

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 09/01/2024
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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	<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** 47408</p> <p>Based on interviews, residents' record review, review of a facility policy titled Abuse Prohibition, review of Facility Reported Incidents (FRIs) received by the State Agency, and review of the facility's investigative files, the facility failed to protect residents right to be from abuse perpetrated by staff of the facility.</p> <p>On 07/01/2023 Resident Identifier (RI) #398 was physically abused by Certified Nursing Assistant (CNA) #14.</p> <p>On 03/10/2024 RI #48 was physically abused by CNA #10.</p> <p>The facility further failed to substantiate the allegations as abuse.</p> <p>These deficient practices affected RI #48, RI #81 and RI #398, three of four sampled residents reviewed for employee to resident abuse.</p> <p>This deficiency was cited as a result of the investigation of FRI/complaint/report numbers AL00044697 and AL00047200.</p> <p>Findings include:</p> <p>Review of the facility's abuse policy titled, Abuse Prohibition, with a revision date of 10/24/2022, revealed the following:</p> <p>POLICY</p> <p>Centers prohibit abuse, mistreatment, neglect . for all patients .</p> <p>Federal Definitions:</p> <p>Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish . Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</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>Verbal Abuse is any use of oral, written language that willfully includes disparaging and derogatory terms to patients or their families, or within hearing distance, regardless of their ability to comprehend, or disability . Examples of verbal abuse includes, but are not limited to: threats of harm; saying things to frightened a patient .</p> <p>Physical Abuse includes hitting slapping, pinching, kicking, etc.</p> <p>Mistreatment is defined as inappropriate treatment . of a patient .</p> <p>1) RI #398 was admitted to the facility on [DATE], with diagnoses to include Cerebral Infarction, Hemiplegia, Affecting Right Dominant Side, and Anxiety Disorder,.</p> <p>A Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/26/2023, identified RI #398 as scoring a five of 15 on the Brief Interview of Mental Status (BIMS) indicating RI #398 had severely impaired cognition.</p> <p>The Alabama Department of Public Health Online Incident Reporting System form, dated 07/06/2023 documented:</p> <p>. Incident Type . Abuse - Physical .</p> <p>Incident Detail .</p> <p>Name(s) of resident(s) involved: (RI #398) .</p> <p>Name of staff member who became aware of the incident: (Social Worker [SW]) .</p> <p>Narrative summary of incident: Resident informed (his/her) family, who informed the Center Social worker that resident is claiming an unnamed staff member on Saturday night was rough during care . Describe any injury to the alleged victim . bruising on wrist .</p> <p>The facility's Allegation Summary, documented that the facility's investigation determined:</p> <p>On Thursday July 6, 2023 (RI #398) alleged than an unnamed CNA had been rough with care on the previous Saturday. (RI #398) had stated that the CNA had grabbed (his/her) wrist and that (he/she) had bruising on them .</p> <p>Center Investigation:</p> <p>The investigation consisted of interviews with residents and staff. Also included were skin assessments of residents.</p> <p>Center Finding:</p> <p>On Thursday July 6, 2023 it was stated to facility staff that (RI #398) was stating he/she had bruising on his/her wrists and that a CNA was rough during care on the previous Saturday . (RI #398) had some reddened areas on his/her wrist .</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>Center Conclusions:</p> <p>This investigation is unable to substantiate abuse in this instance. Based on the investigation care provisions was being complicated and (RI #398) began striking the CNA. The CNA did grab his/her wrist in order to stop him/her from striking her .</p> <p>On 08/24/2024 at 4:25 PM a telephone interview was conducted with RI #398's Responsible Party (RP). When asked what she could tell the surveyor about an incident occurring on 07/01/2023, involving bruising to RI #398's wrists. The RP said when her sister visited the facility on 07/01/2023, RI #398 mentioned a lady that had not been nice to him/her. The RP said RI #398 said the staff member was always ugly to him/her and told him/her to "shut up and threw his/her arms down. The RP said when she visited RI #398 on 07/02/2023, she noticed the dark red/purple to black bruises on RI #398's wrists. The RP said she notified the social worker.</p> <p>On 08/24/2024 at 4:45 PM, the surveyor conducted a telephone interview with RI #398's daughter. RI #398's daughter said RI #398 informed her the CNA was always mean to him/her, and they called that CNA big trouble. RI #398's daughter said RI #398 informed her the CNA grabbed him/her and was hurting him/her, and would not let him/her go. RI #398's daughter said on 07/02/2023 when she went to visit RI #398, she noticed the bruises on RI #398's wrist. RI #398's daughter said RI #398's RP reported the incident to facility staff.</p> <p>On 08/24/2024 at 5:13 PM, an interview was conducted with the SW. When asked what she could tell the surveyor about an incident involving RI #398 and CNA #14 occurring on 07/01/2023, the SW said RI #398's daughter called and stated a CNA was rough with RI #398. The SW said she reported this to the ADM. The SW said the CNA being rough with RI #398 would be consider physical abuse if it occurred.</p> <p>The facility's investigative file was reviewed and a typed statement signed by the DON on 07/06/2023, revealed the following:</p> <p>A resident (RI #398) . called his/her Sponsor (name of responsible party) on Saturday, July 1, 2023 with his/her cellphone and told her that Big Trouble grabbed his/her wrist and was rough with him/her. (He/She) stated she (the CNA) said . Don't call me anymore either. The Sponsor called the Social Worker (name of SW) and reported it to her on July 5, 2023 . The Social Worker went to the resident's room and she returned and stated the resident said that someone grabbed his wrist but (he's/she's) not telling her who it was. I then went to the resident's room with the charge nurse (LPN #22) . I observed red bruises to both forearms .The resident went on to say he/she was getting good care at the facility and proceeded to hug his assigned CNA (CNA #14) . Witness statements were obtained . One of the employees (CNA #14) that worked with the resident on the evening of July 1, 2023, stated during my investigation that the resident was fighting her that night and she had to hold his/her wrist to block him/her from hitting her. She stated she went and immediately reported to Charge Nurse (LPN #17) and another Nurse was standing there . Both Nurses were interviewed and they corroborated the story from (CNA #14) . The abuse allegation cannot be substantiated.</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 08/25/2024 at 5:46 PM, an interview was conducted with the DON. The DON said she was made aware, by the ADM, of the incident involving RI #398 and CNA #14 on 07/06/2023. The DON said she was informed that CNA #14 had grabbed RI #398's wrist. The DON said when she did a head-to-toe assessment on RI #398, there were discolorations on RI #398's arms. When asked could CNA #14 have just walked away from RI #398 and reported the incident, the DON said CNA #14 could have but according to her statement she was trying to stop RI #398 from hitting her. The DON said RI #398 could sit up in the bed independently, but required a mechanical lift for transfer out of the bed and was not ambulatory or able to walk. The DON said the facility was not aware RI #398 nicknamed CNA #14 big trouble until after the ADM interviewed RI #398. The DON said CNA #14 resigned in October of 2023 due to personal reasons.</p> <p>Unsuccessful telephone attempts were made to contact CNA #14 on 08/24/2024 at 5:42 PM and on 08/25/2024 at 3:02 PM.</p> <p>Review of a Late Entry Progress Note for RI #398, dated 07/01/2023, documented by LPN #17 on 07/08/2023 revealed the following:</p> <p>During last rounds CNA was changing the resident and (he/she) got upset and was yelling and proceeded to hit the aide. To keep from getting hit the aide grabbed (his/her) forearm and moved away from (him/her). She came out of the room and informed the nurse at the desk . This nurse went into room to assess the resident. Resident was calm .</p> <p>On 08/27/2024 at 12:25 PM, a telephone interview was conducted with LPN #17. LPN #17 said she did make the late entry concerning the incident involving RI #398. LPN #17 said she would consider the incident to be abuse. LPN #17 said she should have reported the incident to the abuse coordinator.</p> <p>On 08/28/2024 at 5:45 PM, an interview was conducted with the Registered Nurse/Nurse Practice Educator (NPE). The NPE said a CNA grabbing a resident by the wrist to keep the resident from hitting the CNA would be considered physical abuse.</p> <p>On 08/25/2024 at 4:40 PM an interview was conducted with the ADM. The ADM said according to the facility report, he was made aware of the incident involving RI #398 and CNA #14 on 07/06/2023. The ADM said RI #398 informed the Social Worker that on Saturday night (07/01/2023) an unnamed staff member was rough during care. The ADM said he reported the incident to ADPH (Alabama Department of Public Health) and initiated an investigation to identify the unnamed staff member. The ADM said during the investigation, CNA #14 stated RI #398 was hitting her and she stopped RI #398 by grabbing his/her wrists and reported it to LPN #17. The ADM said he did not substantiate the incident as abuse because he did not believe CNA #14 had any intention of harming RI #398. The ADM said he categorized the incident as physical abuse because the allegation was physical in nature. The ADM said he did not substantiate the incident as abuse because he did not believe CNA #14 had any intention of harming RI #398. When asked how it would make a reasonable person feel if someone grabbed them by the wrist and left bruising on them, the ADM said he would want it to stop.</p> <p>29671</p> <p>2) RI #48 was admitted to the facility on [DATE], with diagnoses to include Alzheimer's Disease and Dementia.</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 Quarterly MDS assessment with an ARD of 01/02/2024 identified RI #48 had a BIMS score of 03 of 15 which indicated RI #48 had severe cognitive impairment.</p> <p>The Alabama Department of Public Health Online Incident Reporting System form, dated 03/10/2024 documented:</p> <p>. Incident Type . Abuse - Physical .</p> <p>Incident Detail .</p> <p>Name(s) of resident(s) involved: (RI #48) .</p> <p>Name of alleged perpetrator(s): (CNA #10)</p> <p>What was reported . It is alleged that (RI #48) grabbed (CNA #10) collar and (CNA #10) pushed (RI #48) back into the bed .</p> <p>Action(s) taken by the facility in response to the incident.</p> <p>Resident asses for injury, none noted, CNA #10 placed on administrative leave .</p> <p>The facility's incident summary, documented that the facility's investigation determined:</p> <p>Allegation Summary: On March 10, 2024 . Center Conclusion: This investigation is unable to substantiate abuse. (CNA #10) in attempting to remove (RI #48's) hand did result in (RI #48) losing his/her balance. The witnessing staff felt this situation could have been handled better and felt that frustration did play a factor in the interaction .</p> <p>An interview was conducted with Activity CNA #8 on 08/24/2024, at 11:59 AM. During this interview, CNA #8 recounted an incident that occurred on 03/10/2024, in which CNA #21, CNA #10 and she, were providing care to RI #48. CNA #8 stated that while they were providing care to RI #48, the resident pulled away from CNA #10. In response, CNA #10 placed both hands on RI #48's arms, turned the resident around, and shook him/her two to three times, resulting in RI #48's body hitting the footboard of the bed. CNA #8 indicated that she removed CNA #10's hands from RI #48 and then left the room to report the incident to Licensed Practical Nurse #11.