STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015133	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Ridge	420 Dean Drive Gardendale, AL 35071

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 0580 Level of Harm - Immediate jeopardy to resident health or safety 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, record review, and review of a facility policy titled, Change in Condition: Notification of, the facility failed to ensure the physician was when a significant change was identified on 04/07/2025 when Resident Identifier (RI) #9 was noted to have continued bleeding from a surgical incision ten days after being admitted and 13 days after the surgical procedure. The facility further failed to ensure the physician was notified on 04/09/2025 Resident Identifier (RI) #9's hemoglobin was 7.7 g/dL (grams per deciliter). On 04/07/2025 a change of condition was noted in RI #9's medical record related to bleeding from his/her surgical incision. The Certified Registered Nurse Practitioner (CRNP) was notified, and orders were obtained to hold RI #9's Eliquis for three days and obtain Complete Blood Count (CBC) on 04/08/2025. RI #9's Abixipan (Eliquis) was held on 04/07/2025 at 8 PM until 04/10/2025 at 8 PM. On 04/09/2025 at 10:41 AM the lab reported hemoglobin of 7.7 g/dL (low at 12, critical at 6.5). The facility did not notify the physician. On 04/10/2025 at 8:00 PM RI #9's Eliquis was resumed and administered. During the Medical Director's interview, he said the Eliquis should not have been resumed on 04/10/2025. On 04/16/2025 a repeat hemoglobin was drawn and resulted on 04/17/2025 with a value of 4.9 g/dL. RI #9 was transferred to the hospital on [DATE]. It was determined the facility's noncompliance with one or more requirements of participation has cause, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.10 Resident Rights at F580 - Notify of Change (Injury/Decline/Room, Etc.). On 05/31/2025 at 7:08 PM, the interim Administrator and the Market Clinical Advisor were provided a copy of the IJ template and notified of the findings of immediate jeopardy in the area of Resident Rights at F580-Notify Changes (Injury/Decline/Room, Etc.) (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The IJ began on 04/09/2025 and continued until 06/03/2025 when the survey team verified onsite that corrective actions had been implemented. On 06/04/2025 the immediate jeopardy was removed. F580 was lowered to the lower severity of no actual harm with a potential for more that minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revised their corrective actions as necessary to achieve substantial compliance. This deficient practice affected RI #9 one of 18 sampled residents. Findings Include Cross reference F757 and F841 Review of the facility's policy titled, Change in Condition: Notification of, with a revision date of 07/01/2024 documented the following: . POLICY A Center must immediately inform the patient, consult with the patient's physician, and notify, consistent with their authority, the patient's representative, where there is: . A Significant change in the patient's physical mental, . (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complication); . A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment); . When making notification of above, the Center must ensure that all pertinent information is available and provided upon request to the physician. PURPOSE To provide appropriate and timely information about changes relevant to the patient's condition. On 05/29/2025 at 12:27 PM an interview was conducted with Registered Nurse (RN) #61, Unit Manager. RN #61 was asked, what was the facility's policy for notifying the physician. RN #61 said the physician was to be notified immediately if a resident had a significant change. RN #61 was asked, how did staff know whether to contact the physician or Medical Director and the Certified Registered Nurse Practioner (CRNP). RN #61 said it was nursing judgement. RN #61 was asked, was their a policy and RN #61 said, nursing judgment. RI #9 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include Atrial Fibrillation and Displaced Intertrochanteric Fracture of Left Femur, Subsequent Encounter for Closed Fracture with Routine Healing. RI #9's face sheet identified the Medical Director (MD) as RI #9's Primary/Attending physician. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #9's hospital medical record indicated that on 03/25/2025 RI #9 had an Open Reduction Internal Fixation (ORIF) of his/her left hip to repair femur fracture. RI #9 was transferred back to the facility on [DATE]. On 05/28/2025 at 12:00 PM an interview was conducted with Certified Nursing Assistant (CNA) #103 who reported that she provided care to RI #9 after he/she returned from the hospital. CNA #103 reported when RI #9 returned from the hospital the first time, he/she had staples and not a wound vaccum. CNA #103 said that one weekend in April 2025 when she reported to work, the off-going CNA told her to watch RI #9's leg because it was bleeding. CNA #103 said during that shift, RI #9's incision would not stop bleeding. CNA #103 reported the bleeding filled half of a regular bath towel three different times that day during the 7 AM to 3 PM shift. CNA #103 said it looked like a crime scene and she had to change RI #9's sheets every time she changed the bath towel. CNA #103 said she notified the nurse, LPN #62, and thought the nurse notified someone, but she did not know who. CNA #103 did not recall the date, but said it was a weekend. On 05/28/2025 at 2:56 PM an interview was conducted with LPN #62 who said RI #9 returned from the hospital with staples to a surgical wound on his/her left hip. LPN #62 said the wound dressing had to be changed multiple times per shift due to drainage. LPN #62 said the drainage would saturate a four by four (4x4) gauze dressing. LPN #62 said he notified CRNP #75 who came and saw RI #9. On 05/29/2025 at 4:57 PM an interview was conducted with LPN #101. LPN #101 said when RI #9 first returned from hip surgery, his/her anticoagulant were not held or discontinued. LPN #101 said RI #9's wound was closed with staples and was seeping. LPN #101 said she came in on an evening shift and the CNA reported to her that the bed, the gown, and the pad were wet with bloody tinged fluid. LPN #101 said it was reported to her that a CRNP had said that it was normal, and they were waiting on lab work. LPN #101 said she did not notify the CRNP or the physician. Progress Notes for RI #9 dated 04/07/2025, revealed a SBAR (Situation Background Assessment Recommendation) Summary for Providers that documented: Situation: The Change in Condition/s reported on this CIC [Change in Condition] are/were: Bleeding (other than GI [gastrointestinal]) . Nursing observation, evaluation, and recommendations are: Bleeding at incision site left hip . The note indicated that the Primary Care Provider was notified and ordered RI #9's Eliquis 5 mg (milligram) to be held for three days, a hemoglobin and hematocrit to be obtained on 04/08/2025, and apply three drops of Afrin to 4x4 gauze and apply left hip. A Lab Results Report for RI #9 revealed the lab was collected on 04/08/2025 and was reported on 04/09/2025 at 10:41 AM. The results indicated RI #9 had a hemoglobin of 7.7 g/dL which was low. The normal range for a hemoglobin level was 12.0 - 16.0 g/dL. RI #9's hematocrit level was 25.9% (percent) which was also low. The normal range for a hematocrit level was 36.0 - 48.0%. A Progress Note for RI #9 with an effective date of 04/09/2025 at 11:00 AM electronically signed by LPN #26 documented that the MD and CRNP #75 visited RI #9. The note indicated a follow-up X-Ray of RI #9's left hip was ordered and no other orders were indicated. The note also indicated that RI #9 had a follow-up appointment with the orthopedic doctor on 04/10/2025. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Progress Note for RI #9 with an effective date of 04/09/2025 at 11:00 AM electronically signed by the Medical Director (MD) documented: . Continue current POC [Plan of Care] . Nursing staff voices no new concerns. The patient and all other medical conditions are stable at this time . Medications: . Apixaban Oral Tablet 5 MG Give 1 tablet by mouth two times a day for anticoagulants . Physical Exam: . Heart Rate: 106 bpm [beats per minute] . The patient is well developed and in no acute distress . Labs . 7/10/2024 HGB [Hemoglobin] 12.3 and HCT [Hematocrit] 39.5 and 1/6/2025 indicated H&H 11/38. A Progress Note for RI #9 with an effective date of 04/16/2025 at 11:48 electronically signed by the Medical Director (MD) documented: . Continue current POC [Plan of Care] . Nursing staff voices no new concerns. The patient and all other medical conditions are stable at this time . Medications: . Apixaban Oral Tablet 5 MG Give 1 tablet by mouth two times a day for anticoagulants . Physical Exam: . Heart Rate: 62 bpm . The patient is well developed and in no acute distress . Labs . 7/10/2024 HGB [Hemoglobin] 12.3 and HCT [Hematocrit] 39.5 and 1/6/2025 indicated H&H 11/38. Progress Notes for RI #9 dated 04/16/2025 at 3:59 PM documented another Summary for Providers that documented a change in condition was reported to CRNP #75 by LPN #26. The note indicated that RI #9 had poor appetite, confusion, lethargy. CRNP #75 gave order to hold Eliquis x three (3) days, obtain CBC and Comprehensive Metabolic Panel (CMP) labs on 04/17/2025. Another Lab Results Report for RI #9 dated 04/17/2025 documented RI #9 had a hemoglobin of 4.9 g/dL and a hematocrit level of 16.6%. A Progress Note for RI #9 dated 04/17/2025 documented that RI #9 was sent to the hospital related to a hemoglobin level of 4.9. RI #9's History and Physical from the hospital, dated 04/18/2025, revealed the following: Chief Complaint pt (patient) c/o (complained of) recent left hip replacement site has been bleeding for the past several days. pt also states (he/she) is SOB (short of breath) . History of Present Illness . Upon presentation, patient with hypotension 85/53 . tachycardia 113. Blood work significant for hgb (hemoglobin) of 5.5 . Patient ordered 2 units PRBC (Packed Red Blood Cells). Patient developed hypotension and tachycardia. Patient given fluids with some improvement . Assessment/Plan 1. Symptomatic anemia . -In setting of bleeding from surgical site . Patient dropped 3 g in hemoglobin, apparently has been bleeding from surgical site since surgery . (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Ordered for 2 units PRBC . On 05/30/2025 at 5:00 PM, a telephone interview was conducted with RI #9's Orthopedic Surgeon. The Orthopedic Surgeon said he was not aware RI #9 had a Hemoglobin level of 7.7 g/dL when RI #9 came to his office on 04/10/2025 and he would have liked to have been notified. On 05/30/2025 at 5:10 PM, a telephone interview was conducted with the MD. The MD