STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015112	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Haven Health and Rehabilitation Center	603 Wright Street Tuskegee, AL 36083

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 Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and a policy titled .Abuse, Neglect, and Exploitation the facility failed to ensure Resident Identifier (RI) # 90 was free from resident to resident physical abuse perpetrated by RI #57. The facility failed to implement timely and effective interventions to prevent resident to resident abuse on 04/15/2025 after RI #57 complained to staff about RI #90 entering his/her room without permission. On 04/16/2025, RI #57 pushed RI #90 from his/her room into the hallway, causing him/her to fall and sustain a laceration above the left eye and Contrast Tomography (CT) confirmed fractures of the left maxillary sinus wall and left orbital wall.This deficient practice affected RI #90, one of six sampled residents reviewed for abuse.This deficiency was cited as a result of the investigation of complaint/ report number #463612. Findings Include:Cross-Reference F740.On 04/16/2025 at 1:16 PM, the Alabama State Survey Agency received a Facility Reported Incident (FRI) which indicated RI #57 pushed RI #90 down on the floor in the hallway for entering his/her room. The roommate RI #8 witnessed the incident. RI #90 was noted to have a laceration above the left eye. RI #57 and RI #90 were separated and assessed for injuries. RI #57 and RI #90 were sent to a local hospital for additional evaluation and treatment. An X-ray for RI #90 documented: . 04/16/2025 21:05 (9:05 PM) . (#90) . IMPRESSION: Mildly displaced fractures of the left maxillary sinus wall and lateral border of the left orbit. Multiple sided facial fractures, partially visualized. A review of the facility's investigation dated 04/22/2025 revealed RI #57 admitted pushing RI #90 after he/she entered his/her room. The facility substantiated resident to resident physical abuse. The facility's Abuse Policy with a revised date of 11/2017, documented . SUBJECT: Abuse, Neglect and ExploitationPOLICY:Each resident of any facility. has the right to be free from verbal, sexual, physical or mental abuse, neglect, exploitation and misappropriation. Mistreatment, neglect or abuse of residents is prohibited by . facility . All residents will be free of mental and physical abuse and shall receive considerate care and treatment at all times . RI #90 was admitted to the facility on [DATE] with an admitting diagnoses of Unspecified Dementia, Mood Disorder, Anxiety, Cognitive Deficit and Adjustment Disorder. RI #90's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/04/2025, indicated RI #90 had a Brief Interview for Mental Status Score (BIMS) of 11 of 15 which indicated moderately impaired in cognitive skills for daily decision making, The MDS indicated RI #90 had long- and short-term memory problems. The MDS documented that RI #90 displayed no behaviors. A review of RI #90's care plan with a problem onset date of 05/04/2023 revealed the following . is having increased behaviors/cognitive loss related to dx of Dementia . Approach: encourage participation in . activities .refer to psych services as needed . A review of RI #90's care plan with a problem onset date of 01/15/2025 revealed the following .is at risk for elopement due to wandering. wanders into other residents' rooms. check code alert placement every shift. Consult with MD and psychologist as needed. encourage socialization and participation in activities. RI #57 was admitted to the facility on [DATE] with an admitting diagnoses of Dementia with Agitation (later with Psychotic Behaviors) Mood Disturbance, Anxiety Disorder and Memory Impairment. RI #57's Quarterly MDS with an assessment reference date of 03/11/2025, indicated RI (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	#57 had a BIMS of 15/15 and was cognitively intact with skills for daily decision making, with long- and short-term memory problems. RI #57's Mood Interview indicated 0 and no behaviors. RI #57's Progress Note dated 04/16/2025 at 1:03 PM written by the Social Services Director (SSD) documented . Yesterday (RI #57) made the Assistant Director Of Nursing (ADON) and SSD aware of another resident coming into (his/her) room. (He/she) stated that (he/she) wanted them to leave (him/her) alone. SSD and ADON stated they would discuss this with the other resident and let them know not to come into (his/her) room. SSD and ADON stated to (RI #57) that when someone comes into (his/her) room (he/she) does not want to press the call light or get staff attention. (RI #57) stated that (he/she) understood. On 06/25/2026 at 4:44 PM during an interview the SSD said she became aware of RI #90 entering RI #57's room on 04/15/2025 when RI #57 notified her. When asked what interventions were put in place for RI #90 on 04/15/2025 the SSD stated that interventions began on 04/17/2025 to obtain placement for RI #90 in a memory care facility. The facility's investigation file included the following witness statements:A statement dated 04/16/2025 11:55 am handwritten by Interim Director of Nursing (DON) for RI #8, documented I saw (RI #57) push (RI #90) outside the door.A statement dated 04/16/2025 at 12:28 pm handwritten by Licensed Practical Nurse (LPN) #15 documented I heard someone yell and I looked down the hall & (and) I saw (him/her) on the floor in the hall. laying in the hallway face down.A statement dated 04/16/2025 at 12:55 PM handwritten by Certified Nursing Assistant (CNA) #16, documented I heard a scream . found the resident on the floor in the hallway. (RI #90) was moaning and stating. shoulder and arm . hurting.A statement dated 04/16/2025 at 12:25 PM handwritten by the ADON documented . noted resident lying on floor face down with blood noted coming from left nostril. Laceration and bruising noted to left eye c (with) hematoma to eye (left) bruising noted to left shoulder. turn resident over to see where bleeding was coming from . On 06/24/2026 at 11:49 AM RI #8 was asked what happened on 04/16/2025 between RI #57 and RI #90. RI #8 stated RI #57 was fussing at RI #90 and told him/her to get out of the room. RI #57 pushed RI #90 by the shoulder and RI #90 hit the wall across the hall. RI #8 said he/she could hear RI #90 screaming. RI #8 said RI #57 would fuss at anyone that came near his/her room. On 06/25/2025 at 6:25 AM during a telephone interview LPN #15 was asked what she could tell the surveyor about the incident that occurred on 04/16/2025 involving RI #57 and RI #90. She stated she was on the opposite hall and saw something on the floor and it was RI #90. She said RI #90 was lying on his/her back in front of RI #57's room. She stated the staff was monitoring him/her, and RI #90 was not responsive for a few seconds then was blinking his/her eyes. She stated she saw blood but could not tell where the blood was coming from. On 06/29/2026 at 12:03 PM CNA #16 was asked what she could tell the surveyor about the incident that occurred on 04/16/2025 involving RI #57 and RI #90. She said she was passing trays on the North Hall and heard someone say Ugh and looked down the hallway and RI #90 was in the middle of the floor facedown. CNA #16 stated she observed a cut on RI #90's forehead, near the eye and in his/her hair. CNA #16 said she notified LPN #15 and other staff came to assist. CNA #16 said she asked RI #57's roommate RI #8 what he/she observed. RI #8 said RI #90 was sitting in the empty chair in their room then RI #57 shoved RI #90 out of the room. She stated RI #90 came out of the room and said I told him/ her to stay out of the room. CNA #16 said when RI #90 came back to the facility from the hospital his/her face was purple and his/her chest was very bruised. CNA #16 stated she would consider this incident physical and verbal abuse. On 06/24/2026 at 11:54 AM during an interview the ADON stated that on 04/16/2025 a staff member told her RI #57 pushed RI #90 down. She stated she went to the hall and RI #90 was lying on the floor with blood coming from his/her nose. She stated RI #57 told her that he/she told RI #90 not to come into his/her room and that he/she pushed RI #90 out the door. On 06/29/2026 at 12:52 PM during an interview CNA #17 stated that on 04/16/2025 she was working on the north hall and was in a room and heard a commotion in the hallway. She said she came out of the room and saw RI #90 lying face down on the floor and there was blood but she did not know where it was coming from. CNA #17 said RI #90 was crying and she could tell he/she was in pain. She stated this would be (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	considered physical abuse. On 06/30/2026 at 10:27 AM during an interview the Director of Nursing (DON) stated RI #90 was identified as a wanderer on 01/15/2025 according to the care plans and a progress note. When asked what type of supervision was in place for RI # 90 at the time of the incident, the DON stated general supervision and RI #90 had a code alert monitor in use. The DON stated RI #90 had a diagnosis of dementia and he/she wandered all over the building. The DON stated the incident could have been prevented by moving RI #90. When asked how it would make a reasonable person feel being hit by another resident, the DON stated upset and in pain. The DON stated the facility substantiated abuse. On 06/30/2026 at 12:14 PM the Administrator (ADM) was asked what interventions were in place to protect RI #90, a known wanderer. The ADM stated RI #90 was identified as a wanderer on 01/15/2025 and staff were educated on interventions to assist with wandering. The ADM was asked the level of supervision RI #90 required and she stated he/she was redirected and staff checked the code alert for placement. The ADM asked what interventions were put in place by the ADON and SSD after being notified by RI #57 that he/she did not want RI #90 coming into his/her room to prevent the abuse from occurring. The ADM stated RI #57 was instructed to press the call device when RI #90 entered the room. The ADM stated moving RI #90 or placing him/her on 1 on 1 could have possibly prevented the abuse from occurring. The ADM stated being hit by RI #57 would make a reasonable person feel unhappy.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, interviews, the facility's policies for DIET MANUAL and MENUS, the facility's menus for Spring/Summer 2026, and the facility's posted SCOOP AND DIPPER SIZES; the facility failed to ensure a #10 dipper/scoop was used for Chopped Meat (Hamburger Steak) for Lunch on Tues. 6/23/2026, a #6 dipper/scoop was used for Puree Lasagna for Dinner on Tues. 6/23/2026, and a #10 dipper/scoop was used for Chopped Fried Chicken and a #10 dipper/scoop was used for Puree Chicken when serving Lunch on Wed. 6/24/2026. This affected residents receiving chopped meats, Mechanical Soft diets, and Puree diets; 36 of 84 residents receiving meals at the facility and had the potential to result in weight loss. The facility's policy for DIET MANUAL, revised 8/2017, included the following: . PROCEDURE: . 