</p> <p>An interview was conducted with LPN #11 on 08/24/2024, at 1:17 PM. During the interview, LPN #11 said that on 03/10/2023 CNA #8 reported that she felt CNA #10 was rough while attempting to provide care to RI #48. LPN #11 said she immediately went in the room and completed a body audit with no negative results found. LPN #11 then reported the incident to the weekend supervisor, administrator, responsible party, and medical doctor. LPN #11 reported that CNA #10 was sent home and did not return to work. LPN #11 said RI #48 had normal behavior the remainder of the day. LPN #11 said when a resident was combative, staff should leave the room and look for ways such as providing snacks to calm the 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>A telephone interview was conducted with CNA #10 on 08/26/2024, at 2:50 PM. During the interview, CNA #10 recalled that on 03/10/2024, she was assigned to care for RI #48 and sought assistance from CNA #8 and CNA #21. CNA #10 described an incident in which RI #48 grabbed her shirt, prompting her to grab RI #48's hand and wrist. She said that RI #48 was pulling on her shirt, and she had to tug twice before RI #48 released his/her grip. CNA #10 indicated that when she removed RI #48's hand from her shirt, it resulted in RI #48 falling over the bed. When questioned about her training for managing resistant residents, she stated that the protocol was to leave the room and return later. CNA #10 explained that she did not leave the room because RI #48 required a change, so she continued to provide care. When asked if she believed her actions were appropriate, she admitted that she could have left and returned later, which could have de-escalated the situation. CNA #10 said she did not consider her actions to be physical abuse, as RI #48 was examined and no redness or marks were observed. She acknowledged that she could have approached the situation differently. Following the incident, CNA #10 said she provided a verbal statement after the incident and clocked out for the day.</p> <p>A telephone interview was conducted with CNA #21 on 08/26/2024, at 3:18 PM. During the interview, CNA #21 recalled an incident from 03/10/2024, when she was requested to assist CNA #10 and CNA #8 in providing care to resident #48. CNA #21 said that resident #48 was upset and resisting care at that time. CNA #21 said RI #48 grabbed CNA #10's shirt collar and CNA #10 removed RI #48's hand. CNA #21 said CNA #10 turned RI #48 around and RI #48 fell on to the bed. CNA #21 said it was upsetting the way that CNA #10 handled RI #48 and reported the incident to the unit manager. When asked if she believed the actions she witnessed constituted abuse, she said yes, stating that this was the reason for her reporting the incident. In response to a question about her training for managing residents who resist care, she indicated that the guidance was to leave them alone and return at a later time.</p> <p>An interview was conducted with the ADM on 08/24/2024, at 4:54 PM. During the interview, the ADM said that he became aware of the incident involving RI #48 on 03/10/2024. He reported that an investigation was initiated, a report was submitted to the State Agency, and the employee, CNA #10, was suspended. The ADM noted that CNA #10 denied any allegations of being rough with RI #48, asserting that she was attempting to prevent the resident from hitting the bed. When questioned whether a staff member grabbing and placing a resident onto the bed could be classified as abuse, the ADM said that such an action would be considered abusive. He also mentioned that the resident was evaluated following the incident and found to have no injuries. Upon being asked if he believed RI #48 had been abused, he stated that he could not make a determination, as the accounts he received during the investigation were inconsistent.</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47408</p> <p>Based on interviews, record review, review of the facility's investigative file and review of the facility's abuse policy titled Abuse Prohibition, the facility failed to ensure the abuse policy was implemented following an incident of staff to resident physical abuse. The facility failed to ensure the incident was identified by licensed staff as abuse and protective measures were immediately implemented to prevent further potential abuse. The facility further failed to ensure the incident was reported to the Administrator (ADM) within two hours and thoroughly investigated to identify that abuse occurred and to ensure appropriate actions were taken to prevent further potential abuse.</p> <p>On 07/01/2023, Certified Nursing Assistant (CNA #14) reported to Licensed Practical Nurse (LPN) #17 that she grabbed Resident Identifier (RI) #398's wrists to keep RI #398 from hitting her. The incident was not reported to the ADM and no protective measures were implemented until the family reported the incident on 07/06/2023. On 07/06/2023 red and purple discolorations were noted on RI #398 's bilateral arms and wrists. The ADM failed to substantiate the allegation of physical abuse despite the CNA stating that she grabbed RI #398's wrists. The facility allowed CNA #14 to return to work at the facility.</p> <p>It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or serious psychosocial harm to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect, and Exploitation.</p> <p>On 08/30/2024 at 7:32 PM, the ADM and Director of Nursing (DON) were provided a copy of the IJ template and notified of the finding of immediate jeopardy and substandard quality of care in the area of Freedom from Abuse, Neglect, and Exploitation at F 607- Develop/Implement Abuse/Neglect, etc. Policies.</p> <p>The IJ began on 07/01/2023 and continued until 09/01/2024 when the survey team verified onsite that corrective actions had been implemented. On 09/02/2024 the immediate jeopardy was removed, F 607 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.</p> <p>This deficiency was cited as the result of the investigation of complaint /report #AL00044697.</p> <p>Findings include:</p> <p>Cross-Reference F 610, F 835 and F 867.</p> <p>Review of the facility's abuse policy titled, Abuse Prohibition, with a revision date of 10/24/2022, revealed the following:</p> <p>POLICY</p> <p>Center prohibit abuse . for all patients .</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Center will implement an abuse prohibition program through the following: .</p> <p>Identification of possible incidents or allegations which need investigation;</p> <p>Investigation of incidents and allegations;</p> <p>Protection of patients during investigations;</p> <p>Reporting of incidents, investigations, and Center response to the results of their investigations.</p> <p>Federal Definitions:</p> <p>Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .</p> <p>Physical Abuse includes hitting slapping, pinching, kicking, etc. as well as controlling behavior through corporal punishment .</p> <p>Mistreatment is defined as inappropriate treatment . of a patient .</p> <p>PROCESS .</p> <p>6. Staff will identify events- such as . occurrences . that may constitute abuse .</p> <p>6.1 Anyone who witnesses an incident of suspected abuse . is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately, regardless of shift worked.</p> <p>6.1.1 The notified supervisor will report the suspected abuse immediately to the Administrator .</p> <p>RI #398 was admitted to the facility on [DATE], with diagnoses to include Cerebral Infarction, Hemiplegia, Affecting Right Dominant Side, and Anxiety Disorder.</p> <p>RI #398's Quarterly Minimum Data Set assessment with an Assessment Reference Date of 06/26/2023, identified RI #398 as scoring 5 of 15 on the Brief Interview of Mental Status, which indicated that RI #398 had severely impaired cognition.</p> <p>Review of a Late Entry Progress Note for RI #398, dated 07/01/2023, documented by LPN #17, an agency/contract staff member, on 07/08/2023 revealed the following:</p> <p>During last rounds CNA was changing the resident and (he/she) got upset and was yelling and proceeded to hit the aide. To keep from getting hit the aide grabbed (his/her) forearm and moved away from (him/her). She came out of the room and informed the nurse at the desk . This nurse went into room to assess the resident. Resident was calm .</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 08/27/2024 at 12:25 PM, a telephone interview was conducted with LPN #17. LPN #17 said she did make the late entry concerning the incident involving RI #398; and she would consider the incident to be abuse. LPN #17 said she should have reported the incident to the abuse coordinator.</p> <p>Review of the assignment sheets for the unit RI #398 resided on revealed CNA #14 continued to provide care to RI #398 on 07/02/2023 on the 2 PM to 10 PM shift, on 07/03/2023 on the 2 PM to 10 PM shift, on 07/04/2023 on the 2 PM to 10 PM and 10 PM to 6 AM shifts and on 07/05/2023 on the 6 PM to 2 PM shift.</p> <p>The Alabama Department of Public Health Online Incident Reporting System form, dated 07/06/2023 documented:</p> <p>. Incident Type . Abuse - Physical .</p> <p>Incident Detail .</p> <p>Name(s) of resident(s) involved: (RI #398) .</p> <p>Name of staff member who became aware of the incident: (Social Worker [SW]) .</p> <p>Narrative summary of incident: Resident informed (his/her) family, who informed the Center Social worker that resident is claiming an unnamed staff member on Saturday night was rough during care . Describe any injury to the alleged victim . bruising on wrist .</p> <p>The facility's Allegation Summary, documented that the facility's investigation determined:</p> <p>On Thursday July 6, 2023 (RI #398) alleged than an unnamed CNA had been rough with care on the previous Saturday. (RI #398) had stated that the CNA had grabbed (his/her) wrist and that (he/she) had bruising on them .</p> <p>Center Investigation:</p> <p>The investigation consisted of interviews with residents and staff. Also included were skin assessments of residents.</p> <p>Center Finding:</p> <p>On Thursday July 6, 2023 it was stated to facility staff that (RI #398) was stating he/she had bruising on his/her wrists and that a CNA was rough during care on the previous Saturday . (RI #398) had some reddened areas on his/her wrist .</p> <p>Center Conclusions:</p> <p>This investigation is unable to substantiate abuse in this instance. Based on the investigation care provisions was being complicated and (RI #398) began striking the CNA. The CNA did grab his/her wrist in order to stop him/her from striking her .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Merry Wood Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 280 MT Hebron Road Elmore, AL 36025	
