STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185473	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thomson-Hood Veterans Center	100 Veterans Drive Wilmore, KY 40390

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to protect residents from abuse for 1 of 5 residents investigated for abuse, Resident (R) 134. Review of the facility's investigation revealed the facility determined, on 02/14/2025, R117 entered R134's room and struck him, causing a laceration on R134's forehead that required evaluation at the hospital and closure with steri-strips. The findings include: Review of the facility's policy titled, Resident to Resident Altercations, dated 09/11/2023, revealed facility staff was to monitor residents for aggressive or inappropriate behavior toward other residents. Further review revealed the facility was to identify what might have led to aggressive conduct on the part of one or more residents involved in the altercation. Continued review revealed the facility was to analyze risk factors and care plan appropriate interventions. Review of the facility's investigation, dated 02/14/2025, revealed the facility determined on 02/14/2025, R117 entered R134's room and struck him, causing a laceration on R134's forehead that required evaluation at the hospital and closure with steri-strips. 1. Review of R117 's admission Record revealed the facility admitted the resident on 04/10/2024 with diagnoses including Alzheimer's disease, dementia with mood disturbance, agitation, and unspecified insomnia. Review of R117's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/07/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of four out of 15, indicating severe cognitive impairment. Review of R117's Comprehensive Care Plan [CCP], dated 04/24/2024, revealed the facility identified the resident had an actual behavior problem of wandering into other residents' rooms and lying in their beds. Further review revealed the facility identified R117 was involved in a resident-to-resident altercation on 07/01/2024. Per the CCP, on 02/14/2025, R117 entered another resident's room and hit him several times. Continued review revealed the facility included initial interventions on 04/24/2024 such as provide the resident with meaningful activities, provide a calm atmosphere, anticipate and meet the resident's needs, provide redirection as needed, provide one-on-one if needed, and provide medications as ordered. Additional review of the CCP revealed the facility added the interventions to engage the resident in activities such as watering tomatoes or helping nursing, educating the (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	family on the progressive nature of dementia, and providing a room change as needed on 07/05/2024. Review of R117's Nursing Progress Note, effective date 02/14/2025 at 8:59 PM and written by the Nurse Shift Program Supervisor, stated, Staff was alerted to co-residents' [R134] room after commotion. Resident [R117] was noted to be having an altercation with co-resident [R134]. Resident [R117] immediately removed from co-residents and assessed by nursing staff. Provider notified and order given to send resident out to ER [Emergency Room] for evaluation. Family notified and will take Resident [R117] to ER. Resident [R117] remains one-on-one with staff member until family arrives. Observations on 03/24/2025 at 4:50 PM, 03/25/2025 at 9:45 AM, and 03/27/2025 at 2:38 PM revealed R117 wandered throughout the common areas of the [NAME] Unit. Further observations revealed that staff, including the Unit Manager, redirected R117 by providing him with snacks and activities. Per observation, R117 did not attempt to enter any other residents' rooms. Interview with R117 was attempted on 03/24/2025 at 4:34 PM. However, R117 did not respond to the State Survey Agency (SSA) Surveyor's questions. In an interview on 03/25/2025 at 10:07 AM, R117's resident representative stated she believed R117 might have been defending himself, and since no one had seen the altercation begin, it could not be ruled out. She further stated R117's triggers for behaviors included being told what to do instead of being asked. She stated that when she visited, she observed residents who wandered away from the dining room/activity area that were not supervised. 2. Review of R134's admission Record revealed the facility admitted the resident on 12/05/2024 with diagnoses including Alzheimer's disease, dementia with psychotic disturbance, and violent behavior. Review of R134's annual MDS, with an ARD of 12/11/2024, revealed the facility assessed the resident to have a BIMS score of eight out of 15, indicating moderate cognitive impairment. Review of R134's CCP, dated 12/06/2024, revealed the resident received medication for a diagnosis of psychosis and included interventions of monitoring the resident for behaviors. Review of R134's Nursing Note, effective date 02/14/2025 at 7:20 PM and written by a Licensed Practical Nurse (LPN) stated, This nurse was sitting at desk and heard [sic] rsd [resident, R134] yelling out. [NAME]'s on duty ran to rsd room [R134's room] and explained to this nurse that they found co-rsd [R117] on top of rsd on the ground hitting him. [Sic] Rsd's [Residents] immediately separated and rsd assessed for injury. Bleeding/laceration noted to right eyebrow and bruise noted to left forearm. No other obvious signs of injury noted. Co-rsd assigned to staff member to observe him. Rsd's vitals assessed and WNL [within normal limits], no deficits noted. House charge contacted directly after event who notified physician and family/RP [responsible party]. Observation on 03/25/2025 at 2:01 PM revealed R134 sitting in a recliner in his room on the [NAME] Unit. Further observation revealed no signs of distress. In an interview on 03/25/2025 at 2:03 PM, R134 stated he did not recall