4. The diet manual is the reference for regular, texture-modified and therapeutic diet orders.5. The diet manual is used as the basis for the planned menu and menu modifications. The facility's policy for MENUS, revised 12/2023, included the following: . POLICY:Menus are planned to meet the nutritional needs of the residents in accordance with the Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The facility shall provide residents with a nourishing, palatable, well-balanced diet that meets daily nutritional needs as well as individual preferences and special dietary needs.PROCEDURE:1. Menus for regular and therapeutic diets are preplanned.3. The correct portion size for each menu item is listed for each diet included in the menu modifications. The facility's Spring/Summer 2026 Menu, Week 4 identified Hamburger Steak as the entree for lunch and Lasagna as the entree for dinner on Tuesday, 06/23/2026 and Fried Chicken was the entree for lunch on Wednesday, 06/24/2026. Portion sizes for the modified menu items of concern on these days were listed on the menu as follows:Tuesday, 06/23/2026Lunch - Mechanical Soft Diet - Chopped Hamburger Steak - 1 (one) #10 DipperDinner - Puree Diet - Puree Lasagna - 1 (one) #6 DipperWednesday, 06/24/2026Lunch - Mechanical Soft Diet - Chopped Fried Chicken - 1 (one) #10 DipperPuree Diet - Puree Fried Chicken - 1 (one) #10 Dipper The SCOOP AND DIPPER SIZES, undated, included the following information:#4 8 ounces (oz.) 1 cup#8 4 ounces 1/2 cup#10 3.2 ounces 2/5 cup#12 2.67 ounces 1/3 cup On 06/23/2026 at 10:40 AM, AM [NAME] EI (Employee Identifier) #9 was observed preparing the trayline for the residents' lunch meal. At 11:00 AM, a 3 oz. spoodle was used for serving Chopped Meat (chopped Hamburger Steak). On 06/23/2026 at 5:06 PM, the PM [NAME] was observed using a #8 dipper/scoop to serve the Puree Lasagna for the residents' dinner meal. On 06/24/2026 at 10:22 AM, AM [NAME] EI #10 was observed preparing the trayline for the residents' lunch meal. At 11:30 AM, a 3 oz. spoodle was used for serving Chopped Fried Chicken and a #12 dipper/scoop was used for serving the Puree Fried Chicken.Observations were made of seven trays being served 3 oz. spoodle of Chopped Fried Chicken and five trays being served a #12 dipper/scoop of Puree Fried Chicken. On 06/25/2026 at 9:38 AM, AM [NAME] #10 was interviewed about the lunch service on Wednesday, 06/24/2026. AM [NAME] #10 said the menu instructed her to use #10 dippers/scoops for serving the chopped Fried Chicken and the Puree Chicken. AM [NAME] #10 said the Dietary Supervisor was having a hard time getting dippers/scoops, so she had been instructed by the Dietary Supervisor to use the other utensils. AM [NAME] #10 said a 3 oz. spoodle was not equal to a #10 dipper/scoop and a #12 dipper/scoop was not equal to a #10 dipper/scoop. AM [NAME] #10 said they look at the dipper/scooper chart to know the difference. AM [NAME] #10 further said the problem with serving less than the menu instructs was, it could affect the resident's diet and cause weight loss over time. AM [NAME] #10 said they had been short of dippers/scoops for about a week because the dippers/scoops had broken. On 06/25/2026 at 10:04 AM, the Dietary Supervisor was interviewed. The Dietary Supervisor said there was a shortage of serving dippers/scoops in the facility. When asked about the service of lunch on Tuesday, 06/23/2026; the Dietary Supervisor said a 3 oz. spoodle of Chopped Meat (Hamburger Steak) was not equal to a #10 dipper/scoop and the (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	menu was therefore not followed. The Dietary Supervisor said they could have given a bigger portion dipper/scoop or spoodle to get 3,2 oz. When asked about the service of dinner on Tuesday, 06/23/2026; the Dietary Supervisor said a #6 dipper/scoop should have been used to serve the Puree Lasagna, not a #8 dipper/scoop. The Dietary Supervisor said the menu was not followed for Tuesday dinner. When asked about the service of lunch on Wednesday, 06/24/2026; the Dietary Supervisor said the menu was not followed because a 3 oz. spoodle was used to serve Chopped Fried Chicken and a #12 dipper/scoop was used to serve Puree Fried Chicken. The Dietary Supervisor said the residents could potentially be affected by weight loss from the menu not being followed. The Dietary Supervisor further said the residents' preferences for larger servings might not be met.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, a repair/service report, and the 2022 United States (U.S.) Food and Drug Administration (FDA) Food Code; the facility failed to ensure food was frozen solid in the Reach-in Bread Freezer on 6/22/2026 and further failed to ensure the internal temperature did not reach 45 (degrees) Fahrenheit (F). This had the potential to affect 84 of 84 residents receiving meals from the facility's Food Service Department and possibly exposing them to food borne illness.The 2022 U.S. FDA Food Code included the following: . Temperature and time Control3-501.11 Frozen Food.Stored frozen FOODS shall be maintained frozen.3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding.(A) . TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: .(2) At 5 C (41 F) or less. FDA Food Code 2022 Annex 3. Public Health Reasons/Administrative Guidelines3-501.16 Time/Temperature Control for Safety Food [TCS], Hot and Cold Holding.Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature Danger Zone of 5 C to 57 C (41 F to 135 F) too long.Cold HoldingMaintaining TCS foods under the cold temperature control requirements prescribed in this code will limit the growth of pathogens that may be present in or on the food and may help prevent foodborne illness. During the initial kitchen tour on 06/22/2026 at 4:04 PM, an observation was made of the Two-door Reach-in Bread Freezer. The items in the freezer were not frozen solid. Items inside the freezer included Pancakes, French Fries, Onion Rings, and Hush Puppies, which were soft to touch. The internal thermometer reading was 45 degrees F. The external digital thermometer reading was 31 degrees F. Once notified of the situation, the Dietary Supervisor made a call for an outside service company to come and repair the freezer unit. On 06/23/2026 at 4:38 PM, the Dietary Supervisor said the service company representative fixed the freezer the night before on 06/22/2026. The facility provided the service invoice, dated 06/22/2026, that included the following: . Customer states that the freezer was up to 45 degrees. It is down to 0 degrees now. I pulled the cover and found the condenser coils completely clogged with dirt. I told (name of Dietary Supervisor) that the maintenance man needs to be cleaning the coils monthly. I cleaned the coils and checked the refrigerant pressures. All ok. On 06/25/2026 at 10:43 AM, the Maintenance Director was interviewed. When asked about routine maintenance provided for the refrigeration/freezer equipment in the Food Service Department; the Maintenance Director said the filters and coils were cleaned every 30 days or as needed. The Maintenance Director further said he drained the condenser line and made sure it was defrosting when it was supposed to defrost. When asked for the Maintenance policies, the Maintenance director said he had a monthly report, some have weekly, now he had a computer log. When asked for the Maintenance records, the Maintenance Director said he could try to print off six or seven months. When asked if he knew why the Two-door Reach-in Bread Freezer failed to operate properly on Monday, 6/22/2026; the Maintenance Director said the reason the freezer went down was because the A/C (air conditioning) was broken. The Maintenance Director further said the freezer blowers were pushing air through the freezer condenser coils and they were pushing hot air and humidity from the heat of the kitchen. The extra amount of time the blowers were working caused the condensers to be clogged up with dirt and that was what made the freezer go out. When asked if the other freezers and refrigerators could fail for the same reason, from dirty coils; the Maintenance Director said yes, that was why he was to clean the coils every 30 days and they were cleaned two to three weeks before. The Maintenance Director said, the A/C was out for 10 days and they were waiting for the part to come in. The Maintenance Director did not provide the requested maintenance records. On 06/25/2026 at 10:04 AM, the Dietary Supervisor was interviewed. When asked how often Maintenance performs routine checks and maintenance of the kitchen refrigeration/freezer equipment, the Dietary Supervisor said he looked at things every month.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, the Resident Council, and the facility's policy for FOOD FROM OUTSIDE SOURCES, the facility failed to ensure there was a refrigerated area for storage of food brought in to the residents by family and friends. Eleven of eleven residents attending Resident Council on 6/24/2026 affirmed they wanted refrigeration space to be able to store personal food. This had the potential to affect all residents requiring safe storage for personal food requiring refrigeration, 84 of 84 residents eating meals in the facility. The facility's policy for FOOD FROM OUTSIDE SOURCES, revised 10/2017 and reviewed 11/2023, included the following:POLICY: . Food that is brought to residents from family, visitors or volunteers is handled in a safe and sanitary manner. PROCEDURE: . 4. Residents may accept precooked foods from family members or other visitors. Foods may be brought for a specific resident and shared with other residents. b. Food brought to a resident by a family member or visitor may be stored in the food service department. i. Foods brought to the food service department are stored in the refrigerator or freezer immediately. ii. Refrigerated cooked food that is not prepared in the facility is held no longer than 24 hours. iii. The label includes the resident's name and room number, the date it is received and stored, and the date it should be discarded. 7. Residents and family members are informed, orally and in writing, about the facility policy for bringing food. On 06/23/2026 at 5:30 PM, the Dietary Supervisor was asked which refrigerator they kept items brought in by friends and family for individual residents. The Dietary Supervisor said they did not keep them, the dietary staff stop it at the door, and dietary did not have room for food [NAME] in for residents. Resident Council met at 10:00 AM on 06/24/2026. The Resident Council members said there was no refrigerator for the residents to store their food when family members brought food to them. The Resident Council members further said the food had to be thrown away or eaten the same day. Additionally, they said the people in Dietary (Food Service Department) told them they did not have any place to put the food. Eleven of eleven Resident Council members said the residents would like to have a refrigerator to store their food.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interviews, Resident Council, the facility's policy for Daily Dumpster Monitoring, the 2022 United States (U.S.) Food and Drug Administration (FDA) Food Code, and the facility's pest control service records; the facility failed to ensure there was not a build-up of greasy particles on the oil/grease refuse container, there was not a scattering of small particles of trash around the two dumpsters, and there was not a concentration of 30 to 40 flies in the dumpster area on 6/22/2026. This had the potential result of attracting rodents and flies, which could enter the facility to cause contamination and exposure to bites and maggots. This affected Resident Identifier (RI) #8, six of eleven residents in Resident Council, and had the potential to affect all residents in the facility, 88 of 88 residents. The facility's policy for Daily Dumpster Monitoring, dated 10/2006, included the following: . POLICY:Maintenance and Housekeeping staff will inspect all dumpsters each day to ensure that the surrounding area are free of debris and that the dumpster lids are closed . The 2022 United States (U.S.) Food and Drug Administration (FDA) Food Code included the following: . 