

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER Merry Wood Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 280 MT Hebron Road Elmore, AL 36025	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48195</p> <p>Based on interviews, resident record review, review of the facility investigative files, review of Facility Reported Incidents (FRI), and review of a facility policy titled Abuse Prohibition, the facility failed to protect the rights of Resident Identifier (RI) #22 and RI #21, to be free from verbal and physical abuse perpetrated by RI #101.</p> <p>Specifically, the facility failed to provide adequate supervision and interventions per facility policy to prevent occurrences of abuse perpetrated by RI #101. RI #101 was admitted to the facility in July of 2024 with Dementia and Behaviors and was care planned for exhibiting physical behaviors. On 10/04/2024 RI #101 hit RI #22 in the chest while in the dining area for the lunch meal. Witnesses stated, RI #22 put his/her hands up in self-defense while being hit and someone in that situation would feel very upset and scared.</p> <p>Further, on the next day 10/05/2024, just after every 15-minute monitors for the incident the day before had ended, the facility failed to provide adequate supervision and interventions to prevent RI #101 from verbally and physically abusing RI #21. RI #101 called RI #21 a son of a bitch and hit RI #21 in the face while sitting in the day area watching television. Witnesses stated, a person being hit in the face in their own home would feel scared or unsafe and it would hurt to be hit in the face.</p> <p>This affected RI #21 and RI #22, two of five residents sampled for abuse.</p> <p>This deficiency was cited as a result of the investigation of FRI/complaint/report numbers AL00049207 and AL00049197.</p> <p>Findings include:</p> <p>A facility policy titled Abuse Prohibition with a revised date of 10/24/2022, documented the following:</p> <p>POLICY</p> <p>Centers prohibit abuse, mistreatment, neglect, . for all patients.</p> <p>The Center will implement an abuse prevention program through the following: .</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
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Prevention of Occurrences; .</p> <p>Federal Definitions:</p> <p>Abuse is defined as the willful infliction of injury, . intimidation, . or mental anguish. Instances of abuse of all patients, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, . physical abuse, and mental abuse .</p> <p>Verbal Abuse is any use of oral, written, or gestured language that is willfully includes disparaging and derogatory terms to patients or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Physical Abuse includes, hitting, slapping, pinching, kicking, .</p> <p>PURPOSE</p> <p>To ensure that Center staff are doing all that is within their control to prevent occurrences of abuse, mistreatment, neglect, . for all patients.</p> <p>5. Actions to prevent abuse, . will include: .</p> <p>5.2 identifying, correcting, and intervening in situations in which abuse, . is more likely to occur; .</p> <p>6.3 If the suspected abuse is patient-to-patient, the patient who has in any way threatened or attacked another will be removed from the setting or situation and an investigation will be completed.</p> <p>6.3.1 The Center will provide adequate supervision when the risk of patient-to-patient altercation is suspected.</p> <p>6.3.2 The Center is responsible for identifying patients who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation.</p> <p>9. The Administrator or designee will:</p> <p>9.1 Take all necessary corrective action depending on the results of the investigation;</p> <p>9.3 Take steps to revise patients' care plan where indicated if there is a change in the patient's medical, nursing, physical, mental or psychosocial needs or preferences as a result of an incident of abuse; .</p> <p>9.5 Take appropriate corrective actions.</p> <p>On 10/04/2024 the State Agency received a Facility Reported Incident (FRI) alleging RI #101 placed his/her open hand on RI #22's chest in the Memory Care unit. The report indicated the facility notified local law enforcement and RI #101 was placed on every 15-minute checks for 24 hours to monitor for additional aggressive behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>RI #101 was admitted to the facility on [DATE] with diagnoses to include Dementia with Behavioral Disturbance, Mild Neurocognitive Disorder due to known Physiological Condition with Behavioral Disturbance, and Mood Disorder.