said he was not notified on 04/08/2025 of RI #9's hemoglobin of 7.7 g/dL and hematocrit of 26.9% and he would have wanted to be notified. The MD said he should be notified when nursing staff identified a change of condition with a resident, but the facility had CRNPs. The MD said he wanted to be notified, and they could call him at any time and sometimes they call the CRNPs and they handled it. The MD said he would not have resumed RI #9's Eliquis on 04/10/2025 at 8 PM. The MD said the Eliquis should have been held for a longer period of time. The MD was asked, on 04/17/2025 RI #9's hemoglobin was 4.9 g/dL and hematocrit was 16.6% he/she was sent to the hospital, when should the facility have notified him. The MD said they should have notified him immediately. The MD was asked, why was it important for the physician to be notified in instances such as discussed with RI #9. The MD said the physician needed to monitor the resident. On 05/31/2025 at 2:14 PM a follow-up interview was conducted with the MD. The MD said he was not aware that notes he signed in RI #9's medical record in April 2024 included labs from 07/10/2024. The MD said the facility was responsible for notifying him if there were any labs for review. ********** The facility submitted an acceptable plan to remove the immediacy of the identified deficient practice that included: ********** Assessments 1. RI #9 was discharged from the facility on 5/19/25. Audits 1. On 5/31/25, the facility conducted an audit of 118 residents from 04/01/04 to 06/01/25 to identify residents receiving anticoagulant therapy with laboratory orders to verify physician notification. Of 118 residents, 13 residents were identified receiving anticoagulant medications with 1 resident identified with laboratory orders and abnormal lab values. Based on review, the Physician and/or Certified Registered Nurse Practitioner was notified of the abnormal lab values. 2. On 6/01/25, Nurse Managers and/or designee conducted an audit of 118 residents to identify residents with surgical incisions. 3 of 118 residents identified with a surgical incision. On 06/01/25, an assessment was completed with no abnormalities. In-services (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. On 6/01/25, the Director of Nursing and/or designee educated 15 of 16 full-time licensed nurses on the Change in Condition policy with specific emphasis on assessment of surgical incisions to include redness, warmth, swelling, pain, drainage (color, odor, amount) and signs of wound dehiscence and notifying the Physician and/or Certified Registered Nurse Practitioner. If the Certified Registered Nurse Practitioner (CRNP) is notified of a significant change, the (CRNP) will consult with the Physician/Medical Director within 24 hours and document the consultation in the resident's medical record. Additional education included monitoring residents receiving anticoagulant therapy per the plan of care and notifying the Physician and/or Provider of abnormal lab values within 24-48 hours. The facility has 14 PRN/Part-time licensed nurses; 5 of 14 PRN/Part-time licensed nurses received the education on 6/01/25. The facility attempted to contact the 9 PRN/Part-time licensed nurses via phone; the DON and/or designee will monitor the schedule and provide 1:1 in-services before their next scheduled shift. Education on the aforementioned topics was sent to all Licensed Nurses via regroup message. Active licensed nurses, licensed nurses on leave of absence (FMLA), and PRN nurses who have not received the education aforementioned will be educated prior to returning to their assigned shift by the DON and/or designee. 2. On 6/1/25, the Director of Nursing educated the Assistant Director of Nursing and Unit/Nurse Managers on monitoring residents on anticoagulant therapy three times a week in the clinical meeting to ensure the Physician and/or Certified Registered Nurse Practitioner has been notified of changes in condition. If the Certified Registered Nurse Practitioner (CRNP) is notified of a significant change; the CRNP will consult with the Physician/Medical Director as soon as reasonably possible and document the consultation. 3. On 6/3/24, the Medical Director, 2 of 2 Certified Registered Nurse Practitioners', 1 of 1 Optum Nurse Practitioners' and Licensed Nurses were educated on the policy and process related to Change in Condition with specific emphasis on when a Certified Registered Nurse Practitioner (CRNP) is notified of a significant change in condition, the CRNP will consult with the Physician/Medical Director within 24 hours and document the consultation in the medical record. The Licensed Nurse will be educated via regroup message on 6/3/25. 4. On 06/01/25, the Regional Medical Director educated the Medical Director on his/her role in facilitating and coordinating medical care to ensure the appropriateness and quality of medical care. Education consisted of monitoring residents' post-surgery, evaluating surgical incisions, assessing appropriateness of medications, duration, and adequate monitoring. Additional education included monitoring and following up on abnormal lab values and collaborating with other medical providers as needed. Additionally, the Medical Director was educated to review the discharge summary from the hospital records to ascertain pertinent medical information. 5. On 06/01/25, the Director of AlignMed Partners educated 2 of 2 Certified Registered Nurse Practitioner and 1 of 1 Optum Certified Registered Nurse Practitioner on his/her role in facilitating and coordinating medical care to ensure the appropriateness of medical care. Education included specific emphasis on monitoring residents' post-surgery, evaluating surgical incisions, assessing appropriateness of medications, duration, and adequate monitoring. Additional education included monitoring and following up on abnormal lab values and collaborating with other medical providers as needed. ********** (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team verified onsite that the immediate corrective actions had been implemented the Immediate Jeopardy was removed on 06/04/2025. The scope/severity level of F580 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident record reviews, review of a facility policy titled Abuse Prohibition, review of Facility Reported Incidents (FRI) received by the State Agency, and review of the facility investigative file, the facility failed to ensure residents were free from abuse perpetrated by other residents and failed to ensure Resident Identifier (RI) #9 was free from neglect.Specifically the facility failed to ensure:1) Resident Identifier (RI) #53 was free from verbal and physical abuse perpetrated by RI #119 on 04/01/2025 when RI #119 hit RI #53 in the face twice with a closed fist, as witnessed by several staff members. RI #53 had a red mark on his/her face. Staff said, someone hit in that manner would feel hurt and confused.During the investigation, it was revealed that RI #119 was admitted to the facility with diagnoses to include Schizoaffective Disorder. The facility failed to ensure the required Preadmission Screening and Resident Review (PASRR) screening process was completed for RI #119 prior to admission to the facility to identify services in the most integrated setting appropriate for RI #119's needs for mental disorders. The facility failed to ensure RI #119's monthly injection of antipsychotic medication had been administered as ordered for treatment and management of RI #119's Schizoaffective Disorder. Licensed Nurses failed to administer RI #119's monthly injection dose in January and February of 2025 prior to escalating behaviors.Interviews with staff and review of RI #119's facility medical record revealed RI #119 had daily behaviors of cursing and yelling in the facility since RI #119 was admitted on [DATE]. Because the facility failed to report and manage RI #119's daily behaviors, on 03/18/2025 RI #119's behaviors escalated and RI #119 threatened to kill people in the facility. After verbalizing the threat, RI #119 was sent to the hospital for evaluation and returned from the hospital the same day, without any new orders. Because the facility failed to report or investigate the threat and failed to develop or implement any new interventions or supervision of RI #119, to prevent RI #119 from harming or abusing other residents, RI #119's behaviors further escalated to physical abuse against RI #53 on 04/01/2025. Further, the facility failed to prevent RI #119 from continuing to target RI #53, as observed during the survey on 05/08/2025 when RI #119 yelled, cursed, and aggressively responded to RI #53 while in close interaction in the hallway.It was determined the facility's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect and Exploitation.On 05/13/2025 at 3:30 PM, the Administrator, Director or Nursing (DON), Regulatory Compliance Advisor, Clinical Lead and the Market Clinical Advisor were provided a copy of the IJ template and notified of the findings of immediate jeopardy in the area of Freedom from Abuse, Neglect, and Exploitation at F600- Free from Abuse and Neglect.This deficient practice was cited as a result of the investigation of complaint/report/FRI number AL00050808.2) On 05/19/2025, after the facility submitted the removal plan for the above non-compliance and while the removal plan was being validated, the facility submitted another allegation of resident on resident verbal abuse alleging RI #9 screamed and demanded his/her roommate, RI #87, turn off the television.During the investigation of the FRI, it was reported that RI #9 had a history of using derogatory language and incompatibility concerns with his/her previous roommate and was moved into the room with RI #87.The Licensed Practical Nurse (LPN) who witnessed the incident reported that on 05/17/2025 and 05/18/2025, RI #9 yelled at RI #87, his/her roommate, and called RI #87 a bitch and nigg*r. The LPN said she did not identify the incident as abusive. When asked how a reasonable person would feel about being called those names she said, they would feel very awful. RI #9 and RI #87 remained roommates until 05/19/2025 when the incident was reported to the Abuse Coordinator.This deficient practice was cited as a result of the investigation of complaint/report/FRI number AL00051254.3) The facility further failed to ensure RI #9 was free from neglect when the facility failed to ensure antibiotics were ordered and available for administration upon RI #9's re-admission on [DATE]. The facility further failed to ensure sufficient staff were scheduled to administer RI #9's 12:00 AM scheduled dose of Piperacillin-Tazobactam (Zosyn).Specifically, seven doses of Zosyn were not administered on 05/03/2025, 05/04/2025, and 05/05/2025 and two doses of Daptomycin were not administered on 05/03/2025 and 05/04/2025 after RI #9 was re-admitted on [DATE] at 6:18 PM. Further of the 42 times the facility's staff documented that Zosyn was administered to RI #9, five doses were documented as administered days later on 05/14/2025 by RN #25 who was not clocked in at the time the doses were due, two doses were documented as administered days later on 05/14/2025 by the Former Director of Nursing (FDON) #2, and