5-501.15 Outside Receptacles.(B) Receptacles and waste handling units for REFUSE . shall be installed so that accumulation of debris and insect and rodent attraction and harborage are minimized and effective cleaning is facilitated around . the unit. 5-501.110 Storing Refuse, Recyclables, and Returnables.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, recyclables, or returnables shall be maintained free of unnecessary items, as specified under S 6-501.114, and clean.5-501.116 Cleaning Receptacles.(B) Soiled receptacles and waste handling units for REFUSE . shall be cleaned at a frequency necessary to prevent them from developing a buildup of soil or becoming attractants for insects and rodents.6-501.114 Maintaining Premises, Unnecessary Items and Litter.The PREMISES shall be free of: .(B) Litter. The provided facility pest control service records, dated 02/18/2026, 04/29/2026, and 06/08/2026, revealed the last treatment for flies, identified as F for the Target Pest per the Key Codes for IMP (Integrated Pest Management) Applications, was on 02/18/2026. During the initial kitchen tour on 06/22/2026 3:48 PM, one fly was observed in the kitchen seated on back of a plate in the plate lowerator. On 06/22/2026 at 4:43 PM the facility's Dumpster/Oil & Grease Refuse Area was observed with the Dietary Supervisor. There were small particles of trash around the two dumpsters, including a balled-up piece of aluminum foil, a piece of a clothes hanger, and a small bottle with an eye-dropper. In a small grassy section within the pavement near the dumpsters, there was a concentration of about 30 to 40 flies. The Dietary Supervisor said Maintenance was responsible for maintaining the area and said Maintenance rinsed the dumpster area daily. The Dietary Supervisor further said the flies could get into the Kitchen and cause contamination of resident food. In addition, there was a build-up of greasy particles on the outside of the oil/grease refuse container. The build-up of greasy particles was around the top opening of the container and reached up to the top of the opening's cover; approximately a two-inch build-up. The Dietary Supervisor said the build-up of greasy particles would attract flies and rodents that could potentially enter the kitchen and cause contamination. On 06/23/2026 at 10:50 AM, the Maintenance Director said he picks up the trash around the dumpsters and sprays down the pad around the dumpsters with water and either Pine Sol or beach or HDQ (an Ammonium Quat-based disinfectant). The Maintenance Director said he sprays down the dumpsters too. He further said either he or Housekeeping does it. The Maintenance Director said he was not here yesterday (Monday, 6/22/2026). When asked if he also sprayed down the oil/grease container, he said no, The Maintenance Director said it belonged to the commercial provider of the receptacle. On 06/23/2023 at 12:05 PM, RI #8 complained that there were some flies in his room. One fly was observed in the resident's room at this time. During the Resident Council meeting on 06/24/2026 at 10:00 AM with eleven participants attending, three residents said flies had landed on their food in their room and three residents said flies had awakened them while they were (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Haven Health and Rehabilitation Center	603 Wright Street Tuskegee, AL 36083

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	sleeping at night. On 06/24/2026 at 10:22 AM, a fly was observed flying in the kitchen while preparation for the residents' lunch meal was ongoing. On 06/24/2026 at 11:58 AM, one fly was observed flying around the kitchen while the residents' lunch trayline was ongoing. On 06/24/2026 at 4:56 PM, the Housekeeping Supervisor was interviewed. The Housekeeping Supervisor said the Housekeeping Department's responsibilities for maintaining the Dumpster/Oil & Grease Refuse Area were to daily make sure it was clean around the perimeter of the dumpsters and to make sure the dumpster lids were closed. The Housekeeping Supervisor said he personally checked those things daily and Maintenance checked it also. The Housekeeping Supervisor further said, if he saw any types of varmints or rodents, he reported them to Maintenance so Pest Control could be contacted. The Housekeeping Supervisor said HDQ (an Ammonium Quat-based disinfectant) or bleach or Pine Sol was sprayed in the area to keep the flies away. The Housekeeping Supervisor said flies were attracted to urine and feces, which were in the diapers and bed pads in the dumpsters. He further said HDQ worked best in the Summer. The Housekeeping Supervisor said Dietary (Food Service Department) and Maintenance did the cleaning to keep the exterior of the oil/grease refuse container free from a build-up of greasy particles. He further said that would be important to keep rodents from being attracted to it. The Housekeeping Supervisor said he had observed a concentration of flies by the Dumpster/Oil & Grease Refuse Area. The Housekeeping Supervisor said he thought the accumulation of flies was caused by the food, feces, and urine. He further said the shipment of HDQ was late, it just came Monday morning (6/22/2026) and it was supposed to arrive on Friday, 6/19/2026. When asked how the concentration of flies could affect the residents, the Housekeeping Supervisor said, if the concentration was massive enough, the flies could get inside the building and land on the residents, lay eggs, and create maggots. The Housekeeping Supervisor said the concentration of flies in the small grassy area in the pavement near the dumpsters could have been attracted to that area by liquid spilling from the dumpsters when they were emptied and the liquid accumulated in that grassy spot. On 06/25/2026 at 10:43 AM, the Maintenance Director was interviewed. The Maintenance Director said the Maintenance Department's responsibilities for maintaining the Dumpster/Oil & Grease Refuse Area included cleaning the slab and bleaching the surface of the slab and the dumpsters. He further said they clean everything on the concrete slab and spray the oil/grease refuse container as well. The Maintenance Director said they clean Monday through Friday and everything gets sprayed down with bleach or an alternate as needed. He explained that HDQ was a chemical for cleaning and sanitizing. When asked why HDQ or bleach or Pine Sol would be sprayed in the area, the Maintenance Director said they have an old trash truck that comes and picks up the dumpster with a hook and any liquid inside the dumpster leaked out. He further said that when the truck compresses the trash more liquid leaked out from the truck. The Maintenance Director said he was aware of the concentration of flies by the dumpsters. The Maintenance Director said he did not see them over by the grease refuse area, but there were flies there. The Maintenance Director said he uses fly bait Monday through Friday. The Maintenance Director said he thought the accumulation of flies was caused by contaminated liquid from the dumpster and the garbage truck that spills the liquid when the dumpsters are picked up by the truck. The Maintenance Director said residents could be affected by flies biting or by flies swarming on food or by flies getting in patient wounds and causing maggots. The Maintenance Director further said they had three different fly baits, a fly zone blower at the back door, and fly zappers and residents could use fly swatters if they wanted to. When asked about the build-up of grease in the Dumpster/Oil & Grease Refuse Area, the Maintenance Director said they needed to keep it clean. He said Dietary (Food Service Department) should clean the Dumpster/Oil & Grease Refuse Area after they empty the grease. The Maintenance Director also said he would be more mindful to clean/scrub the area after Friday's fish frying day. On 06/25/2026 at 10:04 AM, the Dietary Supervisor was interviewed. When asked if the Food Service Department cleaned the oil/grease refuse container, she said no, that should be washed down when the dumpsters were washed down, which should be daily or as needed. The Dietary Supervisor said it did not look like the oil/grease refuse container had been washed daily when observed on Monday, 6/22/2026.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review, interview, and Payroll Based Journal (PBJ) Report, the facility failed to report accurate staffing data from January 01, 2026 - March 31, 2026, to the Centers for Medicare & Medicaid Services (CMS).This failure affected one quarter of data reviewed during the survey. Findings Include: The PBJ report generated for the quarter of 01/01/2026 through 03/31/2026 documented: . This Staffing Data Report identifies areas of concern that will be triggered . Metric .Excessively Low Weekend Staffing . Triggered = Submitted Weekend Staffing data is excessively low .On 06/25/2026 at 3:45 PM, during an interview, the Administrator (ADM) stated she was responsible for submitting staffing data to CMS. The ADM said she did not know why low weekend staffing was triggered for the second quarter of 2026. She said she compiled the data for the report, sent the information to corporate and a third party company submitted the data to CMS. She said if incorrect data was submitted, CMS would not have accurate information concerning staffing.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and facility policies titled, . TELS Maintenance Services Work Order and . Standard Method of Cleaning Checklist the facility failed to ensure a clean, safe, and homelike environment. Specifically, the facility failed to maintain resident care areas were in good repair and in a sanitary condition as evidenced broken tiles behind the commode in the bathroom belonging to Resident Identifier (RI) #34, RI #26, RI #72, and RI #1. Additionally, the bathroom belonging to RI #8, RI #57, RI #5 and RI #36 had a water damaged wall and dirty floors with urine observed on the floor.These failures affected RI #34, #26, #72, #1, #8, #57, #5, and #36. These failures had the potential to affect residents by exposing them to an environment that was not maintained in a clean, safe and homelike condition.Findings Include: A facility policy titled, TELS Maintenance Services Work Order with an effective date of 08/01/2022 documented: . PROCEDURE: 1. Whenever a need for maintenance services is detected by an employee of the facility, it is their responsibility to report that need by completing an electronic work order in the device located at the nursing station, or other designated location. A facility policy titled, . Standard Method of Cleaning Checklist dated 11/2008 documented: . 5. CLEAN BATHROOMStart at the door and end with the toilet. Use a [NAME] mop inside the bowl and wipe the outside with a cleaning cloth. Do not use the clean cloth on any other surface after cleaning toilet. 