</p> <p>A review of RI #101's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 10/04/2024 revealed a Brief Interview for Mental Status (BIMS) score of a 6 of 15 which indicated severely impaired cognition.</p> <p>RI #22 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include Alzheimer's Dementia with Behavioral Disturbance and Expressive Language Disorder.</p> <p>A review of RI #22's quarterly MDS assessment with an ARD of 09/30/2024 revealed a BIMS score of 9 of 15 which indicated moderately impaired cognition.</p> <p>Review of the facility investigative file for the incident dated 10/04/2024 revealed a Resident to Resident Investigation Summary involving RI #101 and RI #22 that documented:</p> <p>. Investigation Conclusion:</p> <p>Based on current evidence abuse was not substantiated .</p> <p>The investigation does demonstrate that the event did occur, . (RI #101) did strike (his/her) open hand on . (RI #22's) upper chest. While (RI #101) and (RI #22) are severely cognitively impaired the actions were deliberate.</p> <p>Also included in the facility investigative file was a letter addressing To Whom it May Concern: that documented the actions were deliberate as follows: . Allegation Summary: On October 4, 2024, it was reported that (RI #101) had reached out with an open hand and struck (RI #22's) upper chest.</p> <p>According to staff in the area at the time, (RI #101) started to get loud and when staff noted what was occurring, they saw (RI #101) with (his/her) open hand on (RI #22's) upper chest area. One aide present stated that (RI #101) struck (RI #22). (RI #22) also had (his/her) hands up in what staff felt was blocking position.</p> <p>Center Conclusion:</p> <p>The investigation does demonstrate that the event did occur, (RI #101) did strike (his/her) open hand on (RI #22's) upper chest. the actions were deliberate.</p> <p>A WITNESS INTERVIEW RECORD dated 10/04/2024 and signed by Certified Nursing Assistant (CNA) #3 documented: . What did you see? (RI #101) was up and down with . (agitation) before staff could redirect (he/she) swung an open hand at (RI #22's) chest area (RI #22) then put hands up to protect (himself/herself) .</p> <p>A Witness Statement dated 10/04/2024 for Licensed Practical Nurse (LPN) #4 documented: . What did you see? Once I heard (RI #101) hollering I (turned) around to see (RI #101) in front of (RI #22) who was putting (his/her) hands up in defense blocking (his/her) face.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A telephone interview was conducted on 10/16/2024 at 4:06 PM with CNA #3 who witnessed the incident on 10/04/2024 during lunch time on the Memory Care Unit. CNA #3 said, RI #101 was fussing and cursing and rolled his/her wheelchair over to the table where RI #22 was eating lunch and struck RI #22. CNA #3 said, RI #22 then put his/her hands up to his/her face in a defensive and protective manner. CNA #3 said, RI #101 curses and hits out at staff on a daily basis. When asked what type of abuse this incident would be considered, CNA #3 said, it was physical abuse. CNA #3 said, someone in that situation would be very upset.</p> <p>On 10/16/2024 at 3:15 PM LPN #4 was asked about the incident between RI #101 and RI #22 on 10/04/2024. LPN #4 said, she was at the nursing station and heard RI #101 cursing and yelling loudly, so she turned around and saw RI #101 in front of RI #22 who had both hands up blocking his/her face. LPN #4 said, she saw the end of the hit as RI #101's hands were coming off of RI #22. LPN #4 said, this happened in the dining room during lunch. LPN #4 said, prior to the incident RI #101 had been cursing. LPN #4 said, she ran over and separated the residents, both were assessed for injury, and no physical injury was noted. LPN #4 said, every 15-minute checks were initiated to monitor RI #101. LPN #4 said, what she witnessed was physical abuse and someone in that situation, being hit while eating their meal, would feel upset and scared.</p> <p>On the next day, 10/05/2024 at 6:09 PM the State Agency received a Facility Reported Incident (FRI) alleging RI #101 was witnessed striking RI #21 on the Memory Care unit.