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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 08/28/2024 at 5:45 PM, an interview was conducted with the Registered Nurse/Nurse Practice Educator (NPE). The NPE said grabbing a resident by the wrist would be considered physical abuse. The NPE said when the incident was reported to LPN #17, she should have ensured the resident was safe, even if that meant sending the CNA home. The NPE said this incident should have been reported to the ADM immediately.</p> <p>On 08/25/2024 at 5:46 PM, an interview was conducted with the DON. The DON said CNA #14 was suspended for six days after the allegation. The DON said CNA #14 resigned in October of 2023 due to personal reasons.</p> <p>On 08/30/2024 at 4:58 PM, an interview was conducted with the DON. The DON said the facility's concern with LPN #17 was she had a lack of caring for residents and violated company policy. The DON said LPN #17 did not complete an assessment on RI #398 at the time of the incident.</p> <p>On 08/25/2024 at 4:40 PM an interview was conducted with the ADM. The ADM said according to the facility report he was made aware of the incident involving RI #398 and CNA #14 on 07/06/2023. The ADM said RI #398 informed the Social Worker that on Saturday night (07/01/2023) an unnamed staff member was rough during care. The ADM said he reported the incident to ADPH (Alabama Department of Public Health) and initiated an investigation to identify the unnamed staff member. The ADM said during the investigation CNA #14 stated RI #398 was hitting her and she stopped RI #398 by grabbing his/her wrists and reported it to LPN #17. The ADM said he did not substantiate the incident as abuse because he did not believe CNA #14 had any intention of harming RI #398.</p> <p>On 08/28/2024 at 11:00 AM, a follow-up interview was conducted with the ADM. The ADM said LPN #17 should have reported the incident to him. When asked how RI #398 was protected from further potential harm from 07/01/2023 until 07/06/2023, the ADM said RI #398 was not protected. The ADM said he did not investigate how RI #398 obtained the bruises to his/her wrist because he was not aware of the bruising at the time of the investigation. The ADM said he did not have a documented interview with CNA #14 or LPN #17.</p> <p>*****</p> <p>On 09/01/2024 at 6:40 PM, the facility submitted an acceptable removal plan, which document:</p> <p>Date: August 30, 2024</p> <p>F-607-Development and implementation of written Abuse Prohibition policies.</p> <p>On 7/6/23 RI #398's family reported to Center Social Worker that an unnamed CNA had been rough with RI #398</p> <p>On 7/6/23 immediately after speaking with family, Center Social Worker notified the Administrator</p> <p>Administrator spoke with RI #398 on 7/6/23, administrator failed to document interview with resident which resulted in resident not being protected from potential further abuse</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During the interviews, on 7/6/23, DON discovered that CNA #14 had reported to LPN #17 that she had an instance on 7/1/23, in which she had grabbed RI #398's wrist in order to stop the resident from striking her. LPN #17 failed to notify the Administrator on 7/1/23 of the occurrence which delayed interventions to ensure the alleged staff member was removed from the situation and caused a failure to ensure resident safety during the intervening time.</p> <p>On 7/6/23 CNA #14 was placed on administrative leave pending the results of the investigation.</p> <p>RI #398 was discharged on [DATE], from Merry wood Lodge Center.</p> <p>Certified Nursing Assistant #14 is no longer employed at Merry wood Lodge Center. CNA #14's last day worked was 10/14/23</p> <p>Licensed Practical Nurse #17 is no longer employed at Merry [NAME] Lodge Center. LPN #17's last day worked was 7/20/23.</p> <p>On August 30, 2024, The Social Services Director and/or designee interviewed 47 residents deemed as interviewable with a BIMs score ranging from 8-15 regarding Staff being rough with the residents. No concerns were identified</p> <p>On August 30, 2024, Licensed Nurses completed skin assessment on 42 residents identified with severe cognitive impairment with a BIMs score ranging from 0-7 to identify suspicion of Abuse. No additional concerns were identified.</p> <p>On August 30, 2024, the Nurse Practice Educator and/or designee initiated 100% re-education with employees (full-time, part-time) in all disciplines (Nursing, Therapy, Housekeeping, Dietary, Laundry, Activities, and Administration) on Abuse Prohibition policy and procedure, including but not limited to, the definition, types of Abuse (Physical, Mental/Emotional, Neglect, Sexual, and Financial), prevention and supervision, identification, reporting of abuse, and trauma. Identification includes knowing the types of abuse, recognizes deliberate acts, noticing suspicious behaviors, suspicious events, suspicious injuries, trends or patterns. Additionally, education emphasized immediately protecting the resident when abuse is identified and that anyone can be a perpetrator of abuse. The primary method for protecting residents, following staff involved abuse allegations or incidents, will be immediately placing the accused staff member on administrative leave pending the results of investigation. Education included protocols for employees having knowledge of an alleged abuse incident for reporting abuse immediately including first reporting to their Supervisor, the Supervisor will report to the Director of Nursing and Administrator. Employees with knowledge may also report directly to the Administrator as well.</p> <p>Education was completed on August 31, 2024, with all staff present in the Center and for all staff available via telephone communication. The total number of employees educated was 110. The Nurse Practice Educator and/or designee will ensure employees unable to be reached after 3 attempts, those with scheduled time off, on leave of absence (FMLA), vacation, or PRN will be re-educated prior to returning to duty. New hires (full-time, part-time) will be educated on Abuse Prohibition policy during the orientation process by the Nurse Practice Educator or Director of Nursing Services.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On August 30, 2024 Market President educated the Nursing Home Administrator on the implementation of the Abuse Prohibition policy and procedure to include screening of potential hires; training of employees; prevention of occurrences; identification of possible incidents or allegations which need investigation; conducting thorough investigations of incidents and allegations; protection of residents during investigations; and reporting of incidents, investigations, and center response to the results of the investigations. Education included ensuring the Administrator knows and understands that abuse is identified as the individual acts deliberately, the actions of the individual were deliberate in nature and not dependent on the intent of the individual. Administrator has been educated regarding protecting residents by ensuring the accused individual does not have access to repeat the abuse. The accused employee is to be placed on administrative leave pending the results of the investigation.</p> <p>Education on August 30, 2024 also included ensuring the administrator knows his role and responsibility in implementing the abuse policy including investigations, identification, reporting, protection and involvement of QAPI. Administrator knows that staff not reporting abuse is a failure to follow policy and corrective action must be taken up to and including termination of employment.</p> <p>Compliance Date: September 1, 2024</p> <p>*****</p> <p>After review of documentation supporting the above correction actions, including the facility's investigation file, in-service/education records and staff interviews, the survey team verified the facility implemented corrective actions on 09/01/2024.</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47408</p> <p>Based on interviews, record reviews, review of the facility's abuse policy titled, Abuse Prohibition, review of Facility Reported Incidents (FRIs) received by the Alabama State Survey Agency, and review of the facility's investigative files, the facility failed to ensure an allegation of staff to resident physical abuse was thoroughly investigated to identify that abuse occurred, determine if bruising was a result of the abuse, and take appropriate action to prevent further potential abuse.</p> <p>On 07/01/2023, Certified Nursing Assistant (CNA #14) reported to Licensed Practical Nurse (LPN) #17 that she grabbed Resident Identifier (RI) #398's wrists to keep RI #398 from hitting her. The incident was not reported to the Administrator (ADM) and no protective measures were implemented until 07/06/2023. On 07/06/2023 red and purple discolorations were noted on RI #398 's bilateral arms and wrists. The ADM failed to substantiate the allegation of physical abuse despite the CNA stating that she grabbed RI #398's wrists. The facility's investigation did not determine the cause of the bruising. The facility allowed CNA #14 to return to work at the facility.</p> <p>It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect, and Exploitation.</p> <p>On 08/30/2024 at 7:32 PM, the ADM and Director of Nursing (DON) were provided a copy of the Immediate Jeopardy (IJ) template and notified of the finding of immediate jeopardy; substandard quality of care in the area of Freedom from Abuse, Neglect, and Exploitation at F 610-Investigate/Prevent/Correct Alleged Violations.</p> <p>The IJ began on 07/01/2023 and continued until 09/01/2024 when the survey team verified onsite that corrective actions had been implemented. On 09/02/2024 the immediate jeopardy was removed, F 610 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.</p> <p>This deficiency was cited as the result of the investigation of complaint/report #AL00044697.</p> <p>Further the facility failed to thoroughly investigate three allegations of resident on resident abuse and two incidents of injury of unknown origin. These failures did not rise to the level of immediate jeopardy and included the following allegations:</p> <p>2) On 04/19/2023 RI #148 hit RI #25.</p> <p>This deficiency was cited as a result of a Facility Reported Incident, complaint/report number AL00043994.</p> <p>3) On 08/22/2023 RI #51 hit RI #600.</p> <p>This deficiency was cited as a result of a Facility Reported Incident, complaint/report number AL00045350.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>4) On 10/30/2023 RI #198 was observed with bruising around the right eye and was complaining of left hip pain. The facility identified the allegation as injury of unknown origin and failed to thoroughly investigate.</p> <p>This deficiency was cited as a result of a Facility Reported Incident, complaint/report number AL00046026.</p> <p>5) On 11/14/2023 RI #598 alleged she/he was experiencing back pain from being pushed down to the floor. The facility failed to thoroughly investigate the injury of unknown origin involving RI #598.</p> <p>This deficiency was cited as a result of a Facility Reported Incident, complaint/report number AL00046185.</p> <p>6) On 06/25/2024 RI #60 slapped RI #9.</p> <p>This deficiency was cited as a result of a Facility Reported Incident, complaint/report number AL00048245.</p> <p>Findings Include:</p> <p>Cross-Reference F 600, F 835, and F 867.</p> <p>Review of the facility's abuse policy titled, Abuse Prohibition, with a revision date of 10/24/2022, revealed the following:</p> <p>POLICY</p> <p>Center prohibit abuse, mistreatment . for all patients. This includes, . any physical . restraint not required to treat the patient's medical symptoms .</p> <p>The Center will implement an abuse prohibition program through the following: .</p> <p>Identification of possible incidents or allegations which need investigation;</p> <p>Investigation of incidents and allegations;</p> <p>Protection of patients during investigations; and</p> <p>Reporting of incidents, investigations, and Center response to the results of their investigations.</p> <p>Federal Definitions:</p> <p>Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish . Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .</p> <p>Physical Abuse includes hitting slapping, pinching, kicking, etc. (etcetera) .</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Injuries of unknown source are defined as an injury with both of the following conditions.</p> <p>The source of the injury was not observed by any person or the source of the injury could not be explained by the patient; and</p> <p>The injury is suspicious because of the intent of the injury or the location of the injury (e.g., (for example) the injury is located in an area not generally vulnerable to trauma) .</p> <p>Mistreatment is defined as inappropriate treatment . of a patient .</p> <p>PROCESS .</p> <p>6. Staff will identify events - such as suspicious bruising of patients, occurrences, patterns. and trends that may constitute abuse - and determine the direction of the investigation. This also includes patient-to-patient abuse .</p> <p>7.8 The investigation will be thoroughly documented within the Risk Management Portal. Ensure that documentation of witnessed interviews is included .</p> <p>1) RI #398 was admitted to the facility on [DATE], with diagnoses to include Cerebral Infarction, Unspecified, Hemiplegia, Unspecified Affecting Right Dominant Side and Anxiety Disorder.</p> <p>A Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/26/2023, identified RI #398 as scoring a 5 of 15 on the Brief Interview of Mental Status (BIMS) indicating RI #398 had severely impaired cognition.</p> <p>The Alabama Department of Public Health Online Incident Reporting System form, dated 07/06/2023 documented:</p> <p>. Incident Type . Abuse - Physical .</p> <p>Incident Detail .</p> <p>Name(s) of resident(s) involved: (RI #398) .</p> <p>Name of staff member who became aware of the incident: (Social Worker [SW]) .