7. INSPECT THE ROOMReport any needed repairsCorrect any deficiencies. RI #34 was admitted to the facility on [DATE]. RI #26 was admitted to the facility on [DATE]. RI #72 was admitted to the facility on [DATE]. RI #1 was admitted to the facility on [DATE]. RI #8 was admitted to the facility on [DATE]. RI #57 was admitted to the facility on [DATE]. RI #5 was admitted to the facility on [DATE]. RI #36 was admitted to the facility on [DATE]. On 06/22/2026 at 3:45 PM the surveyor observed brown spots on the floor on the main hallway and on the west unit.On 06/23/2026 at 10:39 AM the surveyor observed holes on the wall near the trim behind the commode belonging to RI #34, RI #26, RI #72, and RI #1. On 06/23/2026 at 10:52 AM the surveyor observed water damaged walls in the bathroom belonging to RI #8. An interview was completed with RI #8 who voiced his/her concern was flies inside the facility. On 06/24/2026 at 9:10 AM the surveyor observed a fly on the north hall flying near breakfast trays that were being removed from resident rooms.On 06/29/2026 at 5:45 PM, the surveyor made observations and concurrent interview with the Housekeeping Supervisor (HSUP) of the bathrooms belonging to RI #8, RI #57, RI #5, and RI #36. The HSUP indicated the bathrooms were cleaned daily during the daytime shift. When asked why the bathrooms were not clean, he said that the presence of urine on the floor contributed to the condition of the bathrooms. He said the fix would be a floor replacement. When asked if this was a homelike environment, he said his department attempted to keep the bathrooms clean; but it has continued to be a concern due to urine on the floor.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and a policy titled, . Advance Directives and Refusal of Treatment the facility failed to ensure documentation regarding advance directives was complete and accurate. Specifically, the facility failed to maintain documentation that advance directives were discussed with Resident Identifier (RI) #81 and failed to ensure the advance directive documentation for RI #7 accurately reflected the resident's status. These failures had the potential to affect residents by preventing the facility from accurately identifying and honoring residents' advance directive decisions for 2 of 7 residents reviewed. Findings Include: A facility policy titled, . Advance Directives and Refusal of Treatment revised 11/2013 documented: PURPOSE:The resident has the right to refuse treatment, . to formulate an advance directive for management of his/her care.PROCESS:Prior to admission, the resident/sponsor will be provided information about the following:Advance Directives . Upon the resident's admission to the facility, the Social Services Designee will obtain from the resident or the resident's Family or significant other a copy of any existing Living Will, Health Care Proxy . Durable Power of Attorney for Health Care Decisions, or any previously recorded express written or oral (recorded in writing) declarations. This copy . should be placed in the front of the medical record. The Social Services designee should enter a progress note in the resident's record regarding the existence of an Advance Directive. RI #7 was admitted to the facility on [DATE] with diagnoses to include Hemiplegia and Hemiparesis follow Nontraumatic Intracerebral Hemorrhage Affecting Right Dominant Side. A document titled RESIDENT RIGHTS & ADVANCE DIRECTIVE ACKNOWLEDGEMENT dated 01/25/2025 signed by RI #7's representative indicated RI #7 had an advance directive. Further review of the form did not indicate the type of advance directive. RI #81 was admitted to the facility on [DATE] with a diagnosis to include End Stage Renal Disease. A review of RI #81's medical record revealed no signed acknowledgement that Advance directive was discussed with the resident or representative. On 06/26/2026 at 12:01 PM, the Social Services Director (SSD) stated she was responsible for advance directive within the facility, and that the documentation would be maintained in the resident's medical chart. When asked about the advance directive for RI #7, she said the electronically signed and dated form by the resident representative indicated the existence of an advance directive, but did not specify the type of advance directive. She said RI #7 did not have an advance directive and the form was filled out incorrectly and she should have followed up to correct the error. When asked about the advance directive for RI #7, she said she had been unable to find the paperwork. She said the concern of not having paperwork related to the advance directive for RI #81 would be not knowing if he/she had one which could cause a delay in treatment. The SSD said if a resident had an advance directive, it was important to have a copy to facilitate appropriate healthcare decisions and to prevent any delays in treatment.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure staff followed a physician's order to notify the medical provider when the Resident Identifier (RI) #89's blood glucose exceeded the ordered parameter of 250 mg/dL (milligrams/deciliter). Record review revealed a physician's order dated 03/07/2025 directing staff to check the resident's blood glucose four times daily before meals and at bedtime, document the results, and notify the medical provider for blood glucose readings below 70 mg/dL or above 250 mg/dL.Review of the Nurse Medication Administration History dated 03/01/2025 through 03/31/2025 revealed RI #89's had multiple blood glucose readings that exceeded the physician ordered notification and the medical provider was not notified. This deficient practice affected RI #89 one of four residents whose Medication Administration Record (MAR) was reviewed for physician notification during the survey. This citation was cited as a result of complaint/report number 463611. Findings include:A review of a facility policy titled, . ADMINISTRATIVE PROCEDURESUBJECT: Change in Medical Condition of ResidentsSTANDARD: Based on federal regulations, when there is a change in a resident's condition, notification of the physician, legal representative, or responsible relative, should occur promptly. Parties should be immediately notified. Abnormal blood glucose levels and blood glucose changes outside of physician parameters.RI #89 was admitted to the facility on [DATE] at 1:15 PM with a diagnosis of Type 2 Diabetes Mellitus without Complications.Review of RI #89's March 2025 Physician Order revealed: Check Blood Glucose four times daily before meals and bedtime, record blood glucose results, notify medical doctor if blood glucose is below 70 or above 250 mg/dl.Review of RI #89's Nurse Only Administration History revealed the following blood glucose levels which were above the 250 mg/dL parameter: On 03/08/2025 the blood glucose was 269 mg/dl. On 03/11/2025 the blood glucose was 309 mg/dl. On 03/12/2025 the blood glucose was 290 mg/dl, 316 mg/dl and 295 mg/dl. On 03/13/2025 the blood glucose was 278 mg/dl, 301 mg/dL and 279 mg/dl. On 03/14/2025 the blood glucose was 352 mg/dL and 300 mg/dl. On 03/15/2025 the blood glucose was 260 mg/dl and 281 mg/dl. On 03/18/2025 the blood glucose was 298 mg/dl. On 03/19/2025 the blood glucose was 259 mg/dl, 381 mg/dl and 301 mg/dl. On 03/20/2025 the blood glucose was 261 mg/dl. Record review revealed there was no evidence that the physician/medical doctor or other provider was notified of the above blood glucose levels. On 06/25/2026 at 11:57 AM an interview was conducted with Registered Nurse (RN) #11. She confirmed awareness of the physician's order requiring physician notification for blood glucose readings greater than 250 mg/dl. RN #11 stated no physician notification had been documented and no new physician orders had been received. RN #11 acknowledged the blood glucose readings exceeded the physician ordered notification parameter of greater than 250 mg/dl. On 06/25/2026 at 12:15 PM, an interview was conducted with the Medical Director (MD). The MD stated he had no recollection or documentation indicating of being notified of the RI #89's blood glucose readings that exceeded the ordered parameter of 250 mg/dL. MD stated no new orders were issued because there was no documentation that notification had occurred. The MD confirmed the notification parameters in the order were appropriate and clearly communicated. The MD further explained that persistent untreated hyperglycemia could result in urinary frequency and dehydration.On 06/25/2026 at 4:15 PM an interview was conducted with the Director of Nursing (DON). When asked what the facility policy and physician order required regarding physician notification for blood glucose readings greater than 250 mg/dl at the time of the event. The DON stated that it depended on the physician's order and that if the order directed staff to notify the physician, that was what we are supposed to do. During the interview, the DON stated the physician's order was present and that nursing staff were expected to follow the physician's order. The DON reported the facility verified physician notifications through daily medical record reviews. The surveyor and the DON reviewed RI #89's blood glucose readings (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ranging from 259 mg/dL to 381 mg/dl. The DON stated the blood glucose values would have been documented on the Medication Administration Record (MAR) and that physician notification should have been documented in the appropriate nursing note. The DON stated there was no evidence to validate that the physician had been notified in the absence of documentation in the medical record. The DON further stated the elevated blood glucose levels represented a potential change in the resident's condition, evidenced by hyperglycemia, and that the physician should have been notified and the notification documented in accordance with the prescribed order.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the Alabama Department of Mental Health Preadmission Screening and Resident Review (PASRR) Level I Screening and Determination documentation, the facility failed to ensure compliance with PASRR requirements for Resident Identifier (RI) #5 by failing to ensure completion of the required PASRR Level II Evaluation. Record review revealed RI #5 had diagnoses including Generalized Anxiety Disorder and Post-Traumatic Stress Disorder (PTSD). Despite the Level I screening dated 11/07/2024 identifying the need for a Level II Evaluation, the required evaluation was not completed until 01/23/2026. This deficient practice placed RI #5 at risk for not being comprehensively evaluated to determine the need for specialized services and support to address RI #5 mental health needs, as required under PASRR regulations. The facility's failure to ensure completion of the required PASRR Level II Evaluation affected RI #5, one of three residents reviewed for PASRR compliance.Findings Include:RI #5 was admitted to the facility on [DATE] with diagnoses of Post-Traumatic Stress Disorder (PTSD) and Generalized Anxiety Disorder.The PASRR Level I Determination dated 11/07/2024 documented that, following a Quality Assurance (QA) review, the nursing facility applicant required a PASRR Level II Evaluation due to documented serious mental illness diagnoses, including PTSD and Generalized Anxiety Disorder. The determination further indicated the resident met the criteria for a Categorical Determination for Convalescent Care and could be admitted to the nursing facility while the required PASRR Level II Evaluation was completed. The PASRR Level I Determination, completed by the facility Social Services Director (SSD) further stated that, to comply with Federal and State PASRR regulations, the admitting nursing facility must report the resident's admission to the Omnibus Budget Reconciliation Act Of 1987 (OBRA) PASRR Office at the time of admission to initiate the PASRR Level II Evaluation process and determine eligibility for specialized services. On 06/26/2026 at 11:45 AM an interview was conducted with the SSD regarding RI #5's PASRR screening. The SSD stated the Level I PASRR screening had been completed prior to admission; however, the required Level II evaluation had not been completed at the time of admission. She stated she did not recall whether RI #5 had been admitted under emergency admission or exempted hospital discharge. The SSD stated RI #5 had diagnoses of Anxiety and PTSD, which required PASRR review, and acknowledged she had been responsible for ensuring the PASRR process was completed. She stated the omission was identified during a chart update on 01/23/2026, at that time the Level I PASRR screening was redone. She further stated the Level II PASRR evaluation was completed on 02/03/2026. She stated timely completion of a Level II evaluation was important to ensure residents with serious mental illness received appropriate recommendations, appropriate placement, and needed mental health services. She further stated failure to complete the required evaluation could result in inappropriate placement, inadequate mental health services, and a decline in the resident's mental health condition.