean, Comfortable, Homelike Environment on 4/27/2025. The Director of Health Services and the Assistant Director of Health Services, once educated, then provided re-education to the licensed nursing staff regarding Trilogy s policy and procedures Preserving Dignity with Indwelling Catheter and regulation F584 483.10(i)(1) A Safe, Clean, Comfortable, Homelike Environment that was initiated on 04/18/25 and completed on 4/28/2025. Any staff member who had not completed the required education and post test in person was educated and post tested by the Director of Health Services and/or Assistant Director of Health Services by phone prior to returning to work. A post test requiring 100% accuracy was completed to ensure educational information was retained. If 100% was not achieved, the staff member was educated until 100% was achieved. The facility does not employ agency staff. Education was completed on 4/28/25. Any newly hired licensed nursing staff will be provided the above-mentioned education as a part of their facility Onboarding. A post test requiring 100% accuracy will be completed to ensure educational material is retained. If 100% is not achieved, the staff member will be educated until 100% is achieved. The Director of Health Services and the Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0584 SS = E	Continued from page 6 to persons and services inside and outside of the facility. Review of the facility's policy titled, "Urinary Catheter Care," dated 12/16/2024, revealed the facility's staff ensured there was no disconnection or leaking of urine from the catheter system. A policy that addressed homelike environment was requested but not provided. Observation on 04/01/2025 at 9:50 AM revealed a slight smell of urine upon entrance to the facility. Observation on 04/03/2025 at 9:47 AM revealed a strong urine smell in the 100 Hall. Observation on 04/04/2025 at 8:32 AM revealed a urine odor noted in the front lobby near the receptionist's desk which was located at the entrance to the 100 Hall. Observation of Room 110 on 04/03/2025 at 4:13 PM revealed the Senior Director of Environmental Services (SDEV) had just shampooed the carpet, but it still smelled of urine. In an immediate interview, the SDEV stated the room smelled like urine because a catheter leaked onto the carpet. She further stated the smell might not come out, and the carpet would need to be replaced. In a telephone interview with Family (F) 3 on 04/03/2025 at 3:23 PM, he stated when his family member was a resident at the facility and resided in Room 110, it was a recurrent issue that his catheter leaked. He further stated, he noted on several occasions when he visited the facility there was a towel on the floor underneath the catheter drainage bag. F3 stated there was a blue plastic bag that went around the catheter bag that kept it from leaking, but it was not always there, and the bag leaked onto the carpet. In an interview on 04/04/2025 at 8:25 AM, Registered Nurse (RN) 4 stated the resident that previously resided in Room 110 was easily angered, frequently refused catheter care, and refused to let staff change his shorts when they were wet. RN4 stated anytime the	F0584	Continued from page 6 Environmental Services once educated, then provided re-education to the housekeeping staff regarding Trilogy s policy and procedures SOP Cleaning Health Care Rooms and regulation F584 483.10(i)(1) A Safe, Clean, Comfortable, Homelike Environment that was initiated on 04/18/25 and completed on 04/28/25. Any staff member who had not completed the required education and post test in person was educated and post tested by the Director of Health Services and/or Assistant Director of Health Services by phone prior to returning to work. A post test requiring 100% accuracy was completed to ensure educational information was retained. If 100% was not achieved, the staff member was educated until 100% was achieved. The facility does not employ agency staff. Education was completed on 4/28/25. Any newly hired housekeeping staff will be provided the above-mentioned education as a part of their facility Onboarding. A post test requiring 100% accuracy will be completed to ensure educational material is retained. If 100% is not achieved, the staff member will be educated until 100% is achieved. 4. A Quality Assurance meeting was held on 04/08/25 with the Medical Director regarding the Facility providing a safe, clean, comfortable environment, allowing the resident to use their own personal items as much as possible. Starting on 04/29/25, as part of the facility s ongoing quality improvement plan, the Director of Health Services and Assistant Director of Health Services will review a cumulative total of three resident records of residents with indwelling catheters x 4 weeks, then monthly x 5 months to ensure the resident s catheter is not leaking, the dignity bag is in place, and the room is free from odors. Starting on 04/29/25, as part of the facility s ongoing quality improvement plan, the Director of Environmental Services will complete room rounds on a cumulative total of three residents x 4 weeks, then monthly x 5 months to ensure compliance with the above referenced regulation regarding providing the residents with a room that is free from odors, safe, and homelike. The Director of Health Services and/or Assistant Director of Health Services and the Director of Environmental Services will present the findings from the audits at the monthly QAPI Committee on 5-6-2025. The QA Committee will decide on the ongoing frequency as to the frequency of the monitoring plan based on the findings from the above-mentioned ongoing audits. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0584 SS = E	Continued from page 7 resident's catheter drainage bag leaked, it was changed. She further stated Housekeeping cleaned the carpet because of the urine odor that lingered in the room, and it smelled in the hallway as well. In an interview on 04/04/2025 at 8:34 AM, the SDEV stated it was important to clean urine from the carpet so residents felt like their home was clean, and they were in a good facility. In an interview on 04/04/2025 at 8:58 AM, Licensed Practical Nurse (LPN) 2 stated if she noticed a resident's catheter bag leaked and could not determine the cause, she notified an RN to see if it needed to be replaced. She further stated she placed a dignity cover around the drainage bag, so it was contained and kept off the carpet until it was changed. LPN2 stated it was demeaning if a resident lived in a room that smelled like urine, and no one wanted that. In an interview with the Director of Nursing (DON) on 04/04/2025 at 10:14 AM, she stated their goal was the facility was kept free from odors, but incontinence issues were unavoidable. However, she further stated it was her expectation incontinence issues were cleaned immediately, and the carpet replaced if necessary. The DON stated it was initially thought the resident that previously resided in Room 110 had an issue with a catheter bag that leaked. However, she stated it was later determined an aide had not properly closed the drainage bag, so in-services were held, and aides were re-educated on catheter care. The DON stated she did not remember a specific reoccurrence with the catheter leaking issue, but if it had reoccurred Environmental Services would have cleaned the carpet. The DON stated she thought the Executive Director was going to have the carpet replaced again. The DON stated the facility was a resident's home, so they tried to ensure it was kept as clean as possible without lingering odors because it was a dignity issue. In an interview on 04/04/2025 at 11:15 AM, the Executive Director stated the resident that previously resided in Room 110 was very challenging and refused assistance frequently. She stated he often refused to wear briefs and missed the urinal when he tried to use it. She stated she did not recall exactly when the resident received a catheter but recalled instances where the aide had not properly clamped the catheter, and it was a constant challenge. She stated the carpet	F0584	Continued from page 7 Executive Director has oversight to ensure an effective plan is in place to meet the residents wellbeing as well as an effective plan to find facility concerns and implement a plan of correction. The QA Committee consists of the Executive Director, Director of Health Services, Assistant Director of Health Services, Director of Food Services, Director of Environmental Services, Life Enrichment Director, Director of Social Services, MDS Coordinator, Director of Plant Operations and the Medical Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0584 SS = E	Continued from page 8 in Room 110 was changed about a year ago while the resident was still in the room, and the Environmental Services Director had tried to clean it since then. She stated the carpet might have to be replaced again because no one wanted to live in a house that had an offensive odor. The Executive Director further stated they wanted the facility to be odor free, so they did not make a bad first impression.	F0584		
F0623 SS = D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under	F0623	F623 Notice Requirements before transfer discharge. Per the statement of deficiencies, the facility failed to notify the resident and the resident s representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility did not send a copy of the notice to a representative of the Office of State Long-Term Care Ombudsman. 1. Resident 5 was admitted to the facility on 12/18/2024. Her most recent BIM score was a 1, which shows the resident is cognitively impaired. She was hospitalized from 01/11/2025 - 01/14/2025 for right hip pain. The resident is still in the facility currently. Resident 10 was admitted on 02/17/2025. Her most recent BIMS revealed a 15 out of 15 which means she is cognitively intact. On 02/16/2025 she experienced a sudden onset of uncontrolled muscle movement. The resident s daughter was present in the facility, and she requested her mother to be sent to acute care. The transfer/discharge form, bed hold policy and notification were completed. These forms would have been given to the resident since she was cognitively intact. 2. All residents have the potential to be affected by this deficient practice. 3. The Trilogy Health Services Campus Clinical Support provided re-education to the Executive Director, Social Service Director, Director of Health Services, and the Assistant Director of Health Services regarding Trilogy s policy and procedures referencing Guidelines for Transfer and Discharge (including AMA) and the above referenced regulation regarding Bed Hold policy and notice to the Ombudsman notification on 4/11/2025. The Executive Director provided re-education to the Director of Social Services regarding Ombudsman notification that was initiated on 04/18/25. The DHS developed a transfer/discharge packet which	05/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0623 SS = D	Continued from page 9 paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must	F0623	Continued from page 9 includes the transfer/discharge notice, bed hold notice, bed hold policy and the requirement to notify the Ombudsman of the transfer/discharged, and a copy of the regulatory requirements related to transfer and discharge. These packets are being stored at each nurse s station. In addition, a discharge checklist is available to help in guiding the nurses. The Director of Health Services and the Assistant Director of Health Services once trained, then provided re-education to the licensed nursing staff regarding Trilogy s policy and procedures regarding Guidelines for Transfer and Discharge (including AMA) , the above referenced