

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Wellington Parc of Owensboro		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 New Hartford Road Owensboro, KY 42303	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview, record review, and review of facility policy, the facility failed to ensure allegations of abuse were immediately reported to the State Survey Agency and other officials (Department for Community Based Services) in accordance with state law for three (Resident (R) 35, R17 and R 32) of 17 sampled residents. Specifically, the facility failed to report allegations of abuse to the State Survey Agency and the Department for Community Based Services (DCBS) when R31 hit and squeezed R32's ankle, when R65 smacked R17 with a flyswatter and when R65 hit R35 on the head.</p> <p>The findings include:</p> <p>Review of the facility's undated policy titled, Abuse, Neglect, & Exploitation, revealed Any alleged incidence of abuse, neglect or exploitation must be reported immediately to the Administrator of the facility. The Administrator or their designee will then immediately notify the Department of Community Based Services, the Office of the Inspector General (OIG) and other appropriate state/local agencies as required by law.</p> <p>Further review of the policy revealed abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Defined under Physical Abuse included hitting, slapping, pinching, or kicking. As well as controlling behavior through corporal punishment.</p> <p>Continued review of the policy revealed, If a resident-to-resident altercation occurs, the resident's safety will first be assured. The residents shall be separated from each other, and the family and physician shall be notified. An investigation will be performed to determine if abuse has occurred as defined on page one. If it is determined that abuse has occurred, an evaluation of the abusing resident shall be completed to determine if there is a problem that would require medical intervention. The incident will be viewed as a reportable incident with proper protocol followed with notification to the Department of Community Based Services, to the OIG and other state/local agencies as required.</p> <p>Review of the medical records of R17, R31, R32, R35 and R65 revealed the following resident-to-resident altercations:</p> <p>1. Review of R35's medical record which included progress notes dated 10/03/2024 at 4:30 PM revealed R35 was in an activity when R35 touched R65's walker and R65 hit R35 in the head with a closed fist. Per the progress notes, no injury was observed to R35, but the resident was placed on Alert Documentation for 72 hours to monitor for latent injury or pain with no changes in condition observed.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 185436
		If continuation sheet Page 1 of 3

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R65's medical record which included progress notes dated 10/03/2024 at 4:30 PM revealed R65 was sitting in the activity room when R35 touched her walker. R65 told R35 don't do that and then punched R35 in the head with a closed fist. Further review of the progress notes revealed that when R65 was asked if she had hit R35, she raised her closed fist and stated, I'll do it again.</p> <p>During an interview on 10/10/2024 at 8:29 PM, Activity Aide (AA) 12 stated that she witnessed the altercation on 10/03/2024 and wrote a statement regarding the event. She stated R35 was walking around and then went to R65's walker. Per the Activity Aide, R35 was touching R65's walker and R65 said to stop. She stated R35 did not stop and R65 hit R35 in the side of her head.</p> <p>An interview with State Registered Nursing Assistant (SRNA) 10, revealed R65 was sitting at the table with her walker to her side. R35 was bending over like she does to grab imaginary things. Per the SRNA, R65 said 'stay away from my buggy.' and R65 held her fist up to hit R35. SRNA10 stated R35 bent over and R65 hit her in the side of the head near her ear with a closed fist.</p> <p>During an interview on 10/11/2024 at 8:45 AM, the Director of Nursing (DON) stated the incident where R65 hit R35 was not reported to the State Survey Agency or to the Department of Community Based Services (DCBS).</p> <p>2. Review of R17's medical record which included nursing progress notes dated 07/26/2024 at 2:40 PM revealed R17 was participating in an activity called balloon bat when another resident began to smack him on the left arm with a fly swatter.</p> <p>Review of R17's Quarterly MDS assessment with an Assessment Reference Date (ARD) of 09/17/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact.</p> <p>Review of the nursing progress notes for R65 on 07/26/2024 at 1:50 PM revealed R65 began to hit another resident with a fly swatter. The residents were separated, and the fly swatter was removed. The physician and Power of Attorney (POA) were notified of the event.