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, record review and review of a facility policy titled, Care Plans the facility failed to develop a comprehensive person-centered care plan to address the use of oxygen for Resident Identifier (RI) #1 and RI #35.This deficient practice affected RI #1 and RI #35 two of 30 residents whose care plans were reviewed. Findings Include:Review of a facility policy titled, Care Plans with a revised date of 09/2009 documented: . PURPOSE: Plans of Care are developed by the interdisciplinary team, to coordinate and communicate the plan of care for the resident. STANDARD: . the facility develops a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet a resident's medical needs, nursing and mental/psychological needs that are identified in the comprehensive assessment.PROCESS: . d) Comprehensive Plan of Care- within 7 days of the full assessments (admission, significant change, significant correction of prior full assessment and annual).1) RI #1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with a diagnosis to include Pneumonia, Unspecified Organism.Review of RI #1's June 2026 physician orders revealed: . Administer oxygen at 2L (Liters) via (by way of) NC (nasal cannula) PRN (as needed) for SOB (shortness of breath). PRN for SOB (DX: Pneumonia, unspecified organism) Every shift-PRN: .On 06/23/2026 at 10:39 AM, an observation was made of RI #1 lying in bed, with oxygen on at 2L per nasal cannula.On 06/24/2026 at 9:03 AM, an observation was made of RI #1 lying in bed with oxygen on at 2L per nasal cannula.RI #1's care plans were reviewed and there was no documentation of a care plan developed for his/her oxygen use until 06/24/2026.2) RI #35 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with a diagnosis of Heart Failure, Unspecified.Review of RI #35's June 2026 physician orders revealed: . OXYGEN AT 2 LITERS/MINUTE VIAL NASAL CANNUAL AS NEEDED FOR SOB .On 06/25/2026 at 11:19 AM, an observation was made of RI #35 sitting up in bed with oxygen on infusing at 2L per nasal cannula.RI #35's care plans were reviewed and there was no documentation of a care plan developed for his/her oxygen use until 06/25/2026.On 06/25/2026 at 3:43 PM an interview was conducted with the Minimum Data Set (MDS) Coordinator. The MDS Coordinator stated that she was responsible for developing and updating the care plan. The MDS Coordinator said residents who received oxygen should have a care plan for oxygen therapy. She further stated that if a resident did not have a care plan for oxygen, staff would not know the resident required oxygen use.On 06/30/2026 at 2:15 PM a follow up interview was conducted with the MDS Coordinator. The MDS Coordinator reviewed RI #1 and RI #35's care plans and stated she did not see a care plan for oxygen use prior to 06/24/2026. She stated RI #1 and RI #35 should have had a care plan for oxygen use. She further stated the importance of having a care plan for oxygen use was to alert staff to let them know what to look for related to oxygen and the reason for the oxygen use.

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Magnolia Haven Health and Rehabilitation Center	603 Wright Street Tuskegee, AL 36083

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and review of a facility policy titled, Incident and Accidents, the facility failed to provide evidence how it was determined Resident Identifier (RI) #91 acquired skin tears to the right upper shin, left knee, right buttocks, right hip, right knee and right lower shin on 11/05/2025. This deficient practice affected RI #91, one of two residents sampled for accidents. Failure of the facility to investigate to determine how RI #91 acquired the skin tears placed RI #91 at risk of acquiring further skin tears due to no interventions being implemented to reduce the risk of RI #91 acquiring skin tears. When incidents are not investigated, underlying root causes remain unknown.F689 was cited as result of the investigation of complaint/report number 2653290.Findings Include: Review of a facility policy titled, Incidents and Accidents, with a revised date of 10/2008, revealed the following: . STANDARD: Incidents are categorized as:Incident Type I-an incident is an occurrence that may not be consistent with the routine operation of the facility or the routine care of a particular resident .Examples include . skin tears .PROCESS: .II. Documentation .b. An Incident/Accident report should be completed .c. Initiate an investigation .d. Witness Statements should be completed as follow:Employees having knowledge of, or who witnessed the incident, should be interviewed, .III. Tracking and TrendingEach incident will be entered into the incident tracking module . RI #91 was admitted to the facility on [DATE] with diagnoses to include Senile Degenerative of the Brain, Vascular Dementia, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side and History of Falling. A review of RI #91's Physician Order Report (Physician Orders) for 10/01/2025 - 06/24/2026 revealed RI #91 had treatment orders for the skin tears to his/her right upper shin, left knee, right buttocks, right hip, right knee and right lower shin. RI #91's Progress notes revealed the following: . 10/05/2025 11:28AM Sponsor (name of sponsor) made aware of new areas found on (RI # 91) . This progress note was made by the Treatment Nurse (TX nurse). On 06/24/2026 at 5:01 PM an interview was conducted with the TX nurse. When asked how RI #91 acquired the skin tears, the TX nurse said her notes were showing on 11/05/2025 she contacted the sponsor and made her aware of the new areas (skin tears) found on RI #91. The TX nurse said her documentation did not say who informed her of the skin tears or how the skin tears were acquired. The TX nurse said incident reports should be done for skin tears. The TX nurse said the incident report would tell how the skin tear occurred, but she did not recall if an incident report had been done or not.On 06/30/2026 at 8:41 AM an interview was conducted with the Administrator (ADM). The surveyor shared with the ADM when reviewing RI #91's Physician Orders and November Progress Notes, the surveyor saw where RI #91 acquired several new areas (skin tears) during the month of November 2025. When asked who would have initially identified the areas as skin tears, the ADM said it would be any staff providing care to RI #91. The ADM said she was not sure if it was ever investigated how RI #91 acquired the skin tears. The ADM said according to the facility's Incidents and Accidents policy, skin tears were considered incidents. When asked if according to the policy should an incident/accident report be completed when incidents occur, the ADM said yes. When asked why it would be important to complete incident reports, the ADM said to show what the facility did in the event of an incident or accident. Review of the facility's Event Summary Report (incident tracking module) dated 06/01/2025 to 02/01/2026 revealed no incident report or investigation had been completed related to RI #91's skin tears.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and review of a facility policy titled, DIET AND SUPPLEMENT ORDERS, the facility failed to ensure a water pitcher containing thin liquids was not at the bedside of Resident identifier (RI) #11, resident at risk for aspiration, who was to receive nectar-thick liquids per physician's orders. These observations were made on three of seven days of the survey. This deficient practice affected RI #11, one of four resident's reviewed for nutrition/hydration, and had the potential to result in the resident consuming liquids of an unsafe consistency, placing the resident at increased risk for aspiration and choking. Findings Include: Review of a facility policy titled, DIET AND SUPPLEMENT ORDERS, with a reviewed date of 12/2023 revealed the following:POLICY:The resident's diet is prescribed by the attending physician.PROCEDURE:1. The attending physician writes an order for regular or therapeutic diets . to be served to each resident, according to the resident's nutritional and medical requirements and/or limitations and preferences . RI #11 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Alzheimer's Disease with Late Onset, Esophageal Obstruction, Senile Degeneration of the Brain and Gastro-Esophageal Reflux without Esophagitis. RI #11's care plan identified RI #11 to require thicken liquids related to his/her risk for aspiration. The care plan directed staff to not keep a water pitcher in the resident's room, to provide thickened liquids as ordered, and staff was to have a cooler containing thickened liquids at the bedside. This care plan was initiated on 12/03/2024. RI #11's COMMUNICATION FORM, to nursing from the therapy department, with an effective date of 02/09/2026 revealed a honey thick liquid consistency was changed to nectar thick liquids consistency. RI #11's Physician Order Report (Physician Orders) dated 05/2026 to 06/2026 revealed RI #11 was to have nectar-thick liquids. This order has a start date of 02/09/2026. A review of RI #11's RESIDENT PROFILE, dated 02/09/2026 revealed RI #11's diet was pureed diet with nectar-thick liquids. The profile sheet also revealed the nectar thicken liquids was a swallowing precaution. Documented on the profile was . cooler in room with nectar thicken liquids at bedside . RI #11's Quarterly Minimum Data Set assessment, with an Assessment Reference Date of 05/26/2026, revealed RI #11 had a Brief Interview of Mental Status score of 3 of 15 which indicated severely impaired cognition. The assessment revealed RI #11 was to receive a mechanically altered diet, such as thicken liquids. On 06/22/2026 at 4:00 PM the surveyor observed a water pitcher at RI #11's bedside. On 06/23/2026 at 2:30 PM the surveyor again observed a water pitcher at RI #11's bedside. On 06/25/2026 at 4:41 PM the surveyor observed the water pitcher on top of the over-bed table in RI #11's room. At this time, Certified Nursing Assistant (CNA) #20 entered the room and checked the consistency of the water in the pitcher. CNA #20 said there was no thicken water in the pitcher. When asked the type of diet Resident #11 was receiving, CNA #20 stated, pureed with thickened liquids. When asked who was responsible for ensuring RI #11 had thickened water at his/her bedside, CNA #20 stated she was unsure. On 06/26/2026 at 10:43 AM an interview was conducted with the Registered Dietitian (RD). When asked whether water should also be nectar thickened for a resident prescribed