regulation regarding our Bed Hold policy, the Ombudsman notification of transfer and discharge, and the new transfer/discharge reference packet and it s use began on 4/18/25 and completed on 4/28/2025. The start date for the use of the new transfer/discharge packets was 4/29/2025. Any staff member who had not completed the required education and post test in person was educated and post tested by the Director of Health Services and/or Assistant Director of Health Services by phone prior to returning to work. A post test requiring 100% accuracy was completed to ensure educational information was retained. If 100% was not achieved, the staff member was educated until 100% was achieved. The facility does not employ agency staff. Education was completed on 4/28/25. Any newly hired licensed nursing staff and Social Services staff will be provided the above-mentioned education as a part of their facility Onboarding. A post test requiring 100% accuracy will be completed to ensure educational material is retained. If 100% is not achieved, the staff member will be educated until 100% is achieved. 4. A Quality Assurance meeting was held on 04/08/25 with the Medical Director regarding the above referenced findings from the cited deficiency as well as our process for ensuring residents that are temporarily transferred on an emergency basis to an acute care facility have notifications to the resident and the resident s representative(s) regarding the residents transfer and/or discharge from the campus along with the reasoning for the discharge in writing and in a language and manner that they understand as soon as practicable before transfer. This plan will also ensure the notice of emergency transfer to the Office of the State Long-Term Care Ombudsman monthly or as soon as practicable. Starting on 04/29/25 as part of the facility s ongoing quality improvement plan, the Director of Health	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0623 SS = D	Continued from page 10 update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understood. The facility further failed to send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 2 of 2 residents investigated for hospitalizations, Resident (R) 5 and R10. The findings include: Review of the facility's policy/document titled, "Transfer/Discharge - Bed Hold Notification Process," undated, revealed a transfer/discharge notice was to be filled out at the time of transfer or discharge and included in the transfer packet that was sent with the resident. Further review revealed the Social Services Director (SSD) would notify the ombudsman as soon as possible, and this could be done via email. Additional review revealed the Business Office Manager (BOM), or designee would contact the resident/family/Power of Attorney (POA) and document the conversation in the "Resident Messages" portion of the resident's medical record. 1. Review of R5's "Face Sheet" revealed the facility admitted the resident on 12/18/2024 with diagnoses including dementia and atherosclerotic heart disease. Further review revealed Family (F) 4 was listed as R5's POA.	F0623	Continued from page 10 Services and Assistant Director of Health Services will audit a cumulative total of three resident discharges x 4 weeks, then monthly x 5 months to ensure the residents who are discharged from the facility have all notifications, policies have been explained and provided to the resident or his/her responsible party, and the ombudsman has been notified per regulatory requirements. The Director of Health Services and/or Assistant Director of Health Services and Director of Social Services will present the findings from the audits at the monthly QAPI Committee on 5-6-2025. The QA Committee will decide on the ongoing frequency as to the frequency of the monitoring plan based on the findings from the above-mentioned ongoing audits. The Executive Director manages overseeing and ensuring that there is a plan in place to meet the residents' wellbeing, as well as a plan to identify facility concerns and implement corrections. The QA Committee consists of the Executive Director, Director of Health Services, Assistant Director of Health Services, Director of Food Services, Director of Environmental Services, Life Enrichment Director, Director of Social Services, MDS Coordinator, Director of Plant Operations and the Medical Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0623 SS = D	Continued from page 11 Review of R5's admission "Minimum Data Set [MDS]," with an Assessment Reference Date (ARD) of 12/27/2024, revealed the facility assessed the resident to have a "Brief Interview for Mental Status [BIMS]" score of one out of 15, indicating the resident was severely cognitively impaired. Review of R5's "Hospital Discharge Summary," revealed R5 was hospitalized from 01/11/2025 to 01/14/2025 for right hip pain and anemia. Review of R5's electronic health record (EHR) revealed no documentation that indicated a notice of transfer was provided in writing to the resident or the resident's representative. Review of the facility's document "Trilogy-Ombudsman Notification," dated 02/05/2025, revealed the facility notified the ombudsman of R5's transfer. No additional information was provided on the document that indicated information was sent in writing to the ombudsman. 