a time another resident came into his room. He further stated he did not recall having any verbal disagreements or physical altercations with another resident. Per the interview, R134 stated he felt safe in the facility. In an interview on 03/27/2025 at 3:02 PM, the Nurse Aide State Registered ([NAME]) 14 stated R117 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was prone to wandering and was known to wander into other residents' rooms. NASR14 stated staff would redirect a resident who was wandering and would reapproach the resident if they became combative and resisted redirection. Per the interview, NASR14 stated R117 had a history of being combative with staff during care. In further interview, NASR14 stated R117 had not been agitated or resistant to care during the day on 02/14/2025. In continued interview with NASR14, on 03/27/2025 at 3:02 PM, he stated he did not witness R117 enter any other resident's room. However, NASR14 stated, on the evening of 02/14/2025, he had just finished assisting a resident to bed when he heard a commotion and ran toward the noise. NASR14 stated when he arrived at R134's room, he found R117 sitting on top of R134, who was on the floor. In continued interview, NASR14 stated he assisted R117 to his feet and out of the room. Per interview, NASR14 observed a cut on R134's forehead, and R117 had some minor skin tears on his arms. NASR14 stated the facility maintained one-on-one supervision on R117 until the resident's wife came to take him to the hospital. NASR14 stated staff maintained close supervision on R117 when he came back from the hospital, and R117 was more pleasant and easily redirected. In interview on 03/27/2025 at 1:29 PM, NASR11 stated on the evening of 02/14/2025, she was assisting a resident with getting ready for bed when she heard some raised voices in the next room, followed by the sound of something hitting the floor. Per interview, NASR11 ran next door and found R117 on top of R134, who was lying on the ground. She stated NASR14 then entered the room and removed R117, while she assisted R134, got vital signs, and cleaned up R134. In further interview, NASR11 stated R117 liked to wander through the locked unit, and staff would give him activities to redirect him. She stated R117 liked the interactive projector table in the dining room, as well as having a washcloth he could use to dust the counters. Per interview, NASR11 was not aware that R117 had wandered into other residents' rooms and had not seen him in another resident's room prior to 02/14/2025. In an interview on 03/27/2025 at 3:24 PM, NASR12 stated she saw R117 hit R134 while R117 was sitting on top of R134, who was lying on the ground. She stated R117 had not been agitated or given any warning signs that day; however, she knew he was a wanderer. In further interview, NASR12 stated R134 was upset immediately after the altercation and told her that he was shocked someone had hit him in his own room. In an interview on 03/27/2025 at 3:18 PM, Registered Nurse (RN) 1 stated she was working as the house supervisor on 02/14/2025 and responded when staff alerted her to the altercation between R134 and R117. She stated when she arrived at R134's room, staff was assisting R134 off the floor. Per interview, she assessed R134 and notified the physician the resident needed to go to the hospital for evaluation of a laceration to his head, as well as to rule out any internal injuries. In an interview on 03/27/2025 at 10:12 AM, the [NAME] Unit Manager ([NAME]) stated she expected residents on [NAME] to be able to wander freely, even into other residents' rooms. Although, she stated if a particular resident was bothered by that, they could put up Stop signs. She stated the staff took turns as hall monitors to watch for wandering residents. However, she stated there was no hall monitor watching at the time of the altercation. In an interview on 03/27/2025 at 3:47 PM, the Director of Nursing (DON) stated she expected residents on the [NAME] Unit to be allowed to wander freely unless another resident became upset by someone being in their room. She stated if a resident was upset by another resident being in their room, the facility would use Stop signs across the door and redirect the wandering resident away from that room. In a further interview, the DON stated it was very important to supervise wandering residents (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and prevent altercations. She stated residents with dementia had poor impulse control, which increased the risk for resident-to-resident altercations. Additionally, the DON stated it was important to protect residents from abuse because no one would want to be hit, and no one would want to hear their family member had been hit. In an interview on 03/27/2025 at 4:29 PM, the Administrator stated when residents in the [NAME] Unit wandered into other residents' rooms, it was her expectation to allow residents freedom of movement unless another resident complained. She further stated that most residents would not know if someone walked in their room during the day because most residents stayed engaged in activities in the dining room all day long. The Administrator stated residents being in other residents' room, especially lying in their beds, could cause an issue and raise the risk of a resident-to-resident altercation. The Administrator further stated if a resident complained or if there was a resident-to-resident altercation with a wandering resident, her expectations were for facility staff to supervise the wandering resident and offer them a snack, music, or another favorite activity. The Administrator stated she was notified on the evening of 02/14/2025 of R117 hitting R134 in R134's room. She stated staff did not witness the beginning of the altercation and could not determine exactly what caused it.