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident record reviews, review of a facility policy titled, Abuse Prohibition, review of Facility Reported Incidents (FRI) received by the State Agency (SA) and review of the facility investigative file, the facility failed to ensure nurses and staff reported verbal abuse to the abuse coordinator and the SA and took actions to prevent escalating resident on resident abuse in the facility.During the investigation of the FRI alleging physical abuse occurred on 04/01/2025 when Resident Identifier (RI) #119 hit RI #53 in the face, staff told surveyors they did not always document or report RI #119's behavior of yelling and cursing, which was a daily behavior since admission on [DATE], even when it was directed at other residents.Because RI #119's verbally abusive behaviors continued, and escalated, on 03/18/2025 RI #119 threatened to kill people in the facility. The incident was not identified as potential abuse, was not reported as an allegation of abuse, and was not investigated in a manner to prevent further abuse. After a visit to the hospital emergency department RI #119 returned to the facility without any new orders except a new medication order. Because the facility failed to implement new interventions or provide supervision instructions after the threat, abusive behaviors further escalated on 04/01/2025 when RI #119 hit RI #53 in the face twice with a fist.During the survey, on 05/08/2025 at 4:30 PM, RI #119 was observed continuing to target and verbally abuse RI #53. The surveyor verified the Administrator had been made aware of the incident. Still, the facility failed to report the verbal abuse to the State Agency until the next day, 05/09/2025, after 12:00 PM. The facility summary of the incident submitted in the five day report documented the facility did not substantiate the verbal abuse when RI #119 yelled at and used obscene language toward RI #53.It was determined the facility's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect and Exploitation.On 05/13/2025 at 3:30 PM, the Administrator (ADM) and Director or Nursing (DON) were provided a copy of the IJ template and notified of the findings of immediate jeopardy in the area of Freedom from Abuse, Neglect, and Exploitation at F609- Reporting of Alleged Violations.On 05/19/2025, after the facility submitted the removal plan for the above non-compliance and while the removal plan was being validated, the facility submitted another allegation of resident on resident verbal abuse alleging RI #9 screamed and demanded his/her roommate, RI #87 turn off the television.During the investigation it was determined RI #9 did verbally abuse RI #87, calling RI #87 a bitch and a nigger. According to Licensed Practical Nurse (LPN) #100, the incident of verbal abuse occurred on 05/17/2025 and 05/18/2025, but was not reported to the State Agency until 05/19/2025 and RI #9 remained in the room with RI #87 until 05/19/2025.It was determined the facility's noncompliance with one or more requirements of participation has cause, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect and Exploitation.On 05/28/2025 at 9:37 PM, the interim Administrator, the interim DON, and the Market Clinical Advisor were provided a copy of an updated IJ template and notified of the additional findings of immediate jeopardy in the area of Freedom from Abuse Neglect, and Exploitation at F609- Free from Abuse and Neglect.The IJ began on 04/01/2025 and continued until 06/01/2025 when the survey team verified onsite that corrective actions had been implemented. On 06/02/2025 the immediate jeopardy was removed. F600 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.This deficient practice affected RI #53 and RI #87 two of ten sampled residents for abuse.Findings Include:Cross-Reference F600 and F610Review of the facility's policy titled, Abuse Prohibition, with a revision date of 10/24/2022, revealed:POLICYCenters prohibit abuse, mistreatment, neglect, misappropriation of resident/patient (hereinafter patient) property, and exploitation for all patients . PROCESS1. The Administrator, or designee, is responsible for operationalizing policies and procedures that prohibit abuse, neglect, . The Center must ensure that all staff are aware of reporting requirements and must support an environment in which covered individuals report a reasonable suspicion of a crime .7. 2. Report allegations involving abuse (physical, verbal, sexual, mental) not later than 2 hours after the allegation is made.7. 3. Report allegations to the appropriate state and local authority(s) involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property not later than two (2) hours after the allegation is made if the event results in serious bodily

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	015133	A. Building B. Wing	06/05/2025

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Magnolia Ridge	420 Dean Drive Gardendale, AL 35071

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident record review, review of a facility policy titled Abuse Prohibition, during and after the facility investigation, the facility failed to ensure thorough investigations were conducted and appropriate corrective actions were taken or interventions were developed to ensure residents in the facility were protected from residents with unmanaged, escalating abusive behaviors and to prevent further abuse. Resident Identifier (RI) #119 had verbally abusive behaviors which escalated on 03/18/2025 when RI #119 threatened to kill people in the facility. The incident was not identified as potential abuse, was not reported as an allegation of abuse, and was not investigated in a manner to prevent further abuse. On 04/01/2025 RI #119 hit RI #53 in the face twice with a closed fist. The facility investigation was not thorough and effective corrective actions were not developed to ensure the protection and prevention of abuse of residents. RI #119 continued to have access to RI #53 during the survey on 05/08/2025 when RI #119 verbally abused RI #53.It was determined the facility's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect and Exploitation.On 05/15/2025 at 5:00 PM, the Administrator (ADM) and the Director or Nursing (DON) were provided a copy of the IJ template and notified of the findings of immediate jeopardy in the area of Freedom from Abuse, Neglect, and Exploitation at F610- Investigate/Prevent/Correct Alleged Violation.On 05/19/2025, after the facility submitted the removal plan for the above non-compliance and while the removal plan was being validated, the facility submitted another allegation of resident-on-resident verbal abuse after RI #9 screamed and demanded his/her roommate, RI #87, turn off the TV.During the investigation surveyors determined the verbal abuse included derogatory racial language in which RI #9 called RI #87 a bitch and a n*gger. The abuse was witnessed by Licensed Practical Nurse (LPN) #100 on 05/17/2025 and 05/18/2025 and was not reported until 05/19/2025. The facility's investigation did not include a thorough interview or statement from LPN #100 and did not include details about what LPN #100 witnessed RI #9 say to RI #87. On 05/28/2025 at 9:37 PM, the interim Administrator (ADM), the interim DON, and the Market Clinical Advisor were provided a copy of an updated IJ template and notified of the additional findings of immediate jeopardy in the area of Freedom from Abuse Neglect, and Exploitation at F610- Investigate/Prevent/Correct Alleged Violation.The IJ began on 04/01/2025 and continued until 05/30/2025. On 05/31/2025 the immediate jeopardy was removed. F610 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.This deficient practice affected RI #53, RI #87, RI #9 and RI #119 four of 10 residents sampled for abuse.Findings Include:Cross-Reference F600, F609, F835, F867.Review of the facility's policy titled, Abuse Prohibition, with a revision date of 10/24/2022, revealed:POLICYCenters prohibit abuse, mistreatment, neglect, misappropriation of resident/patient (hereinafter patient) property, and exploitation for all patients .PROCESS1. The Administrator, or designee, is responsible for operationalizing policies and procedures that prohibit abuse, neglect, . The Center must ensure that all staff are aware of reporting requirements and must support an environment in which covered individuals report a reasonable suspicion of a crime .7. Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or designee will perform the following.7.7 Initiate an investigation within 24 hours of an allegation of abuse that focuses on:7.7.1 whether abuse or neglect occurred and to what extent;7.7.2 clinical examination for signs of injuries, if indicated;7.7.3 causative factors; and7.7.4 interventions to prevent further injury.7.8 The investigation will be thoroughly documented within the Risk Management Portal. Ensure that documentation of witnessed interviews is included.9. The Administrator or designee will:9.1 Take all necessary corrective action depending on the results of the investigation; .1) On 04/01/2025 at 3:40 PM the State Agency received a Facility Reported Incident (FRI) that alleged physical abuse had occurred when RI #119 hit RI #53 in the face with his/her hand.RI #53 was admitted to the facility 01/14/2025.A review of RI #53's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/17/2025 revealed RI #53 had a Brief Interview for Mental Status (BIMS) of three of 15 which indicated severe cognitive impairment.RI #119 was initially admitted to the facility on [DATE] and readmitted on [DATE].A review of RI #119's MDS assessment with an ARD of 01/02/2025 revealed RI #119's BIMS was 14 of 15 which indicated intact cognition.Cross-reference F600RI #119's progress notes for 03/17/2025 at

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F 0645 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities (continued on next page)