2. Review of R10's "Face Sheet," revealed the facility admitted the resident on 02/17/2025 with diagnoses including metabolic encephalopathy and acute kidney failure. Review of R10's "MDS," with an ARD of 03/05/2025, revealed the resident had a "BIMS" score of 15 out of 15, indicating the resident was cognitively intact. Review of R10's "Progress Note," dated 02/18/2025, revealed the resident had a sudden onset of uncontrolled muscle movements, and the resident's daughter requested R10 be sent to the hospital for evaluation. Review of R10's "Bed Hold Notice," dated 02/18/2025, revealed Family (F) 6 signed the notice, and the resident was transferred to the hospital. In an interview with F6 on 04/03/2025 at 2:57 PM, she stated the facility called to notify her of R10's transfer to the hospital. She further stated she signed and received the bed hold notice when R10 was transferred to the hospital, but transfer paperwork was	F0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0623 SS = D	Continued from page 12 not provided to her. In an interview with Registered Nurse (RN) 5 on 04/04/2025 at 8:22 AM, she stated when a resident was transferred out of the facility, paperwork was sent with the patient to the receiving provider. RN5 further stated she was still on orientation and had not sent a resident out to the hospital. In an interview with RN4 on 04/04/2025 at 8:25 AM, she stated Continuity of Care Documents (CCD, information given to the provider to allow for a smooth transition of care) were given to Emergency Medical Services (EMS) when they picked up a resident for transfer. She further stated the facility had a transfer form that was filled out, but the form was not typically signed by or provided to the family. Additionally, RN4 stated there was a bed hold form that was signed by the family and/or the resident. In an interview with Licensed Practical Nurse (LPN) 2 on 04/04/2025 at 8:58 AM, she stated when a resident was transferred from the facility, transfer documentation was provided to the ambulance service or other transport person. She further stated nursing provided the bed hold paperwork to the resident/family. LPN2 stated the resident's family or representative was notified verbally of the transfer. In an interview with the Director of Nursing (DON) on 04/04/2025 at 10:14 AM, she stated for resident transfer, printed documents sent with the resident included orders, CCD, and the care plan. She further stated the resident was asked at that time about the bed hold. The DON stated she was not aware of documentation mailed to the resident and the resident's representative. In an interview with the Social Services Director (SSD) on 04/04/2025 at 10:43 AM, she stated she notified the ombudsman via email when a resident was transferred or discharged. The SSD stated she had not sent copies of transfer notifications or bed holds to residents and their families in the two years she had worked at the facility. She further stated those notifications were provided by nursing. In an interview with the Executive Director on	F0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0623 SS = D	Continued from page 13 04/04/2025 at 11:15 AM, she stated there was a packet that was used for bed hold and notice of transfer and discharge. She further stated that families were asked about bed holds. The Executive Director stated she was unsure if copies of any of the forms were sent to the resident and their families, and she would have to check on that.	F0623		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of the facility's document and policies, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 2 nourishment refrigerators, near the 300 Hallway. The findings include: Review of the facility's policy titled, "Food Labeling and Dating Policy," dated 04/26/2022, revealed it was the purpose of the policy to provide education and	F0812	F 812 The statement of deficiencies states that it was decided that the facility did not store, prepare, distribute, and serve food by professional standards for food service safety for the nourishment refrigerator found near the 300 hallway. 1. There were no residents found to suffer any adverse events from the above-mentioned deficiency. All residents have the potential to be affected by the deficient practice. The food items and supplements found during the time of survey were at once discarded on 04/ 04/25 by the Director of Food Service and the nourishment refrigerator cleaned. 2. All residents have the potential to be affected by this deficient practice. 3. The Trilogy Health Services Campus Clinical Support provided re-education to the Director of Dining Services, Director of Health Services, and the Assistant Director of Health Services on our policy and procedures Food brought into facility that was conducted on 04/16/25. Once the Director of Health Services and Director of Dining Services were trained, all facility staff were provided education by the Director of Health Services, Assistant Director of Health Services and the Director of Dining Services regarding our policy Food brought into facility that was initiated on 04/18/25 and concluded on 04/28/25. Any staff member who had not completed the required education and post test in person was educated and post tested by the Director of Health Services and/or Assistant Director of Health Services by phone prior to returning to work. A post test requiring 100% accuracy was completed to ensure educational information was retained. If 100% was not achieved, the staff member was educated until 100% was achieved. The facility does not employ agency staff. Education was completed on 4/28/25. All newly hired facility staff will be provided the	05/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0812 SS = E	Continued from page 14 direction on the facility's food labeling and dating guidelines. Further review found it was the facility's policy and procedure to place a printed or handwritten label for any food item brought to the facility. Per the policy, this food product label should have the received on date, production date, and the use by date for the product. The policy stated the label should also have the resident's name and the initial of the staff member that made the label. Observation of the refrigerator for residents' food near the 300 Hallway on 04/03/2025 at 9:55 AM and 10:48 AM revealed two opened tubs of pimento cheese with no resident name but a