</p> <p>Interview with R17 on 10/10/2024 at 3:30 PM regarding the incident on 07/26/2024 at 2:42 PM, revealed he was in activities playing hit the balloon with a fly swatter. He sat down beside her (R65), and she hit him on the arm three times. R17 stated he told her not to do that again and she (R65) hit him three more times on the arm. He states she did not hurt him, but he got up and moved to a different part of the table. Per R17, the staff that was in the activity made sure he was fine. R17 stated he guessed staff reported it to the higher ups, because someone came and made sure he had no injuries. He could not remember who came and checked on him. He stated he still passes the lady (R65) from time to time during the day. Per R17, he speaks to her but does not know if she would remember the incident.</p> <p>During an interview on 10/11/2024 at 8:45 AM, the DON stated the allegation where R65 hit R17 was not reported to the State Survey Agency or to the Department of Community Based Services.</p> <p>3. Review of R32's medical record which included nursing progress notes dated 06/25/2024 at 5:14 PM, revealed R31 walked underneath my stop sign and stood at the foot of my bed and hit my left lower leg then squeezed it. No indentation no redness no hand print noted to left lower leg. Resident stated she will close her door but did not lock it.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R31's medical record which included nursing progress notes for 06/25/2024 at 3:21 PM revealed Reported this resident went into another resident's room, walked underneath the stop sign and stood at the foot of the bed and hit and squeezed the left ankle of another resident. Removed resident and placed her on 15-minute checks x 2 weeks. Further review of the nursing progress notes revealed the resident was placed on Alert Documentation for 72 hours following the event.</p> <p>Review of R32's most recent Quarterly MDS with an ARD of 09/13/2024, revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating the resident was cognitively intact.</p> <p>In an interview on 10/09/2024 at 3:44 PM with R32 revealed there was an incident earlier this year where R31, entered her room uninvited. R32 stated R31 hit her on the ankle and squeezed it. R32 stated that she probably told R31 to get out of her room and that probably made her mad. R32 stated she put her call light on to summons staff but before the staff could come to the room, the resident wandered out. R32 stated the nurse examined her leg and did not find an injury; however, she did report it hurt when the resident squeezed her leg.</p> <p>During an interview on 10/09/2024 at 3:15 PM, Licensed Practical Nurse 1 (LPN1) stated that she thought staff made her aware of the incident and she went to R32's room. LPN1 stated she checked the resident for signs of injury and there was no injury found. LPN1 stated she documented the incident in the nurse's notes. LPN1 stated the process she followed if an incident occurred was to notify the DON, a family member, and the physician. LPN1 stated she did not know if there was an investigation of the incident completed. LPN1 stated residents were to be initially separated and kept safe then both residents would be placed on alert charting for 72 hours for monitoring related to the incident. LPN1 stated the perpetrator in this resident-to-resident altercation was placed on 15-minute checks for two weeks.</p> <p>In a phone interview on 10/10/2024 at 2:42 PM, the Administrator, he stated he was aware of the resident-to-resident altercations were not reported to the Office of Inspector General (OIG - State Survey Agency). He further stated that historically the facility had looked at intent with resident-to-resident altercations involving residents with dementia. He stated if there was no intent to harm and the incident involved residents with dementia, the facility did not deem the altercation as abuse. Per the Administrator, he had recently attended a training presented by OIG and will now have to take a different look at the resident-to-resident altercations. He stated the recent training redefined what we thought with Alzheimer's and dementia patient and altercations can still be considered abuse.</p> <p>During an interview on 10/11/2024 at 8:45 AM, DON stated the allegation where R31 hit R32's ankle was not reported to the State Survey Agency or to the Department of Community Based Services.</p> <p>In an interview with the Medical Director, he stated on 10/11/2024 at 9:30 AM, They [the facility] call me right away with everything. He stated he was unaware the facility was not reporting resident-to-resident altercation events.</p>		