</p> <p>RI #21 was admitted to the facility on [DATE] with diagnoses of Dementia without Behavior Disturbance.</p> <p>RI #21's quarterly MDS assessment with an ARD date of 07/29/2024 revealed a BIMS score of 5 of 15 which indicated severely impaired cognition.</p> <p>Review of the facility investigative file for the incident dated 10/05/2024 revealed a Resident to Resident Investigation Summary that documented RI #101 had verbally and physically aggressive history and included that the actions were deliberate as follows: . The investigation does demonstrate that the event did occur (RI #101) did strike (his/her) open hand on (RI #21's) face. While (RI #101) and (RI #21) are severely cognitively impaired the actions were deliberate. this investigation cannot substantiate abuse at this time.</p> <p>A review of a facility handwritten witness statement from CNA #5 dated 10/05/2024 at 3:20 PM documented: . (RI #101) kept . standing up snatching on (RI #21's) wheelchair. (RI #21) told (RI #101) to stop (RI #101) cussed . (at) (RI #21) and hit (RI #21) in the face.</p> <p>A more detailed handwritten statement signed by CNA #5, dated 10/11/2024 documented: . Employee (CNA #5) stated resident (RI #101) was in the dining area watching TV with other residents she was monitoring the dining area . (RI #101) was given a snack and placed at a table near (RI #21) shortly after being place there (he/she) had moved from the table in (his/her) wheel chair towards (RI #21) which (he/she) then was pulling at (RI #21's) wheelchair to help roll (his/her) self Employee stated she heard (RI #21) saying stop and realize (RI #101) moved from the table so she went and redirected (him/her) after several minutes of (him/her) staying put she was tending to other residents when she heard (RI #21) yell out to stop again she turned to see what was going on and (RI #101) was standing up and swung (his/her) hand at (RI #21) she hurried over to redirect both resident .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/17/2024 at 3:33 PM an interview was conducted with CNA #5 who was working with RI #101 on 10/05/2024. CNA #5 said, upon arriving to work that day around 2:00 PM, RI #101 was assisted out of bed and taken to the activity room. CNA #5 said, RI #101 was calm initially however, started getting agitated and cursing, getting up and down. CNA #5 said, RI #101 was at his/her own table, then rolled over to RI #21's wheelchair and she redirected RI #101 back to the table area, provided a snack, offered to take RI #101 back to bed, and RI #101 said, no and cursed at CNA #5. CNA #5 said, RI #101 ate the snack, and she went to assist another resident. Soon after, CNA #5 said, she heard RI #101 cursing, getting agitated, heard RI #21 say stop, and CNA #5 saw RI #101 pulling up on RI #21's wheelchair. CNA #5 said, before she could get back over to intervene, RI #101 had hit #21 on the right side of the face. CNA #5 said, it was not a hard hit, however, it could have been painful to be hit in the face. CNA #5 said, she jumped between them to keep RI #21 from hitting RI #101 back, because RI #21 wanted to fight back. The two residents were immediately separated and CNA #5 assisted RI #101 back to his/her room to lie down and calm down.</p> <p>A WITNESS INTERVIEW RECORD dated 10/09/2024 and signed by Activity Assistant (AA) #7 documented: . (RI #101) hit (RI #21) in the face .</p> <p>A more detailed handwritten statement signed by AA #7 dated 10/11/2024 documented: We was all watching the football game in the back dining area. (RI #101) was trying to stand up the entire day. (He/she) rolled forward behind (RI #21's) chair and used the hand-rail on the back of (RI #21's) chair to stand up. (He/she) was told by the CNA to sit back down in (his/her) chair. (He/she) sat back down in (his/her) chair and was rolled back to the table. (RI #21) didn't know at the time that (RI #101) was on the back of (his/her) chair. We continued to watch the football game and (RI #101) did the same thing in regards to standing up using . (RI #21's) chair. This time (RI #21) asked (RI #101) to get off the back of (his/her) chair. (RI #101) then slapped (RI #21) on the side of (his/her) face. We then separated the (RI #21 and RI #101).