handwritten date of 03/13/2025. There were also four opened yogurt containers in a bag, 12 unopened supplement shakes, and one opened bottle of an oral rehydration solution that also replaced electrolytes, with only the manufacturers' expiration date. None of those products had resident names, received dates, or initials of staff that placed them in the refrigerator. There were two opened containers of Med Pass supplement, given to residents who needed extra nutrition for wound healing and weight gain, and an opened jar of olives that had received dates, expiration dates, and who received them written on the label, but there was no resident name of to whom they belonged. Additional observation on 04/04/2025 at 9:15 AM of the refrigerator for residents' food near the 300 Hallway revealed the tubs of pimento cheese were removed. There continued to be 12 supplement shakes that were not labeled with a resident's name, a received date, and who received them. There were still two containers of Med Pass supplement and a jar of olives that had received dates, expiration dates, and who received them written on the label, but there was no resident name of to whom they belonged. In an interview with Certified Registered Care Aide (CRCA) 1 on 04/03/2025 at 9:30 AM, she stated when staff placed any food items belonging to a resident provided by their family it should be labeled with the date received, expiration date, staff initials, and resident's name. She stated she was unsure about the yogurt, supplements, olives, and pimento cheese as to whom they belonged. In an interview with Registered Nurse (RN) 1 on 04/03/2025 at 9:51 AM, she stated she was unsure as to	F0812	Continued from page 14 above-mentioned education as a part of their facility Onboarding. A post test requiring 100% accuracy will be completed to ensure educational material is retained. If 100% is not achieved, the staff member will be educated until 100% is achieved. On 04/04/2025 the Director of Dining Services placed food labels along with pens/markers on the nourishment refrigerator near 300 halls for employees to use to label and date all resident personal food brought into facility when placed inside the refrigerator. Directions on what is needed on the food label were posted on the door of the refrigerator, as a reminder of the policy guidelines. 4. A Quality Assurance meeting was held on 04/08/25 with the Medical Director about the above referenced findings from the cited deficiency as well as our process for ensuring how the campus will check to ensure compliance with storing, preparing, distributing, and serving food in accordance with professional standards for food service safety for the nourishment in accordance with the above-mentioned regulation. Starting on 4/29/25 as part of the facility s ongoing quality improvement plan, the Director of Health Services will perform walking daily rounds to audit. The campus 3 days X 1 week, then weekly x 4 weeks, then monthly x 5 months to ensure the campus is in in compliance with the above-mentioned regulation. The Director of Health Services and/or Assistant Director of Health Services and the Director of Food Services will present the findings from the above-mentioned audits at the monthly QAPI Committee on 5/6/2025. The QA Committee will decide on the ongoing frequency as to the frequency of the monitoring plan based on the findings from the above-mentioned ongoing audits. The Administrator has the oversight to ensure an effective plan is in place to meet the residents wellbeing as well as an effective plan to show facility concerns and implement a plan of correction. The QA Committee consists of the Executive Director, Director of Health Services, Assistant Director of Health Services, Director of Food Services, Director of Environmental Services, Life Enrichment Director, Director of Social Services, MDS Coordinator, Director of Plant Operations and the Medical Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0812 SS = E	Continued from page 15 whom the yogurt, supplements, olives, and pimento cheese belonged. She stated it was the facility's policy to label foods brought from family for residents with their name and to date them. In an interview with the Assistant Director of Health Services (ADHS) on 04/03/2025 at 10:40 AM, she stated she was unsure as to whom the items in the resident refrigerator belonged. She stated it was important for foods from an outside source to be labeled with a resident's name and the date it was opened to prevent residents from eating spoiled food. She stated it would also prevent a resident from getting another resident's food to which they could be allergic that could cause an adverse reaction from the food if consumed. In an interview with the Director of Health Services (DHS) on 04/04/2025 at 10:35 AM, she stated it was the facility's policy and procedure to place a name and date on any food brought in by a resident's family. She stated it was the duty of dietary to take care of labeling and dating the food. She stated if the food was given to a nursing staff member it was her expectation that they take it to dietary to be labeled and dated. In an interview with the Director of Dietary Services (DDS) on 04/04/2025 at 9:10 PM, he stated he did not put resident foods in the refrigerator. He stated if there were unlabeled foods in the refrigerator, he would print a label that had a received by date, expiration date, and his initials when he did the daily temperature checks. However, he stated it was not his responsibility to place the name of the resident on the food item. In an interview with the Executive Director on 04/03/2025 at 2:17 PM, she stated the facility did not have a policy specifically about food brought by family to the facility but only a general policy about any food received at the facility and how it should be labeled. She stated she did not know that all foods in the residents' refrigerator should have a resident's name on them.	