</p> <p>Narrative summary of incident: Resident informed (his/her) family, who informed the Center Social worker that resident is claiming an unnamed staff member on Saturday night was rough during care .</p> <p>The facility's Allegation Summary, documented that the facility's investigation determined:</p> <p>On Thursday July 6, 2023 (RI #398) alleged than an unnamed CNA had been rough with care on the previous Saturday. (RI #398) had stated that the CNA had grabbed (his/her) wrist and that (he/she) had bruising on them .</p> <p>Center Finding:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On Thursday July 6, 2023 it was stated to facility staff that (RI #398) was stating (he/she) had bruising on (his/her) wrists and that a CNA was rough during care on the previous Saturday .</p> <p>Center Conclusions:</p> <p>This investigation is unable to substantiate abuse in this instance. Based on the investigation care provisions was being complicated and (RI #398) began striking the CNA. The CNA did grab (his/her) wrist in order to stop (him/her) from striking her .</p> <p>The facility's investigative file was reviewed and a WITNESS INTERVIEW RECORD statement dated 07/06/2023, signed by CNA #14 documented the following:</p> <p>. I worked with (him/her) Saturday. When I was changing (him/her) (he/she) begin to hit me and I Told (him/her) to stop and (he/she) didn't And I When (went) and got the nurse And Told her what (he/she) was doing And When you try To give (him/her) patient care (he/she) begin to fight.</p> <p>Review of a Late Entry Progress Note for RI #398, dated 07/01/2023, documented by an agency staff member, LPN #17 on 07/08/2023 revealed the following:</p> <p>During last rounds CNA was changing the resident and (he/she) got upset and was yelling and proceeded to hit the aide. To keep from getting hit the aide grabbed (his/her) forearm and moved away from (him/her). She came out of the room and informed the nurse at the desk .</p> <p>On 08/25/2024 at 4:40 PM an interview was conducted with the ADM. The ADM said according to the facility report he was made aware of the incident involving RI #398 and CNA #14 on 07/06/2023. The ADM said RI #398 informed the Social Worker that an unnamed staff member on Saturday night (07/01/2023) was rough during care. The ADM said he reported the incident to ADPH and initiated an investigation to started to try to identify the unnamed staff member. The ADM said the investigation revealed CNA #14 stated RI #398 was hitting her and she stopped RI #398 by grabbing his/her wrists and reported it to LPN #17. The ADM said he did not substantiate the incident as abuse because he did not believe CNA #14 had any intention of harming RI #398. When asked how it would make a reasonable person feel if someone grabbed them by the wrist and left bruising on them, the ADM said he would want it to stop.</p> <p>On 08/28/2024 at 11:00 AM, a follow-up interview was conducted with the ADM. When asked how he investigated the alleged abuse occurring with RI #398 on 07/01/2023, the ADM said he interviewed any staff that worked from 07/01/2023 to 07/06/2023. The ADM said he was not aware RI #398 had bruises until the surveyor informed him on 08/25/2024. The ADM said he interviewed CNA #14, LPN #17 and LPN #7, but did not document they had been interviewed. When asked if he should have kept a record of the staff being interviewed, the ADM said yes.</p> <p>2) RI #25 was admitted to the facility on [DATE].</p> <p>A Quarterly MDS assessment with an ARD date of 01/28/2023, identified RI #25 as scoring a 10 of 15 on the BIMS, indicating RI #25 had moderate impaired cognition.</p> <p>RI #148 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A Quarterly MDS assessment with an ARD date of 03/10/2023, identified RI #148 as scoring a 6 of 15 on the BIMS, indicating RI #148 had severe impaired cognition.</p> <p>The Alabama Department of Public Health Online Incident Reporting System form, dated 04/19/2023 documented:</p> <p>. Incident Type . Other Facility Incidents .</p> <p>Incident Detail .</p> <p>Name(s) of resident(s) involved: (RI #25 and RI #148) .</p> <p>Narrative summary of how injury was discovered: Reportedly RI #148 hit RI #25 on his/her arm while in the dining area. When asked why RI #148 states that RI #25 was in his way .</p> <p>A review of the facility's investigation summary documented: .On April 19, 2023, it was reported that RI #148 had struck the arm of RI #25. When asked RI #148 stated he/she needed him/her to move out of his/her way. RI #148 was attempting to exit the dining area and from his/her perspective RI #25 was impeding his/her route out of the dining room . At this time we are unable to substantiate abuse occurred based on the fact that RI #148 had no intent to harm RI #25 but to merely compel him/her to relocate .</p> <p>Review of the facility's investigative file revealed no documentation of interviews completed during the investigation.</p> <p>An interview was conducted with the ADM on 08/26/2024, at 4:20 PM. During the interview, the ADM was asked about the documentation of any interviews related to the investigation involving RI #148 and RI #25. The ADM said that he had conducted interviews with RI #148, as well as with witnesses and other residents present in the dining room. When questioned about the location of these interviews, he stated that he typically retained and submitted them with the investigation; however, he was unable to locate any interviews associated with this case. The ADM said the importance of documenting all statements was to ensure sufficient information was available for a thorough assessment of the situation and the formulation of an appropriate action plan.</p> <p>3) RI #51 was admitted to the facility on [DATE] with a Diagnosis to include but not limited to: Chronic Obstructive Pulmonary Disease and Alzheimer's Disease.</p> <p>A review of RI #51's Quarterly MDS ARD of 07/20/2023, indicated RI #51 had a Brief Interview of Mental Status BIMS score of 15 of 15, which indicated intact cognition. RI #51 ambulated independently with assistance of a walker on the unit.</p> <p>RI #600 was originally admitted to the facility on [DATE], discharged on [DATE] and readmitted on [DATE] with Diagnosis of Dementia with Behavioral Disturbance.</p> <p>A review of RI #600's care plan revealed he/she had the potential to exhibit physical behaviors and noted a prior physical altercation with a resident on 07/07/2023. A review of RI #600's Quarterly MDS with an ARD of 08/8/2023, indicated a BIMS score of 4 of 15 which indicated RI #600's cognition was severely impaired. He/she ambulated independently on the unit with no assistive device.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 08/22/2023 at 8:10 PM, the Alabama Department of Public Health (ADPH) Incident Reporting System documented RI #51 alleged RI #600 hit him/her on the upper back when he/she tried to redirect.</p> <p>Review of the facility's investigation summary revealed:</p> <p>. On 08/22/2023 it was alleged by RI #51 that RI #600 had struck him/her back and arm after he/she had tried to direct RI #600 to change directions in the hall.</p> <p>Center Investigation:</p> <p>The Center investigation included interviews with staff on the unit at the time of alleged event and interview with RI #51. RI #600 is not able to be interviewed.</p> <p>Center Findings:</p> <p>This event was unwitnessed and only reported by RI #51 . According to RI #51 he/she was attempting to redirect RI #600 in the hallway. During this interaction it was alleged at RI #600 struck RI #51 in the back twice and arm once .both assessed for injury. None noted. RI #600 was monitored and assessed for aggressive behavior .</p> <p>Center Actions Taken: .</p> <p>Allegation reported to ADPH</p> <p>Resident RPs and MD notified of occurrence</p> <p>RI #600 monitored for aggressive behavior, none noted</p> <p>RI #51 and RI #600 assessed for injury, none noted</p> <p>RI #51 educated regarding to inform staff if another resident is to be redirected .</p> <p>The facility investigative file was reviewed and revealed no documented evidence of where RI #51 was interviewed. No documented evidence where education was provided to RI #51. Further, the facility investigative file revealed no documented evidence that RI # 600's behavior was monitored to ensure no physically aggressive behavior occurred after the alleged incident.</p> <p>On 08/24/2024 at 4:16 PM, RI #51 was interviewed and recalled the incident on 08/22/2023 when he/she was hit by RI #600. RI #51 said that RI #600 had wandered into his/her room and attempted to take a personal item. When RI #51 provided redirection, RI #600 hit him/her on the back.</p> <p>On 08/24/2024 at 5:10 PM CNA #12 was interviewed and revealed RI #600 exhibited behaviors towards others. CNA #12 said she was working down the hall when she heard RI #51 talking to RI #600 saying do not go in his/her room. CNA #12 said RI #600 was a firecracker, and his/her behavior was unpredictable. When he/she heard the argument, he/she went down the hall quickly to intervene. This was when RI #51 reported that RI #600 hit him/her when redirected. CNA #12 said RI #51 was initially upset, but did calm down.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Merry Wood Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 280 MT Hebron Road Elmore, AL 36025	
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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 08/25/2024 at 4:55 PM, the ADM was interviewed about the allegation between RI #51 and RI # 600 on 08/22/2023. The ADM noted the incident was reported by RI# 51, investigated by the facility, and actions put in place. When asked about documentation from resident interviews and behavioral monitoring for RI #600 for aggressive behavior, the ADM said there was unfortunately no documented evidence of the above actions. The ADM agreed there should be more documentation for a thorough investigation.</p> <p>4) RI #198 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include Anoxic Brain Damage, Expressive Language Disorder, Parkinson's, Vascular Dementia, Long Term (current) use of Aspirin and History of Falling.</p> <p>An Annual MDS assessment with an ARD date of 09/14/2023, identified RI #198 as scoring a 3 of 15 on the BIMS, indicating RI #198 had severely impaired cognition.</p> <p>The Alabama Department of Public Health Online Incident Reporting System form, dated 10/30/2023 documented:</p> <p>. Incident Type . Injuries of Unknown Source .</p> <p>Date and time of when staff became aware of the incident: . 10/30/2023 .Time: 04:00 PM .</p> <p>Incident Detail .</p> <p>Name(s) of resident(s) involved: (RI #198) .</p> <p>Narrative summary of how injury was discovered: Resident discovered with bruising over . (his/her) right eye and complaining of pain in (his/her) left hip. Resident unable to state how injuries occurred and no incidence have been reported explaining how injuries occurred .</p> <p>Review of the facility's investigation summary revealed:</p> <p>. On 10/30/23 it was reported that (RI #198) had bruising around his/her eye and was complaining of hip pain. The origin of these concerns were not known .</p> <p>Center Investigation:</p> <p>The Center investigation included interviews with staff providing care for (RI #198). X-rays were also taken.</p> <p>Center Findings:</p> <p>At the time X-rays did not show a fracture . At this time staff do not report having seen or witnessed any incident that would have explained the injury and pain noted . Resident is unable to provide any information as to the origin of the discoloration over (his/her) eye .</p> <p>Center Actions Taken: .</p> <p>Injuries reported to MD (Medical Doctor) and RP (Representative)</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Injury reported to ADPD</p> <p>Resident assessed for additional injury; none noted</p> <p>Xray obtained, no acute fractures noted</p> <p>Investigation completed .</p> <p>Review of the facility's investigative file revealed a WITNESS INTERVIEW RECORD statement had not been obtained from CNA #10, the CNA providing care for RI #128 on the 6 AM to 2 PM shifts, on 10/28/2023, 10/29/2023, and 10/30/2023.