a therapeutic diet with nectar thick liquids, the RD stated yes. The RD stated the reason for the nectar- thick liquids would be swallowing problems. When asked what could potentially occur if the water was not thicken and the resident received the water, the RD stated possibly chocking. When asked who was responsible for ensuring the resident received the correct water consistency at the bedside, the RD stated the nursing staff was responsible and could obtain thickened water from the kitchen. On 06/29/2026 at 12:56 PM an interview was conducted with the Registered Nurse Unit Manager (RN UMGR). When asked, according to RI #11's physician order what should be the fluid consistency of his/her fluids, the RN UMGR said nectar thick. The RN UMGR said she believed this was the consistency that speech recommended for RI #11. The RN UMGR said the consistency of the water should be nectar-thick liquid as well. The surveyor shared with the RN UMGR that from (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/22/2026 through 06/25/2026, RI #11 had a pitcher with regular water at his/her bedside. The RN UMGR stated RI #11 should not have had a pitcher of water at his/her bedside and she did not know why one was there. When asked how the CNAs providing care for RI #11 knew the required fluid consistency of RI #11's water, the RN UMGR stated they could review the resident's profile sheet in the closet or ask the nurse about the consistency of water RI #11 received. The RN UMGR stated that the CNAs or someone should have known that RI #11 should have had a cooler with thicken water in it at his/her bedside. When asked what could be an outcome if staff had given RI #11 water not in the ordered consistency, the RN UMGR said RI #11 could have strangled, chocked or aspirated.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of a facility policy titled, Oxygen Administration, the facility failed to ensure Resident Identifier (RI) #1's oxygen tubing and RI #35's humidified water bottle was maintained in a manner to prevent contamination.Specifically: 1) RI #1's humidified water bottle was not dated when observed by the surveyor on 06/23/2026.2) RI #35's humidified water bottle was not dated when observed by the surveyor on 06/23/2026 and 6/24/2026. This deficient practice affected RI #1 and RI #35 two of four residents sampled for Respiratory Care. Findings Include:Review of a facility policy title, Oxygen Administration with an effective date of February 1, 2004, revealed the following: . PURPOSE: To administer high purity oxygen for the treatment of certain diseases or conditions. PROCESS: .11. Cannulas, masks and tubing should be changed weekly .1) RI #1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with a diagnosis to include Pneumonia, Unspecified Organism.Review of RI #1's June 2026 physician orders revealed: . Administer oxygen at 2L (Liters) via (by way of) NC (nasal cannula) PRN (as needed) for SOB (shortness of breath). PRN for SOB (DX: Pneumonia, unspecified organism) Every shift-PRN: .On 06/24/2026 at 9:03 AM, an observation was made of RI #1 lying in bed with oxygen on at 2L per nasal cannula. The humidified water bottle did not have a date on it.On 06/24/2026 at 3:57 PM an interview was conducted with Licensed Practical Nurse (LPN) #18. The Surveyor accompanied LPN #18 to RI #1's room to observe the humidified water bottle. LPN #18 stated there was no date on the humidified water bottle. LPN #18 stated the humidified water bottles were change weekly. LPN #18 stated the concern of not dating the humidified water bottle was it could possibly lead to infection.On 06/24/2026 at 4:18 PM an interview was conducted with the Infection Preventionist (IP). The Surveyor accompanied the IP to observe RI #1's humidifier bottle. The IP stated there was no date on the humidifier bottle and it should be dated. On 06/26/2026 at 11:23 AM an interview was conducted with Registered Nurse, Unit Manager (RN UMGR). The RN UMGR stated she observed RI #1's humidified water bottle and did not see a date or any initials. When asked what should be written on the humidified water bottle, she stated the date it was changed and the nurse's initials. 2) RI #35 was admitted to the facility on 0913/2021 and readmitted to the facility on [DATE] with a diagnosis of Heart Failure, Unspecified.Review of RI #35's June 2026 physician orders revealed: . OXYGEN AT 2 LITERS/MINUTE VIAL NASAL CANNUAL AS NEEDED FOR SOB .On 06/23/2026 at 9:22AM, an observation was made of RI #35's oxygen and there was no date on the humified water bottle.On 06/24/2026 at 9:10 AM, an observation was made of RI #35's oxygen concentrator. The humidified water bottle was not dated.On 06/24/2026 at 5:32 PM an interview was conducted with LPN #21. LPN #21 was asked about the date on RI #35's humidified water bottle. She said the humidified water bottle did not have a date, but there should be a date on it.On 06/25/2026 at 3:43 PM an interview was conducted with the Minimum Data Set (MDS) Coordinator. The MDS Coordination stated the oxygen tubing, and humidified water bottles should be changed weekly, and the nurse on the unit was responsible for changing them. She said, she was not sure how the facility ensured the oxygen tubing and humified water bottle was changed. The MDS Coordinator said, the potential harm of oxygen tubing or humidifier water bottles not being changed was they could stop working and the tubing cloud get clogged or water get in it.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and a policy titled . Behavior Management Program the facility failed to timely assess the behavior change and timely implement additional behavior interventions for Resident Identifier (RI) #90 a resident with a history of wandering behavior. Specifically: On 04/16/2025 RI #90 wandered into RI #57's room. RI #57 had a diagnoses of dementia with mood disturbance and staff had been made aware on 04/15/2025 that he/she did not want RI #90 in his/her room. Although staff were aware no interventions were in place to ensure RI #90 did not wander into RI #57's room. When RI #90 entered RI #57's room on 04/16/2025 RI #57 pushed RI #90 out of the room causing him/her to fall and sustain a fracture to the left maxillary sinus wall and lateral border of the left orbit. This deficient practice affected one of two residents reviewed for behavior health. This deficiency was cited as a result of complaint #463612. Findings include: On 04/16/2025 at 1:16 PM the Alabama State Survey Agency received a Facility Reported Incident (FRI) which indicated RI #57 pushed RI #90 down on the floor in the hallway after RI #90 entered RI #57's room. RI #90 was noted to have a laceration above the left eye.The facility's Behavior Management Program Policy with a revised date of 02/2013, documented .PURPOSE:To provide facilities with a standard process for identifying, assessing and managing residents who display mental or psychosocial adjustment difficulties.STANDARD:Residents who display mental or psychosocial adjustment difficulty should receive appropriate services, in an attempt to correct the problem. The social service department may assist with arrangements, for outside professional consultation services, such as psychologists or psychiatrists, when ordered by the attending physician.PROCESS: I. Assessment a) Mental adjustment disorders should be identified through the RAI process, completed after admission of a resident, and periodically throughout the resident's stay. b) The social services designee may conduct further assessments to identify and manage altered mental states, dementia, delirium, and depression.II. Behavior Management Programsa) The plan of care should be developed by the interdisciplinary team.Any resident not identified on the behavior list who exhibits a behavior will be immediately redirected and removed from the stimuli.The behavior will be reported to the unit manager and/ or charge nurse by the staff member who observed the behavior. The unit manager/charge nurse will evaluate the resident for possible causes or precipitating factors. The occurrence will be reported to the physician, if indicated and reported in the clinical record. The Social Service department, Director of Nursing and Administrator will be notified by documentation on a facility communication tool. The sponsor will also be informed of the occurrence by social services and/or nursing service. RI #90 was admitted to the facility on [DATE] with diagnoses of Unspecified Dementia, Mood Disorder, and Adjustment Disorder with mixed Anxiety.RI #90's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/04/2025, indicated RI #90 had a Brief Interview for Mental Status (BIMS) Score of 11/15 indicating moderately impaired cognitive skills for daily decision making, with long- and short-term memory problems. According to the MDS RI #90 displayed no behaviors.A review of RI #90's care plan with a problem onset date of 05/04/2023 revealed the following . is having increased behaviors/cognitive loss related to dx of Dementia . Approach: encourage participation in . activities .refer to psych services as needed .A review of RI #90's care plan with a problem onset date of 01/15/2025 revealed the following . is at risk for elopement due to wandering . wanders into other residents' rooms . check code alert placement every shift . Consult with MD and psychologist as needed . encourage socialization and participation in activities . A review of RI #90's care plans did not indicate interventions were made on 04/15/2025 after RI #57 reported RI #90 wandering into his/her room.RI #57 was admitted to the facility on [DATE] with an admitting diagnosis of Dementia with Agitation. RI #57's Quarterly MDS with an ARD of 03/11/2025, indicated RI #57 had a BIMS Score of 15/15 and was cognitively intact with skills for (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily decision making. RI #57's Mood Interview indicated a score of 0 and revealed no behaviors. RI #57's Progress Note dated 04/16/2025 at 1:03 PM written by the Social Services Director (SSD) documented . Yesterday (RI #57) made the Assistant Director Of Nursing (ADON) and SSD aware of another resident coming into (his/her) room. (He/she) stated that (he/she) wanted them to leave (him/her) alone. SSD and ADON stated they would discuss this with the other resident and let them know not to come into (his/her) room. SSD and ADON stated to (RI #57) that when someone comes into (his/her) room (he/she) does not want to press the call light or get staff attention. (RI #57) stated that (he/she) understood .On 06/25/2026 at 4:44 PM during an interview the SSD said she became aware of RI #90 entering RI #57's room on 04/15/2025 when RI #57 notified her. When asked what interventions were put in place for RI #90 on 04/15/2025 the SSD stated that interventions began on 04/17/2025 to obtain placement for RI #90 in a memory care facility. When asked were interventions put in place to provide adequate protection from foreseeable harm the SSD replied No.On 06/24/2026 at 11:21 AM with RI #57 was asked what happened on 04/16/2025 with RI #90. RI #57 stated RI #90 came up to his/her room about three times and he/she told the nurses that he/she kept coming to his/her room but they would not move him/her. RI #57 said the incident could have been avoided if the staff had removed the resident.On 06/24/2026 at 11:49 AM during an interview RI #8 stated that RI #57 would fuss at anyone who came close to his/her room. On 06/29/2026 at 12:03 PM during an interview Certified Nursing Assistant (CNA) # 16 stated that RI #90 wandered soon after being admitted to the facility and she observed him/her often going in and out of other resident's rooms. She stated she had observed RI #90 go into RI #57's room at least six times and she could hear RI #57 hollering at him/her. CNA #16 stated she told the nurses and suggested that RI #90 be moved to another hall. CNA #16 stated the incident could have been avoid if RI #90 had been moved.On 06/29/2026 at 12:52 PM during an interview CNA #17 stated RI #90 had a history of wandering in and out of other rooms and taking personal items. She stated RI #90 wandered daily and she had observed him/her going into RI #57's room about five times. She stated nothing could have prevented the incident because if they moved him/her RI #90 would continue to wander.On 06/30/2026 at 10:27 AM during an interview the Director of Nursing (DON) stated RI #90 was identified as a wanderer on 01/15/2025 according to the care plans and a progress note. When asked what type of supervision was in place for RI # 90 at the time of the incident, the DON stated general supervision and RI #90 had a code alert monitor in use. The DON stated RI #90 had a diagnosis of dementia and he/she wandered all over the building. The DON stated the incident could have been prevented by moving RI #90. When asked how it would make a reasonable person feel being hit by another resident, the DON stated upset and in pain. The DON stated the facility substantiated abuse.On 06/30/2026 at 12:14 PM the Administrator (ADM) was asked what interventions were in place to protect RI #90, a known wanderer. The ADM stated RI #90 was identified as a wanderer on 01/15/2025 and staff were educated on interventions to assist with wandering. The ADM was asked the level of supervision RI #90 required and she stated he/she was redirected and staff checked the code alert for placement. The ADM asked what interventions were put in place by the ADON and SSD after being notified by RI #57 that he/she did not want RI #90 coming into his/her room. The ADM stated RI #57 was instructed to press the call device when RI #90 entered the room.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and review of a facility policy titled, Oral Medication Administration, the facility failed to ensure the medication nurses initialed on Resident Identifier (RI) #54's Medication Administration Record (MAR) that RI #54's Hydrocodone-Acetaminophen (Norco) 10/325 mg (milligram) and Pregabalin (Lyrica) 200 mg, both narcotic medications, had been administered to RI #54 on 05/02/2026 at 6:00 AM; and on 05/25/2026 at 6:00 PM.This deficient practice affected RI #54, one of four residents whose MARs was reviewed for medication administration. When nurses do not initial or document on the MAR immediately after administering a medication, another nurse may assume the resident did not receive the medication and administer a second dose, which could place the resident at risk of a dangerous overdose.Findings Include:Review of a facility policy titled, Oral Medication Administration, with an effective date of 02/01/2004 revealed the following: PURPOSE:To administer oral medications in an organized and safe manner . PROCESS: .18. Administer medication .21. Return to medication cart, . and document medication administration, with initials in appropriate space on Medication Record (MAR) . RI #54 was admitted to the facility on [DATE] with diagnoses to include Presence of Left Artificial Hip Joint, Polyneuropathy and Cellulitis. RI #54's May - June 2026 Physician Order Report (Physicians Orders) revealed RI #54 was to be administered Pregabalin 200 mg one capsule by mouth three times a day and Hydrocodone-Acetaminophen 10-325 mg by mouth twice daily for pain. A review of RI #54's May 2026 MAR revealed on 05/02/2026 there were no initials on the MAR indicating that RI #54 had been administered his/her Hydrocodone and Pregabalin at 6:00 AM; and on 05/25/2026 there were no initials on the MAR indicating that RI #54 had been administered his/her Hydrocodone and Pregabalin at 6:00 PM. On 06/29/2026 at 5:06 PM a telephone interview was conducted with Registered Nurse (RN) #23, the nurse administering medications to RI #54 on the 3rd shift on 05/02/2026. The surveyor shared with RN #23 that there were no initials on the MAR indicating she had administered RI #54 his/her Hydrocodone and Pregabalin at 6:00 AM. When asked why there were no initials on RI #54's MAR indicating she had administered the medications, RN #23 said she probably forgot to sign the MAR that she had administered them. When asked why it would be important to initial/document on the MAR after the nurse administered the medication to the resident, RN #23 said to show that the nurse had given the mediation and to keep good records. On 06/29/2026 at 4:43 PM a telephone interview was conducted with RN #24, the nurse administering medications to RI #54 on the 2nd shift on 05/25/2026. The surveyor shared with RN #24 that there were no initials on the MAR indicating she had administered RI #54 his/her Hydrocodone and Pregabalin at 6:00 PM. When asked why there were no initials on RI #54's MAR indicating she had administered the medications, RN #24 said she must have overlooked that and not signed the MAR. When asked why it would be important to initial/document on the MAR after the nurse administered the medication to the resident, RN #24 said because you have to keep track of when the medication was given. On 06/29/2026 at 1:22 PM an interview was conducted with the RN Unit Manager (RN UMGR). When asked, after the nurse had administered any medication to a resident what should they do next, the RN UMGR said sign off on the MAR the medication had been given. The RN UMGR said looking at RI #54's May 2026 eMAR (Electronic MAR), it was not signed off that RI #54 received his/her Hydrocodone and Pregabalin on 5/02/2026 at 6:00 AM and on 5/25/2026 at 6:00 PM. The RN UMGR said the facility's policy instructed nurses to initial and sign the MAR that medications had been administered. The RN UMGR said it would be important for the nurse to initial/document on the MAR after the nurse administered medications so that you know which nurse gave the medication and what medication had been given.

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	015112	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Haven Health and Rehabilitation Center	603 Wright Street Tuskegee, AL 36083

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews and review of a facility policy titled, DIET AND SUPPLEMENT ORDERS, the facility failed to ensure Resident Identifier (RI) #3 was served double portions of proteins as a part of the resident's therapeutic diet.This deficient practice affected RI #3, one of four residents that were reviewed for nutrition and was observed during the breakfast and lunch meals on 06/24/2026. RI #3 not receiving his/her double portions of protein placed RI #3 at risk of a decrease in his/her protein levels which may lead to malnutrition, weight loss and muscle wasting. Findings Include: Review of a facility policy titled, DIET AND SUPPLEMENT ORDERS, with a reviewed date of 12/2023 revealed the following:POLICY:The resident's diet is prescribed by the attending physician. PROCEDURE:1. The attending physician writes an order for regular or therapeutic diets . to be served to each resident, according to the resident's nutritional and medical requirements and/or limitations and preferences . RI #3 was admitted to the facility on [DATE] with the diagnoses of End Stage Renal Disease, Dependence on Renal Dialysis, and Muscle Weakness.RI #3's admission Minimum Data Set assessment with an Assessment Reference Date of 05/25/2026, revealed RI #3 had a Brief Interview of Mental Status score of 15 indicating the resident was cognitively intact. The MDS also coded RI #3 as receiving a Therapeutic diet.RI #3's Physician's Order, dated 05/26/2026, included a diet order with special instructions to add large portions to each meal tray, and add boiled eggs on breakfast tray and double meat on each tray for protein.On 06/24/2026 at 8:50 AM RI #3's breakfast tray was observed to contain one boiled egg and one thin turkey sausage patty. RI #3 stated, his/her protein was low and the doctor ordered more proteins a few days ago.On 06/24/2026 at 12:20 PM RI #3's lunch tray was observed to contain two chicken wings.On 06/24/2026 at 3:45 PM an interview was conducted with the Dietary Supervisor (DS). The DS said RI #3 was to receive two boiled eggs and two servings of meat with breakfast. The DS said the two wings were one serving and not a double portion. The DS said these were mistakes made by the kitchen.On 06/25/2026 9:06 AM during a follow up interview with the DS she stated the potential outcome that could occur if the resident's meal did not include double portion of proteins as prescribed would be, RI #3 would not get the nutrition that he/she needed and weight loss.On 06/26/2026 at 10:43 AM, the Registered Dietician (RD) was asked, when a resident was on a therapeutic diet and had an order for double portions and chicken wings were served, how many wings should be served to the resident. The RD said four should have been served. The RD said the dietary staff would be responsible to ensure the residents received double portions. When asked what was the potential when a resident was not served double portions as ordered, the RD said with RI #3, he/she was receiving dialysis and they were trying to double his/her portions to meet his/her protein needs after dialysis. The RD said the facility was trying to get RI #3 his/her additional proteins through diet. The RD said the outcome of RI #3 not receiving double portions would be that RI #3's protein needs would not be met.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interview and a document titled ARBITRATION AGREEMENT AND WAIVER OF JURY TRIAL the facility failed to ensure arbitration agreements were implemented in a manner that protected resident rights. Specifically, the agreement required residents or families to submit written notice to rescind the arbitration agreement within 30 days and did not allow the resident to rescind the agreement verbally. This failure had the potential to affect all residents who executed arbitration agreements with the facility.Findings Include: An agreement titled ARBITRATION AGREEMENT AND WAIVER OF JURY TRIAL documented: . C. Right Not To Sign And To Rescind This Agreement . You are NOT required to sign this agreement in order to be admitted to, or continue to receive care at, the facility. You are permitted to rescind this Agreement within the first 30 days after you sign this Agreement. To do so, send a signed letter to the Facility at [ADDRESS.] The letter should include your full name, address, and the last four digits of your social security number, and should state that you are exercising your right to rescind this Agreement. On 06/25/2026, at 10:46 AM, the Social Service Director (SSD) stated that her responsibility in the arbitration process was to explain the arbitration agreement to families and residents before their admission. She indicated that after the arbitration agreement was signed, a resident or their representative had a period of 30 days to retract their consent by submitting a written request to the facility. She said the arbitration agreement did not allow a verbal withdrawal from the agreement. When asked if this was a concern, she said no, that she would be available to assist with the written request if asked by a family or resident to withdraw the arbitration agreement.