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F0880	F880 According to the statement of deficiencies, the facility did not set up and incorporate an infection prevention and control program designed to ensure a	05/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0880 SS = D	Continued from page 16 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will	F0880	Continued from page 16 safe, sanitary, and comfortable environment, thus not preventing the development and transmission of communicable diseases and infections. 1.Residents 31 and 36 are still at the facility and have not suffered any adverse reactions related to the deficient practice. 2. All residents have the potential to be affected by the deficient practice. All residents have been assessed by the Director of Health Services with routine infection control monitoring on 4/9/2025 and no adverse affects noted related to employee not following infection control practices related to handwashing, medication administration, enhanced barrier precautions, and donning/doffing PPE. 3. The Trilogy Health Services Campus Clinical Support provided re-education to the Director of Health Services, the Assistant Director of Health Services, and the Executive Director on our policy and procedures referencing Infection Control, Enhanced Barrier Precautions, Handwashing, and Donning/Doffing PPE on 4/18/25. Once trained, the Director of Health Services and Assistant Director of Health Services provided re-education to all nursing staff regarding our policy and procedures referencing Infection Control, Enhanced Barrier Precautions, Handwashing, and Donning/Doffing PPE that began on 04/18/25 and completed on 04/28/25. Any staff member who had not completed the required education and post test in person was educated and post tested by the Director of Health Services and/or Assistant Director of Health Services by phone prior to returning to work. A post test requiring 100% accuracy was completed to ensure educational information was retained. If 100% was not achieved, the staff member was educated until 100% was achieved. The facility does not employ agency staff. Education was completed on 4/28/2025. Any newly hired licensed nursing staff will be provided the above-mentioned education as a part of their facility Onboarding. A post test requiring 100% accuracy will be completed to ensure educational material is retained. If 100% is not achieved, the staff member will be educated until 100% is achieved. 4. A Quality Assurance meeting was held on 04/08/25 with the Medical Director about the above referenced findings from the cited deficiency as well as our	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0880 SS = D	Continued from page 17 transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, review of the enhanced barrier precaution (EBP) signage from the Centers for Disease Control and Prevention (CDC), and review of the facility's policies, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 out of 6 sampled residents, Resident (R) 31 and R36. 1. Licensed Practical Nurse (LPN) 1 with the aid of Nursing Student (NS) 1 was observed pulling up R36 in bed prior to giving her medications. R36 had signage posted on her door that stated she was on Enhanced Barrier Precautions (EBP) for a pressure ulcer. LPN1 and NS1 only had on gloves when pulling up R36 and did not have on a gown. 2. LPN1 was observed dropping a pill on the top of the medication cart and then picking it up with her ungloved hand and placing it in the pill cup with the other pills for R31. Shortly thereafter, LPN1 was observed donning (putting on) gloves prior to giving insulin and not performing hand hygiene prior to donning the gloves.	F0880	Continued from page 17 process for ensuring how the campus will check to ensure compliance with Infection Control, Enhanced Barrier Precautions, Handwashing, and Donning/Doffing PPE in accordance with the above-mentioned regulation. Starting on 04/29/25 as part of the facility s ongoing quality improvement plan, the Director of Health Services will perform observations of a cumulative of three staff members entering a rooms x 4 weeks, then monthly x 5 months to ensure staff are following Trilogy s policy and procedures for infection prevention and control when completing handwashing, Donning/Doffing PP, and when entering a residents room on Enhanced Barrier Precautions. The Director of Health Services and/or Assistant Director of Health Services will present the findings from the above-mentioned audits at the monthly QAPI Committee on 5-6-2025. The QA Committee will decide on the ongoing frequency as to the frequency of the monitoring plan based on the findings from the above-mentioned ongoing audits. The Administrator has the oversight to ensure an effective plan is in place to meet the residents wellbeing as well as an effective plan to show facility concerns and implement a plan of correction. The QA Committee consists of the Executive Director, Director of Health Services, Assistant Director of Health Services, Director of Food Services, Director of Environmental Services, Life Enrichment Director, Director of Social Services, MDS Coordinator, Director of Plant Operations and the Medical Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0880 SS = D	Continued from page 18 The findings include: Review of the facility's policy titled, "Enhanced Barrier Precautions (EBP) Standard Operating Procedure," dated 04/01/2024, revealed the policy was to provide guidance for EBP to decrease the risk of residents becoming colonized and developing infections with multidrug resistant organism (MDRO) status. Further review revealed EBP would be in place during high contact care activities for residents with a chronic wound such as a pressure ulcer. Review