</p> <p>On 08/26/2024 at 12:50 PM, a telephone interview was conducted with CNA #10, the CNA providing care for RI #198 on the 6 AM to 2 PM shifts, on 10/28/2023, 10/29/2023 and 10/30/2023. CNA #10 said she did recall RI #198 having a bruise to one of his/her eyes back in October of last year but could not remember which eye it was and could not describe how the bruise looked. CNA #10 said she got RI #198 out of bed around 10:30 AM on 10/29/2023, because RI #198 was becoming fidgety. CNA #10 said when she got RI #198 out of bed she placed RI #198 in his/her geriatric chair and left RI #198 in his/her room. CNA #10 said probably around lunch time she went back to check on RI #198 and noticed RI #198 had the bruise. CNA #10 said she took RI #198 to the nurse to show the nurse the bruise. When asked did she write a statement about what she had observed, CNA #10 said no one asked her to write a statement about what she witnessed.</p> <p>On 08/28/2024 at 9:38 AM, an interview was conducted with the ADM. The ADM said RI #198's bruise was considered an injury of unknown origin because the bruise was from an unknown source. When asked how an investigation was conducted to determine if abuse or neglect occurred, the ADM said staff who had provided care for RI #198 a couple of days before the bruise was identified were interviewed. The surveyor showed the ADM the assignment sheet for 10/28/2023 and 10/29/2023 and asked the ADM which CNA provided care to RI #198 on the 6 AM to 2 PM shift. The ADM said CNA #10. The ADM said looking at the interviews collected during his investigation he did not see where CNA #10 completed a Witness Interview. The ADM said since CNA #10 provided care for RI #198 during the time frame the bruise was observed, she should have completed a Witness Interview Record form. The ADM said since CNA #10's statement was not obtained, this was probably not a thorough investigation.</p> <p>5) RI #598 was admitted to the facility on [DATE] with a Diagnosis of Dementia with Behavioral Disturbance.</p> <p>A review of RI #598's Quarterly MDS with an ARD of 06/15/2023 revealed he/she scored a 10 of 15 on the BIMS which indicated RI #598's cognition was moderately impaired. He/she ambulated on the unit independently with assistance of a walker. RI # 598's balance during transitions was coded as not steady, but able to stabilize without staff assistance.</p> <p>RI #598 was care planned for the potential to demonstrate verbal outburst towards others. A review of RI #598's care plan documented 11/08/2023 he/she exhibited verbal outbursts toward staff.</p> <p>A review of RI #598's medical record documented that on 11/13/2023 at 7:35 PM RI #598 started an argument with another resident, became agitated, cursing, and required staff intervention.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 11/14/2023 at 7:11 AM, the Alabama Department of Public Health Online Incident Reporting System form documented . RI #598 of our memory care unit stated to nurse that he/she had back pain because he/she was pushed down to the floor last night. He/she was unable to state by whom.</p> <p>Review of the facility's investigation summary revealed:</p> <p>. On 11/14 2023 RI #598, a resident in our memory care unit, claimed that he/she was having back pain. Nurse treated for pain and RI #598 claimed he/she was pushed down to the floor on the night before. Unable to state who or where.</p> <p>Center Investigation:</p> <p>Investigation included interviews with staff that had worked with RI # 598.</p> <p>Center Findings:</p> <p>RI # 598 is unable to state how, why or who pushed him/her down on the night shift. X-ray were taken, no fractures noted. Some mild osteoarthritis was noted. No other signs of injury were found. Staff interviewed stated they did not witness a fall, nor any incident of RI #598 being pushed. They did not find him/her on the floor at any point on the shifts.</p> <p>Center Actions Taken: .</p> <p>ADPH notified</p> <p>MD and RP notified</p> <p>Resident assessed for injury, none noted</p> <p>Resident treated for pain with good effect</p> <p>X-Ray of back taken, no fracture noted</p> <p>Resident monitored for change in behaviors or interactions with others, none noted</p> <p>Social Services provided as needed .</p> <p>A review of the facility investigative file revealed no staff or resident interviews were conducted prior to 11/14/2023 when RI #598 complained of back pain from being pushed down the night before. Further, the facility file revealed no documentation from staff that witnessed the altercation on 11/13/2023. No documentation that the incident on 11/13/2023 was investigated.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 08/26/2024 at 2:54 PM, the ADM was interviewed and said the facility investigation concluded there were no witnesses to a fall, or incident of RI #598 being pushed down the night before. When the ADM was asked if staff/resident witness statements were conducted days prior to 11/14/2023 to assist in determining if abuse did or did not occur, the ADM said no. The ADM agreed that more interviews should have been completed and documented. The ADM said he was not aware of an incident that occurred on 11/13/2023; therefore, no witness statements obtained nor investigated. When asked if the incident on 11/13/2023 should have been investigated further, the ADM said yes.</p> <p>6) RI #9 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include Schizoaffective Disorder, Depressive Type.</p> <p>An Admission MDS assessment with an ARD date of 04/04/2024, identified RI #9 had a BIMS of 5 of 15 which indicated that RI #9 had severely impaired cognition.</p> <p>RI #60 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include Adjustment Disorder.</p> <p>A Quarterly MDS assessment with an ARD date of 06/20/2024, identified RI #60 as scoring a 12 of 15 on the BIMS, indicating RI #60 had moderate impaired cognition.</p> <p>The Alabama Department of Public Health Online Incident Reporting System form, dated 06/25/2024 documented:</p> <p>. Incident Type . Other Facility Incidents .</p> <p>Incident Detail .</p> <p>Name(s) of resident(s) involved: (RI #9 and RI #60) .</p> <p>Narrative summary of how injury was discovered: RI # 9 was in another residents room, RI #60 came by and attempted to redirect RI #9 out of the room. RI #60 allegedly slapped RI #9's hand and told him/her they should not be in this room. RI #60 denies slapping RI #9 .</p> <p>A review of the facility's five day summary documented: . On June 25, 2024 it was alleged that RI #60 pinched the hand of RI #9 . This was a witnessed resident to resident altercation. Staff witnessing the incident were interviewed. Residents were also interviewed . At this time abuse cannot be substantiated in this instance. RI #60 simply did not understand that RI #9 was an invited guest in the room and . did not intend to cause harm to RI #9 . Both residents were assessed for injury, none noted .</p> <p>Review of the facility's investigative file revealed no documentation of interviews completed during the investigation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the ADM on 08/27/2024, at 12:13 PM. During the interview, the ADM was asked about the documentation of any interviews related to the investigation involving RI #60 and RI #9. He acknowledged that he spoke with those involved in the investigation but had not documented the interviews. He said that he should have documented the interviews. The ADM said the importance of documenting statements would be to provide an accurate and clear understanding of the events, which was essential for formulating an accurate action plan.</p> <p>*****</p> <p>On 09/01/2024 at 6:40 PM, the facility submitted an acceptable removal plan, which document:</p> <p>Date: August 30, 2024</p> <p>F-610-Investigate/Prevent/Correct Alleged Violation</p> <p>On 7/6/23 Center Social Worker was notified by RI#398's family regarding resident RI#398 stating a CNA had been rough during care.</p> <p>On 7/6/23 Center Social worker notified Center Administrator of the allegation</p> <p>Center administrator on 7/6/23 spoke with RI#398 regarding the occurrence. The Administrators failure to obtain the resident's statement, statements from other residents, and potential witness statements resulted in the facility not investigating thoroughly to include determining the cause of the injury to RI# 398 wrist/forearms and implement appropriate corrective actions to prevent further potential abuse.</p> <p>RI #398 was discharged on [DATE], from Merry wood Lodge Center.</p> <p>On August 30, 2024 Market President educated the Nursing Home Administrator on the implementation of the Abuse Prohibition policy and procedure to include screening of potential hires; training of employees; prevention of occurrences; identification of possible incidents or allegations which need investigation; conducting thorough investigations of incidents and allegations; notifying and reviewing each investigation with the Market Clinical Lead before completion; protection of residents during investigations; and reporting of incidents, investigations, and center response to the results of the investigations to include identifying abuse and taking appropriate action for prevention of abuse. Administrator has been trained and understands his role and responsibility in ensuring a thorough investigation is completed. Administrator has been trained on the steps to a thorough investigation. These include identification of an alleged occurrence, ensure all alleged occurrences are reported to the Administrator, protect the resident(s), reporting the event, assess resident for injury, perform and document interviews with all Interviewable residents, interviewing all witnesses and all staff in the Center at the time, reviewing pertinent chart documentation such as progress notes, care plans, physician's order, diagnoses and any other clinical documentation appropriate to the investigation. Investigating bruises and injuries are also a key component to investigation. Developing appropriate conclusions, including substantiation or not correctly, and also developing appropriate actions to take in order to prevent future occurrences from occurring.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Center QAPI Committee which included the Market Clinical Lead by way of phone, business office manager, MDS coordinator, dietary manager, office assistant, recreation director, nurse practice educator, admissions director, social services director, medical records, environmental services supervisor, dietary supervisor, Director of Nursing Services, and Administrator met on 9/1/24 at 12:45 pm to discuss staff on resident incidents after the incident occurring on 7/1/2023. Two were identified reviewed to determine if correct determination was made and if appropriate corrective action has been taken the findings are as follows:</p> <p>RI# 81 event dated 1/2/24- Based on QAPI review, thorough investigation was not completed, the determination remains appropriate, the actions taken at the time were appropriate however QAPI committee determines that additional actions needed to be taken these additional actions taken include:</p> <p>Accused CNA no longer works at Merry [NAME] Lodge, her last day of work at the Center was March 10, 2024.</p> <p>On 8/31/24 47 residents were interviewed regarding rough treatment from staff and 42 residents skin assessments were completed for any signs of abuse, none were noted.</p> <p>On 8/31/24 110 staff members were re-educated regarding Abuse Prohibition Policy including the ability to prevent abuse, identify signs and evidence of abuse, and report abuse to the charge nurse and ultimately to the Administrator.</p> <p>On 8/30/24 Administrator was educated regarding conducting thorough investigations and protecting residents during the investigation. Administrator was also educated regarding identifying abuse as a part of the thorough investigation process and implementing corrective actions to prevent further occurrences. Administrator was also instructed to review all reportable events with Market Clinical Lead prior to finalizing investigation protocols.</p> <p>On 8/31/24 QAPI committee was educated regarding thoroughly reviewing all reportable events during the QAPI process for thoroughness of the investigation, appropriateness of the determination, and any further corrective actions that may need to be taken.