| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185482 | A. Building<br>B. Wing | 05/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Willows at Fritz Farm | 2710 Man O War Boulevard<br>Lexington, KY 40515 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on observation, interview, record review, review of a job description, and review of the facility's policy, the facility failed to revise the comprehensive care plan for 1 of 13 sampled residents (R), R20. R20 had a Velcro lap belt ordered on 12/01/2025 which was discontinued on 12/27/2025. Per an observation and interview, the lap belt was no longer utilized for R20. However, review of R20's Care Plan revealed it was not revised to discontinue the lap belt and was still an active intervention. The findings include:Review of the facility's policy titled, Comprehensive Care Plan Guideline, revised on 05/22/2018 and most recently reviewed on 12/10/2025, revealed that if a previous care plan was no longer needed, it would be resolved from the active care plan.Review of R20's Face Sheet revealed the facility initially admitted the resident on 06/14/2017, and her most recent admission date was 04/21/2026. Her primary diagnosis was chronic obstructive pulmonary disease (COPD) with exacerbation.Review of R20's annual Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 04/08/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, indicating intact cognition. Further review revealed her functional ability required that she utilize a wheelchair for mobility, and she required partial assistance to self-propel up to 50 feet due to a respiratory diagnosis. It also revealed the resident was a fall risk and had experienced a fall since her admission.Review of R20's Care Plan [CP] dated 02/17/2020, revealed a problem focus of falls, with an active intervention initiated on 11/11/2025 for the use of a self-releasing Velcro seat belt, per resident request.Review of R20's Physician Order Report revealed an order, dated 12/01/2025, for a self-releasing Velcro seat belt on the wheelchair that was discontinued on 12/27/2025.Review of the MDS Coordinator job description, undated, revealed it was the responsibility of the MDS Coordinator to develop a written preliminary and comprehensive plan of care for each resident and to review and revise care plans and assessments as necessary, but at a minimum, quarterly.Observation on 05/12/2026 at 10:18 AM revealed R20 was in a manually operated wheelchair without a self-releasing seat belt. Additional observations on 05/13/2026 at 2:10 PM and on 05/14/2026 at 3:48 PM revealed R20 was in a wheelchair without a self-releasing seat belt attached to the chair.During an interview on 05/13/2026 at 2:18 PM with R20, she stated she did not want the seat belt on her chair because she was able to make her own decisions, and she did not like it.During an interview on 05/14/2026 at 8:21 AM with Certified Resident Care Assistant (CRCA) 1, she stated she was unaware that R20 ever had a seat belt on her wheelchair. She stated she was a fall risk and was supposed to have staff assistance for transfers; however, she was occasionally not compliant.During an interview on 05/15/2026 at 8:43 AM with Registered Nurse (RN) 1, she stated she thought she remembered the seat belt used by R20, but it was a long time ago, and she did not work with R20 often. She stated the information was on the care plan, and the care plan was the most accurate picture of the residents' current care orders.During an interview on 05/15/2026 at 12:06 PM with the Minimum Data Set (MDS) Nurse, also referred to as the Campus Support Assessment (CSA) Nurse, she stated orders were reviewed in the morning clinical meetings, and the care plans were updated as they were discussed. She stated others in nursing management could do this, but it was her responsibility to ensure it was done. She<br>(continued on next page) |

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

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

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | stated interventions that were no longer in use or had been resolved would not be reviewed in the same way as the current care plan. She stated anything seen on the care plan should reflect the most up-to-date and accurate plan of care for residents.During an interview on 05/15/2026 at 9:18 AM with the Director of Health Services (DHS), she stated orders were reviewed during morning clinical meetings, and care plans were updated accordingly. She stated the CSA Nurse typically did this, but she [the DHS] also updated care plans if she was aware of an order being placed, and the CSA was made aware of the change. She stated she expected care plans to be updated promptly to reflect an accurate picture of the residents' care needs.During an interview on 05/15/2026 at 12:31 PM with the Administrator, she stated she expected staff to follow care plan policies. She stated she was not clinical, but she knew the care plan was used by staff for resident care guidance, and the residents' needs might have changed. She stated the residents might not receive the most accurate care if the care plans were not revised. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of the facility's policy, the facility failed to ensure that medications and biologicals were stored safely, securely, and properly according to manufacturers' recommendations for medications that belonged to 2 of 33 sampled residents (R), R48 and R32. In addition, two unopened vials of heparin, with no resident identification or directions for use, were observed in the same compartment as the ophthalmic solutions. The findings include:Review of the facility's policy titled, Medication Storage in The Facility, revised 11/2018, revealed medications and biologics are stored at their appropriate temperature and humidity and medications that require refrigeration or a cool place were refrigerated unless otherwise directed. It further revealed when the original seal of a manufacturer's container was broken, the container or vial would be dated, and a date opened sticker shall be placed on the medication. The policy stated, No expired medication will be administered to the resident.Observation on [DATE] at 10:34 AM during an audit of the 300 Hall medication cart revealed medications that belonged to R48, which included brimonidine 0.2% eye drops (used to lower pressure in the eye) with a date on the box but not on the bottle; a second bottle of brimonidine 0.2 % eye drops with no date on the package or bottle; and azestaline 0.05% eye drops (an antihistamine used to treat itching of the eye) with no date on the box or bottle. Further observation revealed medications that belonged to R32 included an unopened Amdelog insulin pen, dispensed on [DATE], that was labeled for refrigeration when unopened. In addition, two unopened vials of stock heparin (an injectable anti-coagulant) were observed in a medication cup located in the top drawer of the medication cart, in the same compartment as the ophthalmic solutions.During an interview on [DATE] at 10:34 AM with Kentucky Medication Aide (KMA) 4, she stated KMAs did not give insulin or administer shots, so she was not aware how long those medications had been in the cart. She also stated when a multi-use medication was opened, it was the responsibility of the person giving the medication to label the bottle/vial as well as the box with the opened date. She stated it was important to know that date so that no medication was given after it had expired. She stated giving expired medication to residents could cause them harm. She stated she was not sure when the medications in question were opened.During an interview on [DATE] at 10:38 AM with Registered Nurse (RN) 1, she stated medication bottles/vials should be dated when opened, per policy, to decrease the possibility of medications being used past the expiration date. She stated the insulin pen should have been refrigerated, and it should not be this way. She stated a risk of insulin not being stored properly was that it could cause it to be less therapeutic. The medications were removed from the cart, and RN1 stated she would return them to the pharmacy. She stated the heparin was floor stock, and it was not supposed to be stored in the cart, specifically in an area designated for anything other than injectable medications.During an interview on [DATE] at 3:10 PM, the Pharmacist from the facility's contracted pharmacy stated the packages of multi-use medications, such as eye drops or insulin, were labeled by the pharmacy to identify the medication name, strength, dosage, fill date, and information for appropriate storage. The Pharmacist stated it was the responsibility of the facility to store the medication per instructions and put an opened date on the actual medication container. The Pharmacist stated medication expiration dates varied but were determined by the date opened; for example, insulin was good for 28 days from the date opened. The Pharmacist stated the risk of using medications after an expiration date or not being stored appropriately could cause a less therapeutic effect and possible illness, depending on the medication type, extreme temperatures, or how long it had been expired.During an interview with the Director of Health Services (DHS) on [DATE] at 9:18 AM, she stated her standard training for staff included her expectation of staff to label the vial/bottle with an opened date. She stated it was to help ensure medications were not used past their expiration<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | dates and prevent confusion if the medications were separated from the dated box. She stated she expected unopened insulin to be stored in the refrigerator and according to the manufacturer's recommendation until it was ready for use. She stated she was not sure how long the observed insulin had been in the cart. She stated the medication storage of stock medications, such as heparin, was in the medication room and should not be on the cart or in an area designated for other types of medications, such as ophthalmic solutions.During an interview on [DATE] at 12:31 PM with the Administrator, she stated she deferred clinical management to the Director of Health Services but expected staff to adhere to the facility's medication storage and labeling policy. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, record review, and review of the facility's policy, 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 3 of 8 residents reviewed for meal service, Resident (R) 23, R39, and R52.Observation of the meal service on 05/13/2026 at 12:10 PM revealed Licensed Practical Nurse (LPN) 1 did not sanitize her hands between giving trays to residents and the residents' meal setup. In addition, she provided feeding assistance to R23, R39, and R52 using the same, unsanitized hands between each resident. Further observation revealed LPN1 had a personal drink at the table that she drank while providing meal assistance to the three residents. The findings include:Review of the facility's policy titled, Guideline for Handwashing/Hand Hygiene, revised 02/09/2017 and reviewed 11/18/2025, defined hand hygiene as a general term that applied to hand washing or the use of an antiseptic hand rub. It also revealed that health care workers (HCW) shall use hand hygiene at times such as before/after eating, before/after direct physical contact with residents, and before/after preparing or serving meals and drinks.Observation of the midday meal service on 05/13/2026 at 12:10 PM revealed eight residents in the restorative dining area. Licensed Practical Nurse (LPN) 1 gave out multiple plates of food to the residents without washing or otherwise sanitizing her hands in between. After trays were given, LPN1 and Certified Resident Care Assistant (CRCA) 1 sat at one table with four residents. They provided hands-on feeding assistance during their meals. LPN1 assisted R39 with a forkful of food, then adjusted R52's lap blanket and offered her a bite of food from her plate before returning to R39. R23, who also required assistance with her meal, was sitting at the table behind LPN1. LPN1 stood, walked to R23's table, and offered her a bite of food from her plate while verbally encouraging her to eat. LPN1 returned to her seat, took a drink from her personal cup, rubbed her same hand across the nose/mouth area of her face, and continued to offer food to R39. LPN1 did not wash or otherwise sanitize her hands, nor did she alternate which hand she used at any time during the meal service. Review of R23's Face Sheet revealed the facility admitted the resident on 12/30/2025 with a primary diagnosis of Parkinsons disease. Review of R23's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 04/15/2026, revealed R23 required staff to provide physical assistance with all personal needs, including meals.Review of R39's Face Sheet revealed the facility admitted the resident on 12/18/2024 with diagnoses of dementia and rheumatoid arthritis. Review of R39's quarterly MDS, with an ARD of 03/12/2026, revealed R39 required staff to provide physical assistance with all personal needs, including meals.Review of R52's Face Sheet revealed the facility admitted the resident on 12/10/2023 with a diagnosis of dementia. Review of R52's quarterly MDS, with an ARD of 02/11/2026, revealed R52 required staff to provide physical assistance with all personal needs, including meals.During an interview on 05/13/2026 at 12:30 PM, LPN1 initially denied any specific concerns of infection prevention because each resident had their own fork. She stated she had her drink at the table but thought it was not a problem since she was not eating. She was not able to explain why she was observed using her hand to wipe her face and continuing resident care without cleaning her hands. LPN1 stated she had received education by the facility regarding infection prevention and verbalized understanding of cross-contamination and the potential risk that it could cause.During an interview on 05/13/2026 at 12:40 PM with the Director of Health Services (DHS), she stated she expected that staff would wash/sanitize their hands before feeding assistance and between residents. She stated, in the dining area, staff was permitted to sit between residents and use one hand for one resident and the opposite hand for the other. However, she stated in the scenario described from the recent meal service, the residents were at risk for cross-contamination. She also stated she expected the staff not to eat or drink in resident care areas, including while residents were given feeding assistance.During an interview on 05/15/2026 at 12:15 PM, the<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Administrator stated staff was trained upon hire, yearly, and as needed regarding multiple subjects, including infection prevention. She stated she expected the staff to follow the policies and guidelines taught by the clinical management team. She stated washing and/or sanitizing hands was required between resident care to decrease the spread of germs. |