of the facility's signage utilized for EBP, undated and labeled as obtained from the CDC revealed: 1) everyone must clean their hands, including before entering and when leaving the room; and 2) providers and staff must also wear gloves and a gown for the following high-contact resident care activities, such as dressing; bathing/showering; transferring; changing linens; providing hygiene; changing briefs or assisting with toileting; device use or care with a central line, urinary catheter, feeding tube, and tracheostomy; or wound care for any skin opening that required a dressing. Review of the facility's policy titled, "Specific Medication Administration Procedures," revised 11/2018, revealed the procedure for administering medications in a safe and effective manner. Further review revealed staff should cleanse hands using antimicrobial soap and water or facility approved hand sanitizer before beginning medication administration, before handling medications, and before contact with a resident. Review of the facility's policy titled, "Guideline for Handwashing/Hand Hygiene," revised date 02/09/2017, revealed the purpose of the policy was to state that handwashing was the single most important factor in preventing transmission of infections. Further review revealed Health Care Workers should use hand hygiene at times such as: before and after having direct physical contact with residents and after removing gloves, etc. The policy also stated hand hygiene included washing with soap and water and using alcohol-based hand rub, depending on the situation. 1. Review of R36's "Face Sheet" from her electronic medical record (EMR) revealed the facility admitted the resident on 02/24/20204 with the medical diagnoses of	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0880 SS = D	Continued from page 19 pulmonary fibrosis, stage four pressure ulcer of sacral region, and acute cystitis. Review of R36's "Physician Orders" from her EMR, dated 02/23/2025, revealed she had an order for staff to use EBP of wearing a gown and gloves during high contact care activities. Review of R36's "Nursing Home Comprehensive (NC) Item Set Minimum Data Set [MDS]," dated 02/27/2025, revealed R36 was assessed as having a stage three pressure ulcer. Review of R36's "Comprehensive Care Plan [CCP]," 02/23/2025, revealed R36 required enhanced barrier precautions (EBP) during high contact care related to the presence of a wound. The goal for this care planned focus was the risk for transmission of infection would be minimized with use of EBP. Interventions placed were to don (put on) and doff (remove) and dispose of Personal Protective Equipment (PPE) systematically and appropriately per policy; a face mask should be used as needed. Per the CCP, staff should perform hand hygiene before and after care, per policy; staff should utilize gown and gloves per EBP policy when performing high contact activities of daily living (ADLs) such as dressing, showering/bathing, hygiene, transfers, toileting/changing briefs, and during linen changes; and staff should also utilize gown and gloves per EBP policy during indwelling device care such as central lines, urinary catheters, feeding tubes, and tracheostomies. Observation on 04/03/2025 at 8:34 AM revealed that LPN1 and NS1 entered R36's room to give medications and did not put on PPE as specified for EBP on the signage on R36's door. Further observation revealed LPN1 and NS1 pulled up R36 in bed wearing only gloves and not gowns. In an interview on 04/03/2025 at 8:34 AM with LPN1, she stated the EBP signage posted on R36's door meant that R36 had a wound and that gown, gloves, and mask/face shield should be worn when staff provided wound care but was not needed when routine care, such as pulling up a resident in bed, was performed. In an interview with Certified Registered Medication Aide (CRMA) 5 on 04/03/2025 at 9:35 AM, she stated EBP	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0880 SS = D	Continued from page 20 signage on a resident's door was placed there to let staff know the resident had a wound/pressure ulcer, catheter, ostomy, intravenous catheter (IV), etc. She stated when personal care for the resident was performed, staff should don a gown and gloves and, in some circumstances, wear a mask and/or face shield. In an interview with Certified Registered Care Aide (CRCA) 1 on 04/03/2025 at 9:30 AM, she stated for a resident with EBP precautions, staff did not need to put on a gown when dropping off a meal tray but did when providing direct resident care, such as pulling up a resident in bed, changing a resident, moving a resident, or changing a resident's sheets. In a combined interview with CRCA4 and CRCA6 on 04/03/2025 at 4:55 PM, both stated EBP was used when a resident had a wound, and staff should put on a gown, gloves, and mask/face shield each time they entered the resident's room. In an interview with CRMA3 on 04/03/2025 at 4:59 PM, she stated she did not don a gown for giving medications to a resident on EBP. In an interview with Registered Nurse (RN) 1 on 04/03/2025 at 9:51 AM, she stated EBP signage on a resident's door indicated she should wear a gown and gloves when performing wound care or perineal care for a resident with a catheter. She stated when routine care such as pulling up a resident in bed was performed a gown was not needed. In an interview with RN2 on 04/03/2025 at 10:10 AM, she stated EBP signage was placed so staff knew to be cautious about not transmitting an infection to those residents who had the signage. She stated it was for residents with a wound, catheter, etc., and staff should wear a gown and gloves when providing direct contact resident care, such as pulling up a resident in bed. 2. Observation on 04/03/2025 at 9:12 AM revealed LPN1 was preparing medications for R31 and dropped a pill onto the top of the medication cart. LPN1 was observed