</p> <p>RI #48-Event dated 3/10/24- Based on QAPI review, a thorough investigation was not completed, the determination was incorrect, the corrective actions taken at the time were appropriate however the QAPI committee has determined additional actions necessary to be taken. These actions include:</p> <p>Accused CNA no longer works at Merry [NAME] Lodge, her last day of work at the Center was March 10, 2024.</p> <p>On 8/31/24 47 residents were interviewed regarding rough treatment from staff and 42 residents skin assessments were completed for any signs of abuse, none were noted.</p> <p>On 8/31/24 110 staff members were re-educated regarding Abuse Prohibition Policy including the ability to prevent abuse, identify signs and evidence of abuse, and report abuse to the charge nurse and ultimately to the Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 8/30/24 Administrator was educated regarding thorough investigations and protecting residents during the investigation. Administrator was also educated regarding identifying abuse as a part of the thorough investigation process and implementing corrective actions to prevent further occurrences. Administrator was also instructed to review all reportable events with Market Clinical Lead prior to finalizing investigation protocols.</p> <p>On 8/31/24 QAPI committee was educated regarding thoroughly reviewing all reportable events during the QAPI process for thoroughness of the investigation, appropriateness of the determination, and any further corrective actions that may need to be taken.</p> <p>On 09/01/2024 at 4:25 pm the Center QAPI Committee which included the Market Clinical Lead by way of phone, business office manager, MDS coordinator, dietary manager, office as [TRUNCATED]</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>29671</p> <p>Based on observations, interviews, the 2022 United States (U.S.) Food and Drug Administration (FDA) Food Code, and a facility's policy titled Environment, the facility failed to ensure the kitchen floor was maintained in a clean and sanitary manner.</p> <p>This had the potential to affect all residents who received meals from the facility's kitchen.</p> <p>Findings Include:</p> <p>A review of 2022 United States (U.S.) Food and Drug Administration (FDA) Food Code, documented:</p> <p>(A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean .</p> <p>A review of policy titled Environment Revised 9/2017 documented: .The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation .</p> <p>On 08/20/2024 at 10:16 AM, the Surveyor along with the Dietary Manager conducted an initial inspection of the kitchen. During the tour, it was noted that the kitchen floor was sticky, and an unidentified black substance was present in both the center and corners of the floor.</p> <p>On 08/22/2024 at 11:52 AM, a follow up kitchen inspection was conducted. The kitchen floor was observed to be unclean and sticky, with an unidentified black substance on various sections of the floor.</p> <p>On 08/28/2024 at 5:09 PM, and interview was conducted with the Director of Operations. The Director acknowledged the issue of sticky floors in the kitchen. He explained that the floors were old and a monthly deep clean was being considered. He was unsure the last time the floors had been deep cleaned. When asked about the black substance observed on the floor, the Director said it could be resolved through the deep cleaning process, as mopping and sweeping had proven ineffective in addressing those areas. The Director said the floors required attention and a new cleaning schedule would be implemented. He said it was important to maintain clean, non-sticky floors to prevent the attraction of insects, pests, and rodents.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>29671</p> <p>Based on observation, interview, review of a facility policy titled, Environmental Services Policies and Procedures and review of the 2017 U.S. (United States) Public Health Service Food Code, the facility failed to ensure the grounds around the dumpster's were free of a burn pile with an accumulation of discarded cardboard boxes piled on top of the burn pile.</p> <p>This had the potential to attract rodents and pests and affect all 98 residents living in the facility.</p> <p>Findings Include:</p> <p>A review of the the 2017 U.S. (United States) Public Health Service Food Code revealed:</p> <p>. 5-501.110 Storing Refuse, Recyclables, and Returnable's.</p> <p>REFUSE, . shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents . 5-501.115 Maintaining Refuse Areas and Enclosures. A storage area and enclosure for REFUSE, . shall be maintained free of unnecessary items . and clean .</p> <p>The facility manual entitled Environmental Services Policies and Procedures included a policy titled ENV207 with a revision date of 03/01/2024 which documented: .Trash is removed from the Center/Community on a scheduled basis. Purpose To prevent accumulation of trash .</p> <p>The facility policy titled Environment with a revision date of 03/01/2024 documented: . 7. All trash will be disposed of in external receptacles (dumpsters) and the surrounding area will be free of debris.</p> <p>On 08/20/2024 at 10:16 AM the outside dumpster area of the facility was observed with the Dietary Manager. During the inspection a burn pile in close proximity of the dumpster area was observed. The burn pile contained multiple discarded cardboard boxes stacked on the burn pile.</p> <p>On 08/20/2024 at 10:20 AM an interview was conducted with the Dietary Manager. The Dietary Manager confirmed the presence of the burn pile and did not know how long it had been there. She said cardboard should not be stacked on the burn pile, as it may attract animals, pests or snakes. She said that cardboard was typically disposed of in the dumpster's.</p> <p>On 08/24/2024 at 11:49 AM an interview was conducted with the Administrator (ADM). The ADM said the burn pile located near the dumpster's was used by maintenance to burn old furniture and some debris. The ADM confirmed that discarded cardboard boxes were observed by the surveyor on 08/20/2024 and said cardboard should not be burned but rather disposed of in the dumpster's. The ADM said the concern of a burn pile near the outside dumpsters and the facility would be the possibility of a fire.</p>

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47408</p> <p>Based on interviews, record review, review of the facility's investigative file, review of the facility's abuse policy titled Abuse Prohibition, and review of the job responsibilities of the Administrator (ADM), the ADM failed to ensure the Abuse Policy was implemented, failed to investigate abuse thoroughly, failed to identify abuse, and take appropriate action for prevention of abuse.</p> <p>On 07/01/2023, Certified Nursing Assistant (CNA #14) reported that she grabbed Resident Identifier (RI) #398's wrists to keep RI #398 from hitting her to Licensed Practical Nurse (LPN) #17. The incident was not reported to the Administrator (ADM) and no protective measures were implemented until 07/06/2023. On 07/06/2023 red and purple discolorations were noted on RI #398 's bilateral arms and wrists. The ADM failed to substantiate the allegation of physical abuse despite the CNA stating that she grabbed RI #398's wrists. The facility's investigation did not determine the cause of the bruising. The facility allowed CNA #14 to return to work at the facility.</p> <p>It was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.70 Administration.</p> <p>On 08/30/2024 at 7:32 PM, the ADM and the Director of Nursing (DON) were provided the IJ templates and notified of the findings at the immediate jeopardy level in the area of Administration at F835-Administration.</p> <p>The IJ began on 07/01/2023 and continued until 09/01/2024 when the facility implemented corrective actions. On 09/02/2024, the immediate jeopardy was removed, F 835 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.</p> <p>The failure of the Administrator to ensure the Abuse Policy was implemented to ensure allegations of abuse were investigated thoroughly and identified as abuse to ensure appropriate actions were implemented to prevent further potential abuse had the potential to affect all residents of the facility.</p> <p>This deficient practice was cited as a result of the investigation of a Facility Reported Incident, complaint/report number AL00044697.</p> <p>Findings Include:</p> <p>Cross Reference F 607, F 610, and F 867.</p> <p>48195</p> <p>Review of the facility's abuse policy titled, Abuse Prohibition, with a revision date of 10/24/2022, revealed the following:</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Merry Wood Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 280 MT Hebron Road Elmore, AL 36025	
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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>POLICY</p> <p>Center prohibit abuse, mistreatment . for all patients .</p> <p>PROCESS</p> <p>1. The Administrator . is responsible for operationalizing policies and procedures that prohibit abuse .</p> <p>Review of the Administrator's Job Description, with an effective date of 06/01/2022, revealed the following:</p> <p>. POSITION SUMMARY</p> <p>. Responsible for assuring that the center operates in full compliance with Federal and State regulations . Accountable for all activities and departments of the Center subject to rules and regulations promulgated by government agencies to ensure proper health care services to residents .</p> <p>The facility's Allegation Summary, documented that the facility's investigation determined:</p> <p>On Thursday July 6, 2023 (RI #398) alleged than an unnamed CNA had been rough with care on the previous Saturday. (RI #398) had stated that the CNA had grabbed (his/her) wrist and that (he/she) had bruising on them .</p> <p>Center Investigation:</p> <p>The investigation consisted of interviews with residents and staff. Also included were skin assessments of residents.</p> <p>Center Finding:</p> <p>On Thursday July 6, 2023 it was stated to facility staff that (RI #398) was stating he/she had bruising on his/her wrists and that a CNA was rough during care on the previous Saturday . (RI #398) had some reddened areas on his/her wrist .</p> <p>Center Conclusions:</p> <p>This investigation is unable to substantiate abuse in this instance. Based on the investigation care provisions was being complicated and (RI #398) began striking the CNA. The CNA did grab his/her wrist in order to stop him/her from striking her .</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 08/29/2024 at 3:24 PM, an interview was conducted with the facility's ADM. The ADM said his responsibilities were to oversee the facility operations, ensure policies were being followed, staff were properly trained, investigate abuse allegations, and report timely. The ADM said investigating abuse allegations entailed gathering all needed information to determine what actually occurred through interviews, obtaining clinical input, and putting corrective action in place to ensure safety of the resident. The ADM was asked about an allegation of physical abuse that alleged Certified Nursing Assistant (CNA) #14 grabbed Resident Identifier (RI) #398's wrist to stop the resident from striking her. The ADM said he did not substantiate the allegation because CNA #14 said she was stopping RI #398 from hitting her and the ADM was thinking that there was no intent to harm. The ADM said the allegation should have been substantiated and CNA #14's employment should have been terminated.</p> <p>21055</p> <p>*****</p> <p>On 09/01/2024 at 6:40 PM, the facility submitted an acceptable removal plan, which document:</p> <p>Date: August 30, 2024</p> <p>F-835- Administration</p> <p>On 7/6/23 Center Social Worker informed Center Administrator that RI#398 family informed her that RI#398 told them that a CNA had been rough with RI# 398 during care.</p> <p>On 7/6/23 it was discovered during DON interviews that CNA #14 had reported to LPN #17 that she had had an incident on 7/1/24 where she had grabbed the wrists of RI#398. LPN #17 failed to report this occurrence to the Administrator which delayed interventions and investigation from occurring to ensure RI#398 was protected.</p> <p>On 7/6/23 Administrator failed to document interview with RI #398. This resulted in the investigation failing to be completed thoroughly.</p> <p>The failure of a thorough investigation resulted in a failure to substantiate the allegation of physical abuse RI #398 was discharged on [DATE], from Merry wood Lodge Center.