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F 0801 Level of Harm - Potential for minimal harm Residents Affected - Many Note: The nursing home is disputing this citation.	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interviews, the facility's CERTIFIED DIETARY MANAGER JOB DESCRIPTION, and a certificate of completion for Nutrition and Foodservice Professional Training Pathway III(b) from the University of Florida; the Dietary Supervisor in charge of the facility's Food Service Department/Dietary Department did not meet minimum qualifications as a director of food and nutrition services. This had the potential of affecting 84 of 84 residents receiving meals from the facility's Food Service Department/Dietary Department while it was under the direction of an unqualified individual. Findings Include: The facility's CERTIFIED DIETARY MANAGER JOB DESCRIPTION, dated 5/2003, included the following: . General Purpose: To assist in planning, organizing, developing and directing the overall operation of the Dietary Department in accordance with current federal, state and local standards governing the facility, and as may be directed by the Administrator, to ensure that quality nutritional services are provided on a daily basis and that the Dietary Department is maintained in a clean, safe and sanitary manner.Qualifications: Must be a Certified Dietary Manager in good standing with the State of Alabama or in training to satisfactorily complete the requirements to become a Certified Dietary Manager .A certificate of completion for Nutrition and Foodservice Professional Training Pathway III(b) from the University of Florida, dated September 17, 2025, naming the Dietary Supervisor as the recipient. On 06/22/2026 at 4:38 PM, the Dietary Supervisor was asked for her credentials. The Dietary Supervisor said she had not taken her CDM (Certified Dietary Manager) test yet. The Dietary Supervisor said she needed to take the CDM exam, The Dietary Supervisor further said she had not scheduled the exam yet, because she was studying for it still and because of the cost, $400. The Dietary Supervisor said she had completed the CDM course in September 2025. When asked about support management staff, the Dietary Supervisor said the RD (Registered Dietitian) Consultant came twice a month, the Corporate RD came once a month, and the Corporate CDM came once a month along with the Corporate RD.On 06/23/2026 at 2:17 PM, the Dietary Supervisor was asked if she had an Associate's Degree or Bachelor's Degree in Nutrition or Hospitality or Food Service. She said no, just the online CDM course from the University of Florida. On 06/25/2026 at 10:04 AM, the Dietary Supervisor said she had worked at the facility for eight years in her current position, managing the Food Service Department. On 06/25/2026 at 12:39 PM, the Administrator was interviewed. The Administrator said she had been the facility's Administrator since June 2023. Upon being asked why the Dietary Supervisor was hired to direct the facility's Food Service Department/Dietary Department eight years ago when she was not qualified, the Administrator said she was not here eight years ago. When asked if she followed up to see if the Dietary Supervisor became certified, the Administrator said she did. The Administrator further said the Dietary Supervisor was previously in training, but had not completed it, so she did follow up and encouraged her to complete the training, The Administrator said the goal was for everyone to meet the potential maximum requirement of the duty.

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F 0809 Level of Harm - Potential for minimal harm Residents Affected - Many Note: The nursing home is disputing this citation.	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on interview, the Resident Council Meeting, the facility's MEAL SERVICE TIMES, and the facility's policy for FREQUENCY OF MEALS; the facility failed to ensure cart deliveries of meals were not scheduled to exceed 14 hours between service from Dinner to Breakfast for Rehab/West Hall, North Hall, South Hall, and Meal Assist. This had the potential to affect 84 of 84 residents receiving meals at the facility.Findings Include: The facility's policy for FREQUENCY OF MEALS, last revised 6/2017 and last reviewed 12/2023, included the following: . POLICY: . There is no more than a fourteen (14) hour span between a substantial evening meal and breakfast. The facility's MEAL SERVICE TIMES, undated, included the following: Breakfast Cart 1 - Rehab/West Hall 7:15 AMCart 2 - North Hall 7:30 AMCart 3 - South Hall 7:40 AMCart 4 - Meal Assist 8:00 AMDinnerCart 1 - Rehab/West Hall 5:00 PMCart 2 - North Hall 5:15 PMCart 3 - South Hall 5:30 PMCart 4 - Meal Assist 5:45 PM. Resident Council met at 10:00 AM on 06/24/2026 with eleven residents in attendance. During this meeting, the Resident Council members said they had not agreed to a time span greater than 14 hours between the service of dinner and breakfast. On 06/25/2026 at 10:04 AM, the Dietary Supervisor was interviewed. The Dietary Supervisor said the residents who request a snack and Diabetic residents will get a HS (Hour of Sleep) snack. The Dietary Supervisor said 14 hours was allowed between the service of dinner and the service of breakfast. While the Dietary Supervisor was looking at the facility's MEAL SERVICE TIMES, she was asked about time frames for meals. The Dietary Supervisor said there were 14 hours and 15 minutes between service of dinner and service of breakfast for the following carts: Rehab/West Hall, North Hall, and Meal Assist. She further said there were 14 hours and 10 minutes between service of dinner on the South Hall and service of breakfast on that same hall. When asked how the time periods extending over 14 hours could potentially affect the residents, the Dietary Supervisor said weight loss.

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and a review of the facility's Resident Rights the facility failed to ensure residents received mail in a timely manner by not delivering mail received on Saturdays. This failure had the potential to affect all residents who received mail at the facility by delaying access to correspondences and other mailed information. Findings Include: A review of the Resident Rights with a revised date of 01/2017, revealed: . SUBJECT: Residents Rights .15. The Resident has the . right to access private communication of all kinds, . On 06/23/2026 at 10:00 AM a Resident Council Meeting was held. The eleven residents in the meeting stated that they did not receive mail on the weekend. When the residents were asked why they did not receive mail on Saturday, residents stated that there was no one to pass the mail out. On 06/25/2026 at 11:26 AM an interview was conducted with the Social Services Director (SSD). She was asked the process for residents to receive mail on Saturday. She stated she was not sure, and it was handled through the business office. She also stated that no one worked in the business office on Saturdays. The SSD stated during the week was the Postman brought mail to the facility's business office, the facility's staff would time stamp it, and then deliver the mail. The SSD stated to her knowledge, the United States Postal Service (USPS) delivered mail to the facility on Saturdays. On 06/25/2026 at 11:45 AM an interview was conducted with the Bookkeeper. She was asked how she handled mail on the weekend. She stated the Postman would take the mail to main station, give staff the mail, the staff would store it in a locked room and give it to the Administrator on Monday morning. The Bookkeeper stated that after she gave it to the Administrator it was delivered to the residents. The bookkeeper was asked when the mail was delivered on Saturday why was it not delivered to residents. She said so the office would have a record of mail received before it was delivered to residents. On 06/25/2026 at 3:19 PM, an interview was conducted with the Administrator (ADM). She was asked does the USPS deliver mail to the facility on Saturday and she stated yes. She was asked what was the process for delivering mail. The Administrator stated the Postman delivered the mail to the nurses' desk. If the residents received mail, it should be given to them and the rest of the mail should be locked up until Monday when it should be sorted. She also stated that there was no policy that directs staff on what to do with the mail for residents when received on Saturday. She was asked do staff who work on the weekend know to pass the residents mail to them and she stated she thought they would know to deliver the mail to the residents once it was received. The Administrator stated the importance of receiving mail on Saturday was to ensure residents received mail directed to them.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide Resident Identifier (RI) #80 and RI #80's representative a written notice of transfer when RI #80 was transferred to the hospital on [DATE] and 03/16/2026. This deficient practice affected RI #80, one of three residents reviewed for hospitalization. Failing to provide a written transfer notice when a resident is transferred to the hospital violates the residents right to return to their nursing facility after a hospital stay. Without a written notice documenting the specific medical reason for the transfer, the facility could discharge the resident and fill their bed while the resident is in the hospital. RI #80 was originally admitted to the facility on [DATE] and had a last readmit on 03/20/2026. RI #80 had diagnoses to include Epilepsy, Cognitive Communication Deficit, Hypertension and Chronic Kidney Disease. A review of RI #80's Progress note dated 03/08/2026 revealed around 9:45 AM, RI #80 was yelling out in his/her room and was very disoriented and agitated. RI #80 was having difficulty breathing and was transported to the hospital. RI #80's discharge summary assessment, with an assessment date of 03/08/2026, revealed this discharge was a discharge with a return anticipated. A review of RI #80's Progress note dated 03/13/2026 revealed RI #80 was readmitted to the facility. A review of RI #80's Progress note dated 03/16/2026 revealed at 4:47 AM RI #80 had a seizure and left the faciity on stretcher by way of ambulance. RI #80's discharge summary assessment, with an assessment date of 03/16/2026, revealed this discharge was a discharge with a return anticipated. A review of RI #80's Progress note dated 03/20/2026 revealed RI #80 was readmitted to the facility. On 06/25/2026 at 9:37 AM an interview was conducted with the Social Services Director (SSD). When asked who was responsible for providing the resident/representative with a written notice of transfer when the resident went to the hospital and was expected to return to the facility, the SSD said she had never provided a resident/or a resident's representative with a written notice of transfer, and she would have to find out. On 06/30/2026 at 8:31 AM an interview was conducted with the Administrator (ADM). When asked did the facility provide written transfer notices to the resident/or representative telling them the reason for the transfer, where they were being transferred to, date of transfer, and information about bed hold policy when the resident was transferred to the hospital in an emergency situation, the ADM said the nurses provided verbal notification to the family members but this information was not provided as a written notification. The ADM said there was no evidence that a written notice of transfer was provided to RI #80 or RI #80's representative when RI #80 was discharged to the hospital on [DATE] and on 03/16/2026. On 06/30/2026 at 10:18 AM a telephone interview was conducted with RI #80's representative. RI #80's representative said when RI #80 was sent to the hospital on [DATE] and then again on 03/16/2026, the facility called her on the telephone and informed her of this. When asked, did she receive a written notice of RI #80's transfers from the facility explaining the reason for the transfer, where RI #80 was being transferred to, and the date of transfer, RI #80's representative said no.