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F 0645 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident record review, and review of a facility policy titled Pre-admission Screening for Mental Disorder and or Intellectual Disability Patients, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR) screening process was completed for Resident Identifier (RI) #119 for a Level I or Level II determination to be made about the level of services RI #119 required for Mental Disorder or Mental Illness (MI) before admission to the facility. RI #19 was admitted to the facility on [DATE] and had a diagnosis of Schizoaffective Disorder which is a Mental Illness.On 03/18/2025 RI #119 threatened to kill people in the facility. On 04/01/2025 RI #119 hit another resident, RI #53, in the face twice with a fist. A Level I determination was not made for RI #119 until 05/08/2025 during the survey.It was determined the facility's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.20 Resident Assessments.On 05/13/2025 at 3:30 PM, the Administrator, Director or Nursing (DON), Regulatory Compliance Advisor, Clinical Lead and the Market Clinical Advisor were provided a copy of the IJ template and notified of the findings of immediate jeopardy in the area of Resident Assessments at F645- PASRR Screening for MD & ID.The IJ began on 04/01/2025 and continued until 05/13/2025. On 05/14/2025 the immediate jeopardy was removed. F600 was lowered to the lower severity of no actual harm with a potential for more that minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revised their corrective actions as necessary to achieve substantial compliance.This deficient practice affected RI #119 one of 18 sampled residents.Findings include:Cross-Reference F600, F740, and F835.A facility policy titled Pre-admission Screening for Mental Disorder (and/or) Intellectual Disability Patients, with a revision date of 02/16/2024, documented: POLICYCenter Social Worker or designated stall will assure that all patients with Mental Disorders (MD) and/or Intellectual Disability (ID) receive appropriate pre-admission screenings according to federal and/or state regulations.PURPOSETo ensure that all individuals are screened for a MD and/or ID prior to admission.To ensure that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs.PRACTICE STANDARDS1. Social Services will coordinate and/or inform the appropriate agency to conductevaluation and obtain results if:1.1 It is learned after admission that Pre-admission Screening and Resident Review (PASRR) was not completed or is incorrect, or 1.2 There is a significant change in status that results in new evidence of possible mental disorder, intellectual disability or a related condition.RI #119 was initially admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include: Schizophrenia; Schizoaffective Disorder, Bipolar Type; Insomnia due to Mental Disorder; and Severe Vascular Dementia with Agitation. RI #119's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 01/02/2025 documented a Brief Interview for Mental Status (BIMS) score of 14 of 15 which indicated intact cognition.RI #119's medical record was reviewed and revealed the following PASRR records: RI #119 was admitted from the hospital with a PASRR form titled State of Alabama Department of Mental Health PASRR Level I Screening & Results for Mental Illness (MI)/ Intellectual Disability (ID)/ Related Condition (RC) dated 12/26/2024 which documented . NOT AN OBRA PASRR LEVEL I DETERMINATION **MAY REQUIRE A LEVEL II** . Number 2a. on the form documented RI #119 had Schizoaffective Disorder; number 4. on the form documented RI #119 had Dementia; number 5. on the form documented RI #119's current behavior or recent history within one year indicated RI #119 was a danger to self or others; number 5a. on the form documented . Patient was in non-violent restraints for interfering with care devices from 12/09/2024 until 12/15/2024. The Level I screening results included: Based on the information provided during the screening process, the individual MAY require a Level II. A VALAD LEVEL 1 DETERMINIATION WILL BE FAXED. The facility received a form for RI #119 titled PASRR Level II Service Determination from Bock Associates, signed by the Registered Nurse (RN) representative, dated 01/15/2025 that documented: . This evaluation was CANCELLED due to: . Rationale and Sign-OffCancel this level. We are waiting on medical records to review. The level will need to be resubmitted when the current medical records are available.On 05/07/2025 at 6:17 PM the Social Service Director (SSD) was asked about RI #119's PASRR screenings not indicating a Level I or Level II determination was made. The SSD said, RI #119 triggered a Level II screening that was canceled after she had not submitted the requested additional medical records timely. The SSD said, she spoke with the Bock Associates RN and she advised the facility to resubmit the Level I. The SSD was asked

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident record review, and review of a facility policy titled, Medication Administration General Guidelines, and review of ALABAMA BOARD OF NURSING ADMINISTRATIVE CODE CHAPTER 610-X-6 STANDARDS OF NURSING PRACTICE the facility failed to ensure licensed staff implemented physician orders and followed standards of practice when they documented administration of Resident Identifier (RI) #9's intravenous (IV) medications. Specifically, on 05/14/2025 the facility submitted a plan to remove the immediacy of jeopardy that included . On 5/14/25, the DON [Director of Nursing (Former DON #2)] and/or designee reviewed Medication Administration Records for the last 60 days and no additional concerns were identified. Upon review of documentation in RI #9's medical record it was identified that of the 42 times the facility's staff documented that Zosyn was administered to RI #9, five doses were documented as administered days later on 05/14/2025 by a Registered Nurse (RN) #25 who was not clocked in at the time the doses were due, two doses were documented as administered days later on 05/14/2025 by the Former DON (FDON) #2, and three doses were documented as administered by a Licensed Practical Nurse (LPN) #101 who was not qualified to administer the antibiotic and reported she did not administer the medication. It was determined the facility's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.21 Comprehensive Resident Center Care Plan. On 05/28/2025 at 9:37 PM, the interim Administrator (ADM), interim Director or Nursing (DON), and the Market Clinical Advisor were provided a copy of the IJ template and notified of the findings of immediate jeopardy in the area of Comprehensive Resident Center Care Plan at F658- Services provided Meet Professional Standards. The IJ began on 05/05/2025 and continued until 05/30/2025. On 05/31/2025 the immediate jeopardy was removed. F658 was lowered to the lower severity of no actual harm with a potential for more that minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revised their corrective actions as necessary to achieve substantial compliance. This deficient practice affected RI #119 one of 18 sampled residents. Findings Include: Cross-Reference F600, F760, F835, F694, and F837. The ALABAMA BOARD OF NURSING ADMINISTRATIVE CODE CHAPTER 610-X-6 STANDARDS OF NURSING PRACTICE included: . 610-x-6-.06 Standard for Documentation (1) The standards for documentation of nursing care provided to patients by licensed nurses are based on principles of documentation, regardless of the documentation format. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(2) Documentation of nursing care shall be: . (d) Timely. 1. Charted at the time or after the care, to include medications. Charting prior to care being provided, including medications, violates principles of documentation. 2. Documentation of patient care that is not in the sequence of the time the care was provided shall be recorded as a late entry, including a date and time the late entry was made, as well as the date and time the care was provided. Review of a facility policy titled, Medication Administration General Guideline, dated 01/25, revealed the following: POLICY . PROCEDURES . 7.1 General Guidelines . Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber. 4. Medications are to be administered at the time they are prepared. 14. Medications are administered within 60 minutes of the scheduled time . Medications should not be given at mealtimes . unless specifically ordered with meal. Documentation: 1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. 2. If a regularly scheduled medication is withheld, refused, or given at other than the scheduled time . the nurse shall be documented in either the Electronic Medication Administration Record or the paper MAR that the dose was withheld, refused, or given at other than the scheduled time, and enter an explanatory note . 4. The administration of the resident's medication is documented by one of the following processes: Documentation of the medication administration in the Electronic Health Record . RI #9 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses that included Vascular Dementia and Cerebral Infarction due to Thrombosis of Middle Cerebral Artery. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Order Summary Report for RI #9 documented a discontinued order for Daptomycin 600 milligram (mg) IV at 25 milliliter (mL) per hour (hr) daily was entered on 05/04/2025 with a start date of 05/05/2025. A second order was entered on 05/09/2025 with a start date of 05/09/2025 for Daptomycin 600 mg IV daily at 60 mL/hr. The facility's Order Summary Report for RI #9 documented an order for Zosyn 4.5 gram every eight hours was entered on 05/04/2025 with start date of 05/05/2025. On 05/24/2025 at 6:16 PM an interview was conducted with Medication Administration Certified (MAC) Assistant #102. MAC #102 said the standard of practice for administering and documenting medication as administered in the EMAR was to look at the medication card to ensure the right medication, right patient, right time, right route and then document whether the medication was administered or not. On 05/25/2025 at 4:45 PM an interview was conducted with LPN #74 who said the standard of practice to administer medications was to review the EMAR and verify correct route, resident, time, and dose. LPN #74 said once the medication was administered the medication was documented as administered. RI #9's EMAR documented that LPN #101 documented that she administered RI #9's 4 PM dose of IV Zosyn on 05/05/2025, 05/06/2025, and 05/07/2025. The EMAR documentation indicated the Zosyn was administered intravenously, and location was to RI #9's abdomen, left upper quadrant. The report also revealed that LPN #101 documented that she administered RI #9's 05/12/2025 dose of IV Daptomycin. The documentation indicated the Daptomycin was administered by LPN #101 intravenously to RI #9's left upper quadrant of his/her abdomen. The report revealed that LPN #101 administered tuberculin injection intradermally to RI #9's left upper quadrant of abdomen on 05/15/2025. On 05/25/2025 at 3:42 PM an interview was conducted with LPN #101 who said she did not administer IV medications. LPN #101 was asked about her documentation that she administered Zosyn to RI #9 and LPN #101 said it was an error and that she did not administer the medication. LPN #101 did not recall who administered those doses. LPN #101 said the facility policy directed staff to make an addendum or follow-up note if a medication was documented by mistake. LPN #101 said she did not make an addendum or follow-up note for those errors because it was not brought to her attention until the week before, and she was told that if it needed to be addressed she would know. During a follow-up interview with LPN #101 on 05/28/2025 at 10:20 AM, LPN #101 said she did not administer the Tuberculin injection to RI #9 in his/her abdomen and that it was a charting error. LPN #101 was asked, what was the risk of documenting that a medication was administered when it was not administered. LPN #101 said it could be perceived that the medication was administered, but she did not give the IV antibiotics. A review of RI #9's EMAR revealed the documentation on the EMAR for administered medications did not include the date or time the medications were administered. A review of the electronic health record's Medication Admin Audit Report revealed documentation for each dose that include date and time dose was scheduled, date and time staff documented the dose as administered, date and time the dose was administered, and the staff who documented each dose as administered. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility report titled Medication Admin Audit Report for RI #9 revealed that on 05/14/2025 at 3:43 PM the FDON #2 documented that she administered RI #9's 05/08/2025 4:00 PM scheduled dose of Zosyn timely on 05/08/2025. The report revealed that on 05/14/2025 at 3:44 PM the FDON #2 documented that she administered RI #9's 05/09/2025 4:00 PM dose of Zosyn timely on 05/09/2025. The facility report titled Medication Admin Audit Report for RI #9 revealed that on 05/14/2024 at 3:49 PM RN #25 documented that she administered RI #9's 05/06/2025 12:00 AM dose of Zosyn as administered. The documentation indicated RI #9's 05/06/2025 12:00 AM dose was administered on 05/05/2025 at 12:49 AM. A review of RN #25's timecard revealed that RN #25 was not clocked in on 05/05/2025 after 1:43 AM or 05/06/2025. The facility report titled Medication Admin Audit Report for RI #9 revealed that on 05/14/2024 at 3:48 PM RN #25 documented that she administered RI #9's 05/07/2025 at 12:00 AM dose of Zosyn. The documentation indicated RI #9's 05/07/2025 12:00 AM dose was administered on 05/06/2025 at 12:48 AM. A review of RN #25's timecard revealed that RN #25 was not clocked in on 05/06/2025 05/07/2025 until 7:04 PM. The facility report titled Medication Admin Audit Report for RI #9 documented that on 05/14/2025 at 3:50 PM RN #25 documented that she administered RI #9's 05/09/2025 at 12:00 AM dose of Zosyn. The documentation indicated the 05/09/2025 12:00 AM dose of Zosyn was administered on 05/08/2025 12:49 AM. Further review of RN #25's timecard revealed that RN #25 was not clocked in on 05/08/2025 or 05/09/2025. The facility report titled Medication Admin Audit Report for RI #9 documented that on 05/14/2025 at 3:51 PM RN #25 documented that she administered RI #9's 05/10/2025 at 12:00 AM dose of Zosyn. The documentation indicated that it was administered on 05/09/2025 at 12:50 AM. Further review of RN #25's timecard revealed that RN #25 was not clocked in on 05/10/2025 until 7:28 AM. The facility report titled Medication Admin Audit Report for RI #9 documented that on 05/14/2025 at 3:47 PM RN #25 documented that she administered RI #9's 05/13/2025 at 12 AM dose of Zosyn. The documentation indicated that it was administered on 05/13/2025 at 3:46 PM. Further review of RN #25's timecard revealed that RN #25 was not clocked in on 05/13/2025 until 11:12 PM. On 05/22/2025 at 5:40 PM an interview was conducted with RN #25 who said she did not work the night shift that began on 05/12/2025 and ended on 05/13/2025. RN #25 was asked; did she administer RI #9's IV Zosyn on 05/13/2025. RN #25 said no, and that RN #61 administered the Zosyn. RN #25 said medication should be documented in the resident's EMAR immediately after administration of the medication. RN #25 was asked, what was the concern with documenting medication administration late, like five days. RN #25 said that it would have been falsified. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/25/2025 at 2:50 PM an interview was conducted with RN #25 who said the FDON #2 called her to the facility on [DATE], but she did not recall why. RN #25 said FDON #2 thought she had missed documenting RI #9's Zosyn at 12:00 AM on 05/14/2025, but it was 05/13/2025. RN #25 said FDON #2 told her to sign the medication as administered. On 05/27/2025 at 4:00 PM during a phone interview with the FDON #2, she said that she was not aware RI #9 had not received his/her IV antibiotics as ordered until the survey team discussed the 12:00 AM doses. The FDON said she did not know how it was possible that 42 doses of Zosyn was documented as administered when the pharmacy delivered 56 doses of Zosyn for RI #9, and 23 doses were observed in the medication room. RI #9's hospital progress note dated 05/22/2025 documented that RI #9 was being treated for . Sepsis with shock Chronic left hip postoperative infection . ********** The facility submitted a plan to remove the immediacy of the identified deficient practice that included: ********** Assessments 1. RI #9 was discharged from the facility on 5/19/25. 2. The new Director of Nursing Services placed RN #25 on administrative leave on 5/28/25. 3. On 5/24/25, the Market Clinical Advisor placed DON #2 on administrative leave and on 5/29/25, DON #2 was informed of employment separation. 4. The Director of Nursing completed 1:1 education with LPN #101 on 5/29/25 on medication administration documentation, standards of nursing practice, and accuracy of medical records. 5. Effective 5/25/25, the facility will not administer IV hydration and/or IV medication. The Administrator updated the Facility Assessment on 5/29/25. Audits 1. On 5/23/25, the Market Clinical Advisor conducted an audit of residents receiving intravenous antibiotic medications, no other residents were identified as receiving intravenous medications. In-services 1. The Director of Nursing educated LPN #101 on 5/29/25 on medication administration documentation, standards of nursing practice, and accuracy of medical records. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On 5/24/25, the Market Clinical Advisor and Market Clinical Lead educated 19 of 22 full-time licensed nurses on the medication administration policy related to administering medications in accordance to the physician orders, documenting medications at the time of administration, late entry process, and medication errors. Education included types of medication errors to include omissions, wrong dose, incorrect duration, wrong time, incorrect dose, incorrect route of administration, and wrong patient. Education completed on acceptable professional standards and practices related to documentation of medications to include accurate and complete medication records. In addition, the education included not documenting medication services not performed, not documenting medication services before they are performed, and timely medication documentation. Education included performing nursing care within the scope of practice and in accordance with nursing standards of care. The facility has 12 PRN licensed nurses; 3 of 12 PRN licensed nurses received the education on 5/24/25. The facility attempted to contact the 9 PRN licensed nurses via phone; the DON will monitor the schedule and provide 1:1 in-services before their next scheduled shift. Active licensed nurses, licensed nurses on leave of absence (FMLA), and PRN nurses who have not received the education aforementioned will be educated prior to returning to their assigned shift by the NPE or designee. 3. On 5/24/25, the Market Clinical Advisor and/or Market Clinical Lead educated 6 of 6 full-time RNs on the medication administration policy related to administering intravenous medications in accordance to the physician orders, documenting medications at the time of administration, and medication errors. Education included types of medication errors to include omissions, wrong dose, incorrect duration, wrong time, incorrect dose, incorrect route of administration, and wrong patient. Education completed on acceptable professional standards and practices related to documentation of medications to include accurate and complete medication records. In addition, the education included not documenting medication services not performed, not documenting medication services before they are performed, and timely medication documentation. Education included performing nursing care within the scope of practice and in accordance with nursing standards of care. The facility has 4 RNs who work on a PRN basis, the facility was able to reach 1 of 4 via phone; attempts were made to contact the remaining 3 RNs that did not receive the education via phone. The Director of Nursing will monitor the schedule and provide the 1:1 in-services to the PRN RNs before their next scheduled shift begins. 4. On 5/29/25, the Market Clinical Advisor educated the Director of Admissions and Director of Marketing on the admission process related to IV therapy and antibiotics to include the facility will not admit, readmit, and/or treat patients with orders for IV hydration or IV medications. 5. On 5/29/25 and 5/30/25, the Administrator educated the Physician, Certified Registered Nurse Practitioners, Pharmacy, and Lumina that the facility will not admit and/or readmit and/or treat patients with IV hydration or IV medication. 6. On 5/30/25, the Administrator communicated to 31 licensed nurses that the facility will not admit and/or readmit patients with orders for IV hydration or IV medications. 7. The DON and/or designee educated the Nurse Managers by 5/30/25 on reviewing the medication administration records to ensure staff are following the standards of practice for medication administration. The DON educated the Nurse Managers to conduct medication administration audits Mon-Friday. The monitoring will be documented on a Medication Administration monitoring tool. ********** (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team verified onsite that the immediate corrective actions had been implemented the Immediate Jeopardy was removed on 05/31/2025. The scope/severity level of F658 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of facility policies titled, Vascular Access Devises and Infusion Therapy Procedures- Maintaining Patency of Peripheral and Central Vascular Access Devices and Administration of IV Fluids and Medication - SETTING UP A PRIMARY INFUSION (HYDRATION OR MEDICATION, and the ALABAMA BOARD OF NURSING ADMINISTRATIVE CODE CHAPTER 610-X-6 STANDARDS OF NURSING PRACTICE the facility failed to ensure Resident Identifier (RI) #9's intravenous antibiotics (IV) were administered in accordance with professional standards of practice. 