</p> <p>On 10/17/2024 at 9:10 AM a telephone interview was conducted with AA #7 who was conducting an activity on 10/05/2024 and witnessed the incident. AA #7 said, RI #101 was sitting at a table by him/herself approximately four feet away from RI #21. AA #7 said, RI #101 was agitated, cursing, rolling over to try and pull him/herself up on RI #21's wheelchair, and CNA #5 redirected RI #101 back to the table and provided a snack. AA #7 said, CNA #5 then went to assist another resident and shortly after she heard RI #21 say stop, and RI #101 was pulling up on RI #21's wheelchair again. AA #7 said, RI #101 cursed RI #21 called him a (SOB) (son of a bitch) and hit RI #21 on the face before staff could intervene. AA #7 said, this incident would be considered physical and verbal abuse.</p> <p>On 10/17/2024 at 4:30 PM, an interview was conducted with the DON. She said, a physician's order for every 15-minute checks for 24 hours was written for the protection of residents from an aggressor. The DON said, the every 15-minute checks for 24 hours started on 10/04/2024 at 12:50 PM and ended 10/05/2024 at 12:50 PM, less than three hours before RI #101 hit RI #21. The DON said, being hit in the chest could cause pain, and a person in that situation would become upset, and the incident of RI #22 being hit in the chest was physical abuse. The DON said, being hit in the face would cause someone to become startled and she would not like to be hit in the face, and the incident of RI #21 being hit in the face was physical abuse.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/17/2024 at 5:04 PM an interview was conducted with Registered Nurse (RN) #6 who was the unit manager/on call when the incident occurred on 10/04/2024. RN #6 said, she was notified by LPN #4 that RI #101 had hit RI #22 in the dining room. RN #6 said, they immediately separated the two, assessed for injuries, made notifications, notified the physician and new orders were received to place RI #101 on 15-minute checks for 24 hours for the protection of other residents. When asked what would happen when the 24 hours lapsed, RN #6 said, the staff remained on high alert to watch and observe for any behaviors and if behaviors continued, the staff would notify the physician. RN #6 was asked what could have been done to prevent the incident from occurring when RI #101 was observed becoming agitated on 10/05/2024 during the activity. RN #6 said, staff could have intervened earlier and moved RI #101 away from the area and to a calmer environment or less stimulating area. RN #6 stated this incident would be considered physical abuse and someone watching a football game in their home would feel scared and unsafe if they were hit and this was the resident's safe space.</p> <p>On 10/17/2024 at 6:15 PM an interview was conducted with the Administrator (ADM). When the ADM was asked what was determined from the facility's investigation, he said, staff had moved RI #101 from the area once where RI #101 was pulling on the wheelchair of RI #21. The ADM said, staff went to assist another resident, and RI #101 rolled back over to RI #21 and this was when the incident occurred on 10/05/2024. When asked what could have been done to prevent the incident from occurring, ADM said, intervening sooner and removing RI #101 from the vicinity where RI #21 was located. When asked what type of abuse this would be considered, the ADM said, physical abuse. The ADM stated someone who was hit in their own home would not feel too happy about it.</p> <p>RI #101's comprehensive care plan that was initiated on 07/09/2024, just after RI #101 was admitted to the facility, contained a focus area of Resident/patient exhibits, or has the potential to exhibit physical behaviors . 7/4/24 -noted in progress notes trying to hit staff & (and) throwing dinner tray; 7/3/24 -cursing at staff, . RI #101's care plan had interventions added on 10/04/2024 such as to do a body audit to check for injury, call law enforcement, notify the doctor/family, and separate the resident from the other resident when it happens. There were not any new interventions or approaches on RI #101's plan of care that would instruct staff on how to prevent occurrences of abuse perpetrated by RI #101 or the level of supervision RI #101 required to prevent residents in the facility from being abused by RI #101.</p>		