picking up the pill using an ungloved hand and placing it into the medication cup containing R31's other medications. Shortly thereafter, at 9:17 AM, LPN1	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0880 SS = D	Continued from page 21 finished giving R31 her medications with a spoon, but wearing no gloves, and she put on a pair of gloves without performing hand hygiene to give R31 her insulin injection. Review of R31's "Face Sheet" from her electronic medical record (EMR) revealed the facility admitted the resident to the facility on 11/04/2024 with the medical diagnoses of dementia, epilepsy, and type 2 diabetes mellitus. In an interview on 04/03/2025 at 9:12 AM with LPN1, she stated she should have put on a glove to pick up the pill she dropped onto the top of the medication cart prior to placing it into the medication cup with the remainder of R31's medications. The State Survey Agency (SSA) Surveyor asked if the top of the medication cart was clean, and LPN1 stated it was when she started medication administration at the start of her shift. LPN1 never stated she should have discarded the dropped pill and got a new one. In an interview with LPN1 on 04/03/2024 at 9:25 AM, she stated hand hygiene should be performed before putting on and after taking off gloves. In continued interview with CRCA1 on 04/03/2025 at 9:30 AM, she stated hand hygiene should be performed before putting on or changing gloves. In continued combined interview with CRCA4 and CRCA6 on 04/03/2025 at 4:55 PM, both stated hand hygiene should be performed before and after resident care and when changing or donning gloves. In continued interview with CRMA3 on 04/03/2025 at 4:59 PM, she stated she wore gloves to give medications and would perform hand hygiene and change gloves between different medication routes (pills to eye drop). In continued interview with RN2 on 04/03/2025 at 10:10 AM with RN2, she stated staff should hand sanitize before and after putting on or taking off gloves and anytime gloves were changed. RN2 stated if she dropped a pill on top of the medication cart, she would discard the pill and get a new pill for administration.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0880 SS = D	Continued from page 22 In an interview with the Assistant Director of Nursing (ADON) on 04/03/2025 at 10:48 AM, she stated her expectation was for staff to follow what the EBP signage posted on a resident's door instructed when performing care, such as giving a treatment or medication. She stated PPE (gown and gloves) should be put on prior to entering a resident's room that was on EBP precautions. She stated hand hygiene should be performed before and after care of a resident. She stated hand hygiene should also be done when changing gloves. The ADON stated if a nurse dropped a pill on the medication cart, it was her expectation that the pill be discarded and a new pill used for medication administration for that resident. She stated it was not acceptable to pick up the pill with ungloved hands and administer the pill. The ADON stated it was her expectation that during medication administration staff should wear gloves. In an interview with the Infection Prevention Nurse (IPN) who was also the Director of Nursing (DON) on 04/03/2025 at 10:40 AM, she stated EBP education was done with all staff in an online format and in person at in-services. She stated at the in-service training sessions she went over Standard Precautions, EBP, and the types of Contact Precautions along with the PPE needed when giving care. The IPN/DON stated she observed and talked with staff weekly to assess for understanding and compliance with PPE for Standard, EBP, and Contact Precautions. The IPN/DON stated staff had annual check offs for donning and doffing of PPE competencies where staff performed a return demonstration of the education. The IPN/DON stated it was her expectation when staff saw the EBP signage on a resident's door, they don the PPE outlined on the signage (gown, gloves, mask) when performing care with direct contact with the resident: bathing/showering, changing the resident, incontinence care, etc. She stated nurses should always put on a gown and gloves when entering a resident's room to give medication for a resident that was on EBP, because residents might need other care that was direct contact care. She stated pulling up a resident in bed was considered direct resident care, and staff should have worn a gown and gloves when doing so. The IPN/DON stated hand hygiene should be performed before and after care, and staff should also do hand hygiene prior to putting on gloves or changing gloves. The IPN/DON stated pills dropped on the medication cart should be discarded and should never be touched with ungloved hands.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT FRITZ FARM	2710 MAN O' WAR BOULEVARD , LEXINGTON, Kentucky, 40515

(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
F0880 SS = D	Continued from page 23 In an interview on 04/03/2025 at 6:03 PM with the Executive Director and Administrator, both stated staff should follow the signage posted on a resident's door and the facility's policy for residents who had EBP signage posted on their room door. Both stated staff only needed to put on a gown and gloves when providing direct resident care, and if a staff member stepped in a room to answer a call light or give a resident some butter, they did not need to put on PPE. However, they stated, if a staff member was pulling up a resident in bed prior to giving medications, the staff member should be wearing a gown and gloves; and hand hygiene should always be performed before touching a resident, before putting on PPE, and after resident care. They both stated, if a staff member dropped a pill onto the top of the medication cart, that staff member would need to dispose of the pill and get a new pill.	F0880		