1) The facility failed to ensure a process was implemented to ensure RI #9's IV antibiotics were ordered and administered upon RI #9's re-admission on [DATE]. Seven doses of Piperacillin-Tazobactam (Zosyn) were not administered on 05/03/2025, 05/04/2025, and 05/05/2025. Two doses of Daptomycin were not administered on 05/03/2025 and 05/04/2025. 2) The facility further failed to ensure facility staff followed their policy for administering and documenting IV medication. On 05/05/2025, 05/06/2025, and 05/07/2025 Licensed Practical Nurse (LPN) #101 documented that she administered RI #9's doses of Zosyn scheduled for 4:00 PM. LPN #101 also documented that she administered RI #9's IV Daptomycin on 05/12/2025. Also, the facility's staff documented RI #9's Zosyn as administered days after the documented dose was scheduled to be administered. Specifically, on 05/14/2025 Registered Nurse (RN) #25 documented that she administered RI #9's 12:00 AM dose of Zosyn scheduled on 05/06/2025, 05/07/2025, 05/09/2025, 05/10/2025, and 05/13/2025. RN #25 was not clocked in and working at the time the 12:00 AM Zosyn was scheduled to be administered on 05/06/2025, 05/07/2025, 05/09/2025, 05/10/2025, and 05/13/2025. On 05/14/2025 the Director of Nursing (Former DON) #2 documented RI #9's 4:00 PM dose of Zosyn scheduled for 05/08/2025 and 05/09/2025. 3) The facility further failed to ensure sufficient Registered Nurses were scheduled to administer RI #9's intravenous antibiotic, at 12:00 AM on 05/07/2025, 05/09/2025, 05/13/2025, or 05/17/2025. RI #9's 12:00 AM dose of Zosyn was not administered on 05/17/2025. RI #9 should have received a total of 50 doses of Zosyn from 05/03/2025 until his/her discharge on [DATE]. Seven doses of Zosyn were not ordered timely and not administered and one dose was not documented as administered. A total 42 doses were documented as administered, but ten of the 42 doses were either documented as administered by unqualified staff, documented late by RN #25 who was not clocked in when the doses she documented late were scheduled to be administered, or documented five to six days later by the FDON #2. 4) The facility further failed to ensure all licensed facility staff who administered IV medications were provided education on the facility's policy and procedures for IV care and medication administration. The facility further failed to ensure RI #9's peripherally inserted central catheter (PICC) was flushed in accordance with standards of care. It was determined the facility's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.25 Quality of Care at F694- Parenteral/IV Fluids. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/28/2025 at 9:37 PM, the interim Administrator, the interim DON, and the Market Clinical Advisor were provided a copy of the IJ template and notified of the findings of substandard quality of care at the immediate jeopardy level in the area of Quality of Care at F694- Parenteral/IV Fluids. The IJ began on 05/02/2025 and continued until 05/30/2025 when the survey team verified onsite that corrective actions had been implemented. On 05/31/2025 the immediate jeopardy was removed. F694 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revised their corrective actions as necessary to achieve substantial compliance. Findings Include: Cross-Reference F600, F658, F694, F760, F835, and F837. The ALABAMA BOARD OF NURSING ADMINISTRATIVE CODE CHAPTER 610-X-6 STANDARDS OF NURSING PRACTICE included: . 610-x-6-.14 Intravenous (IV) Therapy By Licensed Practical Nurses. (6) Tasks that shall not be performed by a licensed practical nurse include: . (b) Administration of: . 7. IV medications via push or bolus through a central line including a peripherally inserted central catheter (PICC). The facility policy titled Administration of IV Fluids and Medication - SETTING UP A PRIMARY INFUSION (HYDRATION OR MEDICATION dated 10/24 documented: . Purpose To correctly and asceptically [sic] set up the primary IV bag and administration set. Policy The professional nurse with documented IV education, as designated by the facility, and as allowed by state regulation may set up a primary infusion. Procedure . 12. begin infusion. 16. Document according to facility procedure. The facility policy titled Vascular Access Devises and Infusion Therapy Procedures- Maintaining Patency of Peripheral and Central Vascular Access Devices dated 10/24 documented: . Purpose (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	To maintain that patency of all peripheral and central vascular access devices (VADs). Policy . Vascular access devices are flushed after each infusion to clear the infused medication from the catheter lumen. 1. A prescriber's order is needed for all IV flushes. Procedure 1. Obtain prescriber order for appropriate flush solutions. 12. Document the flush in the resident's medication record. 1) RI #9 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses that included Vascular Dementia and Cerebral Infarction due to Thrombosis of Middle Cerebral Artery. A review of RI #9's hospital medical record revealed a Progress Note-Generic signed on 05/01/2025 by a hospital physician. The note included: . Medications . DAPTOmycin . 600 mg [milligram] . daily . piperacillin-tazobactam 4.5 g [grams] . q8hr [every eight hours] . Assessment/Plan: . Wound growing Pseudomonas-carbapenem resistant and VRE [Vancomycin Resistant Enterococcus] - Cont [continue] Zosyn and Daptomycin - need long term IV antibiotics - Place PICC . ID [infection disease] has give [sic] DC [discharge] antibiotic regimen - CM [Case Management] is aware - PICC ordered - pt [patient should be ready for DC in am if antibiotics arranged . RI #9's Discharge Summary created by a hospital physician on 05/02/2025 documented: . Hospital Course: . Wound growing Pseudomonas-carbapenem resistant and VRE - Cont [continue] Zosyn and Daptomycin - need long term antibiotics - PICC is in place - DC [discharge] with daptomycin and Zosyn through June 2 . On 05/27/2025 an interview was conducted with the facility's admission Liaison (AL). The AL said when RI #9 was re-admitted on [DATE], she knew RI #9 was returning back on antibiotics and said she thought it was two different types of antibiotics. The AL reported that while RI #9 was still in the hospital, she told the Admissions Director (AD) to let the Former Director of Nursing (FDON) #2 know that RI #9 was returning with IV antibiotics. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/27/2025 at 9:10 AM an interview was conducted with the facility's admission Director (AD). The AD said she did not recall the AL communicating with her about RI #9's medications before RI #9 was re-admitted on [DATE], but said before RI #9 was re-admitted the facility had received progress notes that indicated that RI #9 needed IV antibiotics. The AD reviewed RI #9's hospital records from 05/02/2025 and said RI #9 had a PICC line and needed IV Daptomycin and Zosyn through 06/02/2025. The AD said RI #9 was admitted on [DATE] at 6:18 PM and the IV antibiotics were to start on 05/03/2025 at 12:00 AM. The AD said the hospital did not send paper copies of the prescription for Daptomycin or Zosyn, because there was no need for paper prescription since it was not controlled substances. On 05/27/2025 at 4:00 PM a phone interview was conducted with the FDON #2. FDON #2 said she did not know that RI #9 needed IV antibiotics via PICC until after RI #9 returned to the facility. On 05/27/2025 at 10:47 AM an interview was conducted with LPN Supervisor (LPN-S) #27 who said she did not know what had been communicated when RI #9 was readmitted on [DATE]. LPN-S #27 said when RI #9 was admitted on [DATE] she had the discharge summary but no orders. LPN-S #27 said she reported to RN #25 and FDON #2 that RI #9 did not have orders for antibiotics. LPN-S #27 said the Medical Director should have been contacted when they identified that RI #9 did not have orders for IV antibiotics. The facility's Order Summary Report for RI #9 documented a discontinued order for Daptomycin 600 milligram (mg) IV at 25 milliliter (mL) per hour (hr) daily was entered on 05/04/2025 with a start date of 05/05/2025. A second order was entered on 05/09/2025 with a start date of 05/09/2025 for Daptomycin 600 mg IV daily at 60 mL/hr. The facility's Order Summary Report for RI #9 documented an order for Zosyn 4.5 gram every eight hours was entered on 05/04/2025 with start date of 05/05/2025. RI #9's EMAR documented the first dose of Zosyn was administered on 05/05/2025 at 8:00 AM and the first dose of Daptomycin was administered on 05/05/2025 at 12:00 PM. The EMAR documented that RI #9 did not receive a dose of Zosyn 05/03/2025 or 05/04/2025. The EMAR documented that RI #9 received his/her first dose of Zosyn at the facility on 05/05/2025 at 8:00 AM. The EMAR documented that RI #9 did not receive a dose of Daptomycin on 05/03/2025 or 05/04/2025. 2) Cross-reference F658 A review of RN #25's timecard revealed that she was not clocked in on several shifts in which she had documented medications as administered. The facility report titled Medication Admin Audit Report for RI #9 revealed that on 05/14/2025 RN #25 documented that she administered RI #9's doses of Zosyn scheduled to be administered at 12:00 AM on 05/06/2025, 05/07/2025, 05/09/2025, 05/10/2025, and 05/13/2025. A review of RN #25's timecard revealed that she was not working within two hours of 12:00 AM on 05/06/2025, 05/07/2025, 05/09/2025, 05/10/2025, or 05/13/2025. On 05/25/2025 at 2:50 PM an interview was conducted with RN #25 who said she should be clocked in for the duration of the medication administration when administering IV antibiotics. RN #25 said when the medication was due, she would check the resident's EMAR and then administer the medication. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility report titled Medication Admin Audit Report for RI #9 revealed that on 05/14/2025 FDON #2 documented that she administered RI #9's doses of Zosyn scheduled to be administered on 05/08/2025 at 4:00 PM and 05/09/2025 at 4:00 PM. 3) On 05/28/2025 at 12:49 PM during a follow-up interview with the facility's Staffing Coordinator (SC), she reported that there was no RN scheduled to be at the facility during the 12:00 AM shift on 05/07/2025, 05/09/2025, 05/13/2025, or 05/17/2025. The SC said according to the schedule there was not an RN in the facility at 12:00 AM on those dates. On 05/27/2025 at 4:00 PM during a phone interview with the FDON #2, she said the RNs had a set schedule that was verbally discussed. The FDON said RN #25 worked weekends 7:00 AM to 7:00 PM and the rest worked dayshift during the week. The FDON was asked what was the process to ensure an RN was scheduled to administer RI #9's IV antibiotics. The FDON said, at 8:00 AM, 12:00 PM, and 400 PM RNs were scheduled to be in the building and RN #25 would administer the 12:00 AM doses. The FDON said it was communicated verbally and she did not have anything in writing. RI #9's EMAR documented his/her dose of Zosyn scheduled for 05/17/2025 at 12:00 AM was not administered. During an interview with RN #25 on 05/22/2025 at 5:40 PM, RN #25 said she did not administer RI #9's IV Zosyn on 05/17/2025 at 12:00 AM. 4) On 05/27/2025 at 4:00 PM during an interview with FDON #2, she was asked, what education was provided regarding IV antibiotics. The FDON said no training was documented. The DON said there was no specific training provided regarding IV flushes, PICC assessment, care, or dressing changes. RI #9's Care Plan Report included a care plan initiated on 05/05/2025 for (RI #9) receives IV therapy via PICC line due to wound infection, 5/10/25 PICC site change to rt (right) arm . The care plan included an intervention to flush the PICC line as ordered. RI #9's physician orders included an order dated 05/02/2025 to flush unused lumen with 10 milliliters (mL) of normal saline (NS) daily every seven days. RI #9's Electronic Medication Administration Record (EMAR) documented that RI #9's unused lumen was flushed on 05/10/2025 and 05/17/2025 by RN #25. No IV flushes were documented as administered on RI #9's EMAR from 05/02/2025 through 05/09/2025. RI #9's physician orders included an order with start date of 05/08/2025 for RN to use only red lumen for medication and flush 10 mL NS after each medication administration. RN to flush purple lumen after each medication administration per red lumen only do not give medication via purple lumen every day and evening shift. RI #9's EMAR documented that LPN #101 documented that she flushed RI #9's PICC on 05/08/2025 at 3:00 PM. The flush was documented as administered twice on 05/09/2025 and once on 05/10/2025 by an RN. The order discontinued on 05/10/2025 at 2:59 PM. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #9's Nursing Notes included a note dated 05/09/2025 at 11:15 AM electronically signed by the Nurse Educator, RN #18. The note documented . left PICC line, unable to flush purple port, Red port flushes sluggishly. (PICC Line Insertion Company) notified and will arrive on 5/10/25 to check it. RI #9's physician orders included an order dated 05/10/2025 for assessment or replacement of PICC. A nursing note dated 05/10/2025 at 2:51 PM signed by LPN #27, Unit Manager documented PICC site changed and tolerated procedure well. RI #9's physician orders included an order dated 05/10/2025 for RN to flush both ports with 10 mL of NS after each medication administration. RI #9's EMAR documented the order for RN to flush both ports with 10 mL of NS after each medication administration every day and evening shift, start 05/10/2025 at 4:00 PM. The flush was not documented as administered on 05/12/2025 and 05/13/2025 during the evening shift. RI #9's hospital progress note dated 05/22/2025 documented that RI #9 was being treated for . Sepsis with shock Chronic left hip postoperative infection . ********** On 06/01/2025 the facility submitted the following Plan of Correction: ********** Assessments 1. RI #9 was discharged from the facility on 5/19/25. 2. Effective 5/25/25, the facility will not administer IV hydration or IV medications. The Administrator updated the Facility Assessment on 5/29/25. Audits 1. On 5/23/25, the Market Clinical Advisor conducted an audit of residents receiving intravenous antibiotic medications, no other residents were identified as receiving intravenous medications. In-services 1. The Director of Nursing educated LPN #101 on 5/29/25 on medication administration documentation, standards of nursing practice, and accuracy of medical records. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On 5/24/25, the Market Clinical Advisor and Market Clinical Lead educated 19 of 22 full-time licensed nurses on the medication administration policy related to administering medications in accordance to the physician orders, documenting medications at the time of administration, late entry process, and medication errors. Education included types of medication errors to include omissions, wrong dose, incorrect duration, wrong time, incorrect dose, incorrect route of administration, and wrong patient. Education completed on acceptable professional standards and practices related to documentation of medications to include accurate and complete medication records. In addition, the education included not documenting medication services not performed, not documenting medication services before they are performed, and timely medication documentation. Education included performing nursing care within the scope of practice and in accordance with nursing standards of care. The facility has 12 PRN licensed nurses; 3 of 12 PRN licensed nurses received the education on 5/24/25. The facility attempted to contact the 9 PRN licensed nurses via phone; the DON will monitor the schedule and provide 1:1 in-services before their next scheduled shift. Active licensed nurses, licensed nurses on leave of absence (FMLA), and PRN nurses who have not received the education aforementioned will be educated prior to returning to their assigned shift by the NPE or designee. 3. On 5/24/25, the Market Clinical Advisor and/or Market Clinical Lead educated 6 of 6 full-time RNs on the medication administration policy related to administering intravenous medications in accordance to the physician orders, documenting medications at the time of administration, and medication errors. Education included types of medication errors to include omissions, wrong dose, incorrect duration, wrong time, incorrect dose, incorrect route of administration, and wrong patient. Education completed on acceptable professional standards and practices related to documentation of medications to include accurate and complete medication records. In addition, the education included not documenting medication services not performed, not documenting medication services before they are performed, and timely medication documentation. Education included performing nursing care within the scope of practice and in accordance with nursing standards of care. The facility has 4 RNs who work on a PRN basis, the facility was able to reach 1 of 4 via phone; attempts were made to contact the remaining 3 RNs that did not receive the education via phone. The Director of Nursing will monitor the schedule and provide the 1:1 in-services to the PRN RNs before their next scheduled shift begins. 4. On 5/29/25, the Market Clinical Advisor educated the Director of Admissions and Director of Marketing on the admission process related to IV therapy and antibiotics to include the facility will not admit, re-admit, or treat patients with orders for IV hydration or IV medications. 5. On 5/29/25 to present, the Administrator educated 1 Medical Director, 2 Certified Registered Nurse Practitioners, 4 Nurse Practitioners, 1 Pharmacy, and 1 (after hour group) that the facility will not admit, readmit, or treat patients with IV hydration or IV medication. 6. On 5/30/25, the Administrator communicated to 31 licensed nurses that the facility will not admit, readmit, or treat patients with orders for IV hydration or IV medications via regroup messaging. ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team verified onsite that the immediate corrective actions had been implemented the Immediate Jeopardy was removed on 05/31/2025. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The scope/severity level of F694 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observations, interviews, and record reviews, the facility failed to ensure a Registered Nurse (RN) was consistently scheduled to administer Resident Identifier (RI) #9's 12:00 AM dose of intravenous (IV) antibiotic, Piperacillin-Tazobactam (Zosyn). Six doses of RI #9's Zosyn scheduled to be administered at 12: AM were either not documented as administered or documented days later by RN #25 who was not clocked in at the time the documented doses were scheduled. It was determined the facility's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.35 Nursing Services at F725- Sufficient Nursing Staff. On 05/28/2025 at 9:37 PM, the interim Administrator, the interim DON, and the Market Clinical Advisor were provided a copy of the IJ template and notified of the finding of immediate jeopardy in the area of Nursing Services at F725- Sufficient Nursing Staff. The IJ began on 05/05/2025 and continued until 05/30/2025. On 05/31/2025 the immediate jeopardy was removed. F725 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revised their corrective actions as necessary to achieve substantial compliance. This deficient practice affected RI #9 one of one resident for IV therapy. Findings Include: Cross-Reference F600, F658, F694, F760, F835, and F837. On 05/20/2025 at 1:00 PM an observation was made with Licensed Practical Nurse (LPN) #28 of RI #9's remaining doses of Zosyn. 23 doses of RI #9's Zosyn 4.5 grams (g) was observed in the medication room. RI #9 RX History Report documented that 56 doses of Zosyn 4.5 g were delivered to the facility for RI #9. On 05/20/2025 at 4:50 PM an interview was conducted with the Pharmacist who reported 56 doses of Zosyn were delivered to the facility for RI #9. The Pharmacist said the facility did not stock Zosyn 4.5 g. RI #9's Electronic Medication Administration Record (EMAR) indicated 42 doses of Zosyn were administered. The EMAR documented that RI #9's Zosyn scheduled for 12:00 AM on 05/17/2025 was not administered. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of RI #9's EMAR for the month of May 2025 revealed that RN #25 documented RI #9's 12:00 AM dose of Zosyn as administered from 05/06/2025 through 05/19/2025 except 05/17/2025 which was blank. The EMAR did not document the time the medication was administered or when RN #25 documented the doses as administered. A review of RN #25's timecard revealed that she was not clocked in on several shifts in which she had documented medications as administered. On 05/27/2025 at 4:00 PM during a phone interview with the FDON #2, she said including two MDS RNs, the facility had six full-time RNs in May of 2025. The FDON said the RNs had a set schedule that was verbally discussed. The FDON said RN #25 worked weekends 7 AM to 7 PM and the rest worked dayshift during the week. The FDON was asked what was the process to ensure an RN was scheduled to administer RI #9's IV antibiotics. The FDON said at 8:00 AM, 12:00 PM, and 4 PM RNs were scheduled to be in the building and RN #25 would administer the 12:00 AM doses. The FDON said it was communicated verbally and she did not have anything in writing. On 05/28/2025 at 12:49 PM during a follow-up interview with the facility's Staffing Coordinator (SC), she reported that there was no RN scheduled to be at the facility during the 12:00 AM shift on 05/07/2025, 05/09/2025, 05/13/2025, or 05/17/2025. The SC said according to the schedule there was not a RN in the facility at 12:00 AM on those dates. RI #9's hospital progress note dated 05/22/2025 documented that RI #9 was being treated for . Sepsis with shock Chronic left hip postoperative infection . ********** The facility submitted a plan to remove the immediacy of the identified deficient practice that included: ********** Assessments 1. RI #9 was discharged from the facility on 5/19/25. 