</p> <p>On August 30, 2024, the Market President educated the Nursing Home Administrator on implementing Abuse policies and procedures, reporting alleged violations timely, thoroughly investigating alleged incidents, and center's response to the results of the investigations to include identifying abuse and taking appropriate action for prevention of abuse. Education emphasized the Administrator's responsibility of operationalizing policies and procedures that prohibit abuse, neglect, involuntary seclusion, injuries of unknown source, exploitation, and misappropriation of property.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Education, on August 30, 2024, included ensuring the Administrator understands his role in operationalizing and overseeing policies within the Center, specifically the Abuse Prohibition Policy. The Administrator plays a vital role in ensuring staff are properly trained on the Abuse Prohibition Policy including identification of abuse, protection of the residents, and reporting. Administrator will lead in the investigation process, he will follow up with outstanding activities needed for a thorough investigation. The Administrator will also ensure that each reportable event is taken to the QAPI committee for thorough review of completion, deliberation on investigation findings, and development of appropriate actions to take regarding elimination of future recurrence.</p> <p>Education of the Administrator, on August 30, 2024, also included training the Administrator to notify Market Clinical Lead of each occurrence and keeping them abreast of the progress of the investigation and protection of the resident. Also that the complete investigation is reviewed by the Market Clinical Lead to collaborate on the thoroughness of the investigation, any additional steps that still need to occur and that correct determinations are made based on the details of the investigation.</p> <p>On August 31st, 2024, the Market Clinical Advisor and Market Clinical Lead reviewed allegations of Abuse and Neglect in the last 60 days to ensure written Abuse Prohibition policies and procedures were implemented and allegations were reported timely, thoroughly investigated, and residents were protected. No concerns were identified.</p> <p>On August 31, 2024, the Market President and Market Clinical Advisor hosted an AD HOC Quality Assurance Performance Improvement meeting with key personnel. Key personnel included Administrator, DON, Social Worker, Admissions coordinator, maintenance director, business office manager, environmental services supervisor, dietary department manager, recreation director, and memory care program director. This was also done in collaboration with the Medical Director to review the Abuse Prohibition policy and procedure to ensure residents are free from Abuse and Neglect, Abuse policies and procedures are implemented, alleged violations are reported timely, a thoroughly investigation is completed, and center's response to the results of the investigations to include identification of abuse and appropriate actions to prevent abuse.</p> <p>The Center QAPI Committee which included the Market Clinical Lead by way of phone, business office manager, MDS coordinator, dietary manager, office assistant, recreation director, nurse practice educator, admissions director, social services director, medical records, environmental services supervisor, dietary supervisor, Director of Nursing Services, and Administrator met on 9/1/24 at 12:45 pm to discuss staff on resident incidents after the incident occurring on 7/1/2023. Two were identified reviewed to determine if correct determination was made and if appropriate corrective action has been taken the findings are as follows:</p> <p>RI# 81 event dated 1/2/24- Based on QAPI review, thorough investigation was not completed, the determination remains appropriate, the actions taken at the time were appropriate however QAPI committee determines that additional actions needed to be taken these additional actions taken include:</p> <p>Accused CNA no longer works at Merry [NAME] Lodge, her last day of work at the Center was March 10, 2024.</p> <p>On 8/31/24 47 residents were interviewed regarding rough treatment from staff and 42 residents skin assessments were completed for any signs of abuse, none were noted.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 8/31/24 110 staff members were re-educated regarding Abuse Prohibition Policy including the ability to prevent abuse, identify signs and evidence of abuse, and report abuse to the charge nurse and ultimately to the Administrator.</p> <p>On 8/30/24 Administrator was educated regarding conducting thorough investigations and protecting residents during the investigation. Administrator was also educated regarding identifying abuse as a part of the thorough investigation process and implementing corrective actions to prevent further occurrences. Administrator was also instructed to review all reportable events with Market Clinical Lead prior to finalizing investigation protocols.</p> <p>On 8/31/24 QAPI committee was educated regarding thoroughly reviewing all reportable events during the QAPI process for thoroughness of the investigation, appropriateness of the determination, and any further corrective actions that may need to be taken.</p> <p>RI# 48-Event dated 3/10/24- Based on QAPI review, a thorough investigation was not completed, the determination was incorrect, the corrective actions taken at the time were appropriate however the QAPI committee has determined additional actions necessary to be taken. These actions include:</p> <p>Accused CNA no longer works at Merry [NAME] Lodge, her last day of work at the Center was March 10, 2024.</p> <p>On 8/31/24 47 residents were interviewed regarding rough treatment from staff and 42 residents skin assessments were completed for any signs of abuse, none were noted.</p> <p>On 8/31/24 110 staff members were re-educated regarding Abuse Prohibition Policy including the ability to prevent abuse, identify signs and evidence of abuse, and report abuse to the charge nurse and ultimately to the Administrator</p> <p>On 8/30/24 Administrator was educated regarding thorough investigations and protecting residents during the investigation. Administrator was also educated regarding identifying abuse as a part of the thorough investigation process and implementing corrective actions to prevent further occurrences. Administrator was also instructed to review all reportable events with Market Clinical Lead prior to finalizing investigation protocols.</p> <p>On 8/31/24 QAPI committee was educated regarding thoroughly reviewing all reportable events during the QAPI process for thoroughness of the investigation, appropriateness of the determination, and any further corrective actions that may need to be taken</p> <p>On 09/01/2024 at 4:25 pm the Center QAPI Committee which included the Market Clinical Lead by way of phone, business office manager, MDS coordinator, dietary manager, office assistant, recreation director, nurse practice educator, admissions director, social services director, medical records, environmental services supervisor, dietary supervisor, Director of Nursing Services, and Administrator reviewed the remaining incidents that were previously unverified/unsubstantiated since 07/10/2023. 12 incidents were reviewed. 8 were verified during the review. The corrective actions were reviewed for the 8 incidents verified. The review determined the appropriate corrective action had been implemented for 8 incidents, despite being initially unverified/unsubstantiated. It was determined that the 8 incidents required additional corrective actions to include:</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Policy including the ability to prevent abuse, identify signs and evidence of abuse, and report abuse to the charge nurse and ultimately to the Administrator.</p> <p>On 8/30/24 Administrator was educated regarding thorough investigations and protecting residents during the investigation. Administrator was also educated regarding identifying abuse as a part of the thorough investigation process and implementing corrective actions to prevent further occurrences. Administrator was also instructed to review all reportable events with Market Clinical Lead prior to finalizing investigation protocols.</p> <p>On 8/31/24 QAPI committee was educated regarding thoroughly reviewing all reportable events during the QAPI process for thoroughness of the investigation, appropriateness of the determination, and any further corrective actions that may need to be taken.</p> <p>Compliance Date: September 1, 2024</p> <p>*****</p> <p>After review of documentation supporting the above correction actions, including the facility's investigation file, in-service/education records and staff interviews, the survey team verified the facility implemented corrective actions on 09/01/2024.</p>

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<p>F 0851</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>21055</p> <p>Based on interviews and review of the Payroll Based Journal (PBJ) Staffing Data Report, the facility failed to report accurate staffing data to the Centers for Medicare & (and) Medicaid Services (CMS).</p> <p>This affected the second quarter of the PBJ Staffing Data Report for 2024 (January 1, 2024 - March 31, 2024).</p> <p>Findings include:</p> <p>Review of the CMS PBJ Staffing Data Report for the second quarter of 2024 revealed the following:</p> <p>. Excessively Low Weekend Staffing . Result . Triggered . Definition . Triggered = Submitted Weekend Staffing data is excessively low .</p> <p>On 08/29/2024 at 12:18 PM, an interview was conducted with the former Staffing Manager (SM). The former SM said when she was the SM her job was to make sure the floors were staffed with the right amount of Certified Nursing Assistants (CNAs) and Nurses according to the census. The surveyor shared with the former SM that according to the PBJ Staffing Data Report from CMS, the facility triggered for Excessively Low Weekend staffing for the second Quarter (January 1 - March 31, 2024). The former SM said the assignment sheets would accurately tell who worked. Review of the weekend assignment sheets for the second quarter of 2024 (January 1 - March 31) did not show the facility had low staffing on the weekends.</p> <p>On 08/29/2024 at 2:08 PM, the surveyor conducted a telephone interview with the [NAME] President of Product Management (VPPM), the person responsible for submitting the facility's PBJ information to CMS. The VPPM said she submitted the PBJ electronically, once a quarter. The VPPM said she submits the hours for all employees punching in on the time clock. The surveyor shared with the VPPM that according to the CMS Staffing Data Report, the facility triggered for Excessively Low weekend staffing for the 2nd Quarter of 2024 (January 1 - March 31); and asked the VPPM why would that be. The VPPM said when sending in staffing information to CMS, she does not determine who are nursing staff or not she just sends in the amount of staff who have worked or punched in on the time clock for that quarter. The VPPM said low weekend staffing may have triggered because staff who work during the week would not punch in as working on weekends.</p> <p>(continued on next page)</p>

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	On 09/01/2024 at 10:33 AM, in interview was conducted with the Administrator (ADM). The ADM said the VPPM was responsible for submitting PBJ information to CMS and it was based off of the timecards punched for that quarter. The surveyor shared with the ADM that according to the CMS Staffing Data Report, the facility triggered for Excessively Low weekend staffing for the second Quarter of 2024 (January 1 - March 31). When asked was the facility short of staff at this time, the ADM said not to his knowledge. The ADM said it may have been that salaried staff, who did not have to punch in, worked on some of the the weekends. The ADM said when this happened the staff actually working the weekend might not have been actually counted as working the weekend on the PBJ Staffing Data Report. The surveyor asked, why would CMS need accurate information for the PBJ report. The ADM said basically to show the facility had adequate staff working on weekends.		

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<p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>47408</p> <p>Based on interviews, record review, review of facility policies titled Abuse Prohibition and Center Quality Assurance Performance Improvement Process, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee reviewed and analyzed an allegation of abuse in a manner to analyze causes and implement preventative actions.</p> <p>The committee failed to identify physical abuse against Resident Identifier (RI) #398 and failed to identify concerns with identification, reporting, investigation, and protection for an allegation of physical abuse reported to the State Agency (SA) on 07/06/2023.</p> <p>It was determined the facility's non compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.75-Quality Assurance and Performance Improvement.</p> <p>On 08/30/2024 at 7:32 PM, the ADM and the Director of Nursing (DON) were provided the IJ template and notified of the findings at the immediate jeopardy level in the area of Quality Assurance and Performance Improvement at F867-QAPI/QAA Improvement Activities.</p> <p>The IJ began on 07/01/2023 continued until 09/01/2024 when the facility implemented corrective action to prevent reoccurrence. On 09/02/2024, the immediate jeopardy was removed, F 867 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.</p> <p>The failure of the QAPI committee to review allegations of abuse to analyze causes and implement preventative actions has the potential to affect all residents of the facility.</p> <p>This deficient practice was cited as a result of the investigation of a Facility Reported Incident, complaint/report number AL00044697.</p> <p>Findings Include:</p> <p>Cross Reference F 607 and F 610.</p> <p>29671</p> <p>Review of the facility's abuse policy titled, Abuse Prohibition, with a revision date of 10/24/2022, revealed the following:</p> <p>POLICY</p> <p>Center prohibit abuse . for all patients .</p> <p>Federal Definitions:</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish . Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>Verbal Abuse is any use of oral. written language that willfully includes disparaging and derogatory terms to patients . Examples of verbal abuse includes, but are not limited to: threats of harm; saying things to frightened a patient .</p> <p>Physical Abuse includes hitting slapping, pinching, kicking, etc.Mistreatment is defined as inappropriate treatment . of a patient .</p> <p>10. At monthly Quality Assurance and Performance Improvement (QAPI) meetings, review all allegations of abuse, neglect, misappropriate of patient property, and exploitation that were reported to the state to:</p> <p>10.1 Analyze occurrences to determine what changes are needed, if any, to prevent further occurrences;</p> <p>10.2 Identify situations which have a potential for risk; and</p> <p>10.3 Determine what preventive measures will be implemented by staff .</p> <p>A review of the facility policy titled Center Quality Assurance Performance Improvement Process with a revision date of 10/24/2022 documented:</p> <p>POLICY</p> <p>Centers are committed to incorporating the principles of Quality Assurance and Performance Improvement (QAPI) into all aspects of the Center work processes, service lines, and departments. QAPI activities will be integrated across all care and service areas and include clinical care, quality of life, and patient/resident . choice.</p> <p>PURPOSE</p> <p>To standardize the Center's approach to QAPI culture and processes by implementing the following key elements.</p> <p>QAPI principles will drive the decision making within each Center.</p> <p>The administrator leads the Center's QAPI process and involves all departments, staff and stakeholders-balancing a culture of safety, quality, and patient centeredness.</p> <p>The QAPI process and improvements are based on evidence, drawing data from multiple sources, prioritizing improvement opportunities, and benchmarking results against developed targets.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Improvement Activities (IAs) and Performance Improvement Projects (PIPs) are the structure and means through which identified problem areas are addressed with data analysis, process improvements, and ongoing monitoring whenever necessary using an indiscipline team.</p> <p>Focus areas will include all systems that affect patient, family, and staff satisfaction, quality of care and services provided, and all areas that affect the quality of life for persons living and working in the Center.</p> <p>Successful implementation of QAPI Center-wide enables sustainability of QAPI and Quality Assessment and Assurance (QAA) during periods of transitions of staff and Center leadership .</p> <p>On 08/30/2024 at 4:58 PM an interview was conducted with the DON regarding QAPI. The DON described the facility's process for QAPI coordination regarding abuse allegations. The DON said abuse was not discussed in each QAPI meeting and it depended on whether an issue of abuse had occurred. The DON said once there was an allegation the QAPI team met to see there was an issue that was not managed to the facility's standards, and they used the opportunity to improve on that. The DON said the ADM went over each abuse allegation and went over each opportunity where the facility could improve. The DON said the ADM presented each allegation of abuse that was received during that period. The DON said the incident involving RI #398 was reviewed during QAPI. The DON said the ADM stated the Social Worker was contacted by RI #398's daughter. The QAPI team discussed the bruising of RI #398's wrist. The DON was asked, regarding the incident with RI #398, were all QAPI members in agreement to not substantiate the allegation of abuse that the CNA grabbed RI #398's arm. The DON said, no, the ADM made the decision to substantiate or not. The DON said the ADM asked the QAPI members their input on his decision and no member disagreed with him. He stood firm on his decision to not substantiate the allegation. The DON said based on regulations, abuse did occur when CNA #14 stated she grabbed RI #398's arm and reported to Licensed Practical Nurse (LPN) #17 that she grabbed RI #398's arm. The DON said the QAPI committee's concern with LPN #17's actions was her lack of caring for the residents and not following the company guidelines including reporting the allegation.</p> <p>An interview was conducted with the ADM on 08/29/2024, at 3:24 PM. During the interview, the ADM reported his responsibilities, which included managing the daily operations of the facility and ensuring staff adherence to established policies and procedures. He said that his duties as the abuse coordinator involved preventing abuse, training staff on abuse-related issues, following up on allegations, and conducting prompt investigations and reporting. The Administrator said that the facility's policy mandated a review of all reported abuse allegations through the QAPI process. He said that the QAPI review of abuse allegations included an assessment of the appropriateness of interventions, the execution of investigations, and an evaluation of the effectiveness of those interventions to determine whether new measures were warranted. He also said that the facility's written policies and procedures required that monthly QAPI meetings were held to review all allegations concerning abuse, neglect, and misappropriation of patient property. He said that while the Governing Body oversaw the QAPI process related to allegations, no information regarding abuse allegations had been communicated to the Governing Body from QAPI.</p> <p>21055</p> <p>*****</p> <p>On 09/01/2024 at 6:40 PM, the facility submitted an acceptable removal plan, which document:</p> <p>(continued on next page)</p>		

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 09/01/2024
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.			
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<p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Date: August 30, 2024</p> <p>F-867 - QAPI Program/Plan, disclosure/good faith attempt</p> <p>On 7/28/23 a QAPI meeting was held which included a review of reportables for the month of July 2023, Center QAPI committee failed to thoroughly review and analyze the allegation of abuse in a manner to identify all concerns and address appropriateness of actions</p> <p>On August 31st, 2024, the Market Clinical Advisor and Market Clinical Lead reviewed allegations of Abuse in the last 60 days and the Quality Assurance Performance Improvement Committee meeting minutes to ensure allegations of abuse were analyzed; Abuse Prohibition policies and procedures were implemented; allegations were reported timely; thorough investigation were completed, residents were protected, and appropriate actions were taken to identify and prevent abuse. No concerns were identified.</p> <p>The Market President educated the Nursing Home Administrator on the Quality Assurance Performance Improvement process to include systematic identification, reporting, investigation, analysis, and prevention of abuse or allegations of abuse; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities related to abuse on August 30, 2024.</p> <p>On August 31, 2024, the Market President and Market Clinical Advisor educated the Quality Assurance Performance Improvement Committee on the Abuse Prohibition policy and procedure to ensure residents are free from Abuse and Neglect, Abuse policies and procedures are implemented, alleged violations are reported timely, a thoroughly investigation is completed, and center's response to the results of the investigations with emphasis on identification of abuse and appropriate actions to prevent abuse. The Quality Assurance Performance Improvement Committee includes the Nursing Home Administrator, Director of Nursing, Medical Director, and any other key personnel of at least 3 members. Members present for the education were the Administrator, DON, admissions coordinator, business office manager, recreation director, medical records, social services, memory care program director, recreation director, maintenance director, environmental service supervisor, and dietary services supervisor.</p> <p>Education on August 31, 2024 included emphasizing the importance of analyzing as a team the reportable events of the Center. This analysis should include review of all investigative information, conclusions made, and actions taken. Committee educated that this analysis is important in ensuring all details have been identified and that all necessary and potentially any further actions are implemented to eliminate the risk of event recurrence and resident continued safety.</p> <p>Governing body to include Market President, Market Clinical Advisor, Clinical Lead, Nursing Home Administrator, and Director of Nursing reviewed the Quality Assurance Performance Improvement process and discussed success/barriers for all improvement activities and performance improvement projects to ascertain support, resources, and breakthrough ideas on August 31, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>The Center QAPI Committee which included the Market Clinical Lead by way of phone, business office manager, MDS coordinator, dietary manager, office assistant, recreation director, nurse practice educator, admissions director, social services director, medical records, environmental services supervisor, dietary supervisor, Director of Nursing Services, and Administrator met on 9/1/24 at 12:45 pm to discuss staff on resident incidents after the incident occurring on 7/1/2023. Two were identified reviewed to determine if correct determination was made and if appropriate corrective action has been taken the findings are as follows:</p> <p>RI# 81 event dated 1/2/24- Based on QAPI review, thorough investigation was not completed, the determination remains appropriate, the actions taken at the time were appropriate however QAPI committee determines that additional actions needed to be taken these additional actions taken include:</p> <p>Accused CNA no longer works at Merry [NAME] Lodge, her last day of work at the Center was March 10, 2024.</p> <p>On 8/31/24 47 residents were interviewed regarding rough treatment from staff and 42 residents skin assessments were completed for any signs of abuse, none were noted.</p> <p>On 8/31/24 110 staff members were re-educated regarding Abuse Prohibition Policy including the ability to prevent abuse, identify signs and evidence of abuse, and report abuse to the charge nurse and ultimately to the Administrator.</p> <p>On 8/30/24 Administrator was educated regarding conducting thorough investigations and protecting residents during the investigation. Administrator was also educated regarding identifying abuse as a part of the thorough investigation process and implementing corrective actions to prevent further occurrences. Administrator was also instructed to review all reportable events with Market Clinical Lead prior to finalizing investigation protocols.</p> <p>On 8/31/24 QAPI committee was educated regarding thoroughly reviewing all reportable events during the QAPI process for thoroughness of the investigation, appropriateness of the determination, and any further corrective actions that may need to be taken.</p> <p>RI# 48-Event dated 3/10/24- Based on QAPI review, a thorough investigation was not completed, the determination was incorrect, the corrective actions taken at the time were appropriate however the QAPI committee has determined additional actions necessary to be taken. These actions include:</p> <p>Accused CNA no longer works at Merry [NAME] Lodge, her last day of work at the Center was March 10, 2024.</p> <p>On 8/31/24 47 residents were interviewed regarding rough treatment from staff and 42 residents skin assessments were completed for any signs of abuse, none were noted.</p> <p>On 8/31/24 110 staff members were re-educated regarding Abuse Prohibition Policy including the ability to prevent abuse, identify signs and evidence of abuse, and report abuse to the charge nurse and ultimately to the Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 8/30/24 Administrator was educated regarding thorough investigations and protecting residents during the investigation. Administrator was also educated regarding identifying abuse as a part of the thorough investigation process and implementing corrective actions to prevent further occurrences. Administrator was also instructed to review all reportable events with Market Clinical Lead prior to finalizing investigation protocols.</p> <p>On 8/31/24 QAPI committee was educated regarding thoroughly reviewing all reportable events during the QAPI process for thoroughness of the investigation, appropriateness of the determination, and any further corrective actions that may need to be taken.</p> <p>On 09/01/2024 at 4:25 pm the Center QAPI Committee which included the Market Clinical Lead by way of phone, business office manager, MDS coordinator, dietary manager, office assistant, recreation director, nurse practice educator, admissions director, social services director, medical records, environmental services supervisor, dietary supervisor, Director of Nursing Services, and Administrator reviewed the remaining incidents that were previously unverified/unsubstantiated since 07/10/2023. 12 incidents were reviewed. 8 were verified during the review. The corrective actions were reviewed for the 8 incidents verified. The review determined the appropriate corrective action had been implemented for 8 incidents, despite being initially unverified/unsubstantiated. It was determined that the 8 incidents required additional corrective actions to include:</p> <p>On 8/31/24 110 staff members were re-educated regarding Abuse Prohibition Policy including the ability to prevent abuse, identify signs and evidence of abuse, and report abuse to the charge nurse and ultimately to the Administrator.</p> <p>On 8/30/24 Administrator was educated regarding thorough investigations and protecting residents during the investigation. Administrator was also educated regarding identifying abuse as a part of the thorough investigation process and implementing corrective actions to prevent further occurrences. Administrator was also instructed to review all reportable events with Market Clinical Lead prior to finalizing investigation protocols.</p> <p>On 8/31/24 QAPI committee was educated regarding thoroughly reviewing all reportable events during the QAPI process for thoroughness of the investigation, appropriateness of the determination, and any further corrective actions that may need to be taken.</p> <p>Compliance Date: September 1, 2024</p> <p>*****</p> <p>After review of documentation supporting the above correction actions, including the facility's investigation file, in-service/education records and staff interviews, the survey team verified the facility implemented corrective actions on 09/01/2024.</p>