2. The new Director of Nursing Services placed RN #25 on administrative leave on 5/28/25. 3. On 5/24/25, the Market Clinical Advisor placed DON #2 on administrative leave and on 5/29/25, DON #2 was informed of employment separation. 4. Effective 5/25/25, the facility will not administer IV hydration and IV medications. The Administrator updated the Facility Assessment on 5/29/25. Audits 1. On 5/23/25, the Market Clinical Advisor conducted an audit of residents receiving intravenous antibiotic medications, no other residents were identified as receiving intravenous medications. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On 5/30/25, the Market Clinical Advisor clarified there were no other specialized procedures required only an RN. In-services 1. On 5/24/25, the Market Clinical Advisor and Market Clinical Lead educated 19 of 22 full-time licensed nurses on the medication administration policy related to administering medications in accordance to the physician orders, documenting medications at the time of administration, late entry process, and medication errors. Education included types of medication errors to include omissions, wrong dose, incorrect duration, wrong time, incorrect dose, incorrect route of administration, and wrong patient. Education completed on acceptable professional standards and practices related to documentation of medications to include accurate and complete medication records. In addition, the education included not documenting medication services not performed, not documenting medication services before they are performed, and timely medication documentation. Education included performing nursing care within the scope of practice and in accordance with nursing standards of care. The facility has 12 PRN licensed nurses; 3 of 12 PRN licensed nurses received the education on 5/24/25. The facility attempted to contact the 9 PRN licensed nurses via phone; the DON will monitor the schedule and provide 1:1 in-services before their next scheduled shift. Active licensed nurses, licensed nurses on leave of absence (FMLA), and PRN nurses who have not received the education aforementioned will be educated prior to returning to their assigned shift by the NPE or designee. 2. On 5/24/25, the Market Clinical Advisor and/or Market Clinical Lead educated 6 of 6 full-time RNs on the medication administration policy related to administering intravenous medications in accordance to the physician orders, documenting medications at the time of administration, and medication errors. Education included types of medication errors to include omissions, wrong dose, incorrect duration, wrong time, incorrect dose, incorrect route of administration, and wrong patient. Education completed on acceptable professional standards and practices related to documentation of medications to include accurate and complete medication records. In addition, the education included not documenting medication services not performed, not documenting medication services before they are performed, and timely medication documentation. Education included performing nursing care within the scope of practice and in accordance with nursing standards of care. The facility has 4 RNs who work on a PRN basis, the facility was able to reach 1 of 4 via phone; attempts were made to contact the remaining 3 RNs that did not receive the education via phone. The Director of Nursing will monitor the schedule and provide the 1:1 in-services to the PRN RNs before their next scheduled shift begins. 3. On 5/29/25 and 5/30/25, the Administrator educated 1 Medical Director, 2 Certified Registered Nurse Practitioners, 1 Pharmacy, 4 Optum Partners, and 1 Lumina (after hour physician group) that the facility will not administer IV hydration or IV medication. 4. On 5/29/25, the Market Clinical Advisor educated the Director of Admissions and Director of Marketing on the admission process related to IV hydration therapy and antibiotics to include the facility will not admit, readmit patients, or treat patients with orders for IV hydration or IV medications. 5. On 5/30/25, the Administrator communicated to 31 licensed nurses that the facility will not admit and/or readmit patients with orders for IV hydration or IV medications via regroup messaging. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. On 5/30/25, the Market Clinical Advisor educated the DON and/or designee regarding the responsibility of monitoring orders and care needs Monday thru Friday and communicating with the Scheduler to ensure sufficient staff to provide the necessary care. ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team verified onsite that the immediate corrective actions had been implemented the Immediate Jeopardy was removed on 05/31/2025. The scope/severity level of F725 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident record reviews, and review of a facility policy titled Behaviors: Management of Symptoms, the facility failed to ensure a behavior management process was implemented. Specifically, the facility failed to ensure staff understood what steps to take when resident behaviors were observed or reported, and staff took action to address behaviors and implement interventions and supervision instructions to protect residents in the facility from abuse and prevent escalation of RI #119's behaviors.RI #119 had a history of unmanaged behaviors in the facility including on 03/18/2025 when RI #119 threatened to kill people in the facility. RI #119 was evaluated at the hospital and returned to the facility on the same day without any new orders except a newly ordered medication. The facility failed to develop any plans for intervention or increased supervision of RI #119 to prevent RI #119 from having behaviors affecting others. RI #119's behaviors continued to escalate and on 04/01/2025 RI #119 physically abused RI #53 when RI #119 hit RI #53 in the face twice with a fist on each side of RI #53's face.Because the facility failed to take actions to protect RI #53 from RI #119's abusive behaviors, during the survey RI #119 continued to target RI #53 with verbal and aggressive behavior as observed on 05/08/2025.The facility failed to ensure verbal behavior of cursing and yelling was captured in sufficient detail in behavior documentation to explain frequency, what RI #119 actually said, what RI #119's intentions were, if there were any underlying causes, and to whom the cursing and yelling was directed. The facility Behaviors: Management of Symptoms policy directed staff to . monitor for and document in the medical records any exhibited behavioral symptoms which include, . Verbally aggressive behaviors, such as threatening, screaming, cursing, insulting, or intimidating others .It was determined the facility's noncompliance with one or more requirements of participation has cause, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.40 Behavioral Health. On 05/13/2025 at 3:30 PM, the Administrator and the Director or Nursing (DON) were provided a copy of the IJ template and notified of the findings of immediate jeopardy in the area of Behavioral Health and at F740- Behavioral Health Services.On 05/19/2025, after the facility submitted the removal plan for the above non-compliance and while the removal plan was being validated, the facility submitted another allegation of resident-on-resident verbal abuse that alleged that RI #9 verbally abuses his/her roommate RI #87.During the investigation it was determined that RI #9 had history of incapability with his/her roommate and had a history of using derogatory names. On 05/17/2025 and 05/18/2025 RI #9 called his/her roommate, RI #87, derogatory names including n*gger and bitch. The facility had not developed a care plan that included interventions to protect other residents from RI #9. The care plan did not include the level of supervision required to supervise RI #9 in a manner to ensure other residents were protected. RI #9's behavior monitoring documentation indicated RI #9 did not have any behaviors on 05/18/2025. It was determined the facility's ongoing noncompliance with one or more requirements of participation has cause, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.40 Behavioral Health.On 05/28/2025 at 9:37 PM, the interim Administrator, interim Director or Nursing (DON), Regulatory Compliance Advisor, Clinical Lead and the Market Clinical Advisor were provided a copy of an updated IJ template and notified of the additional findings of immediate jeopardy in the area of Freedom from Abuse Neglect, and Exploitation at F600- Free from Abuse and Neglect.The IJ began on 04/01/2025 and continued until 05/30/2025 when the survey team verified onsite that corrective actions had been implemented. On 05/31/2025 the immediate jeopardy was removed. F740 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revised their corrective actions as necessary to achieve substantial compliance.This deficient practice affected RI #119, RI #53, RI #9, and RI #87; four of ten residents sampled residents for behavior management.Findings include:Cross-reference F600 and F835.A facility policy titled Behaviors: Management of Symptoms dated 07/01/2024, documented: . Policy Patients exhibiting behavioral symptoms will be individually evaluated to determine the behavior. The interdisciplinary team identifies underlying medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes that contribute to the patient's behavior. Mental Disorder is a syndrome characterized by a clinically significant disturbance. in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in psychological, biological, or developmental process underlying mental functioning. Mental disorders are usually associated with

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and Review of Mosby's 2017 Nursing Drug Reference Book, the facility failed to ensure Resident Identifier (RI) 9's Apixaban (Eliquis) was not resumed on 04/10/2025 at 8:00 PM when RI #9 had an actively bleeding surgical incision and abnormal laboratory (lab) blood values. On 04/07/2025, a change of condition was noted in RI #9's medical record related to bleeding from a surgical incision. Certified Registered Nurse Practitioner (CRNP) #75 was notified, and orders were obtained to hold RI #9's Eliquis for three days. RI #9's Eliquis was held on 04/07/2025 at 8 PM until 04/10/2025 at 8 PM.On 04/09/2025 at 10:41 AM, the lab reported the Complete Blood Count (CBC) results that included hemoglobin of 7.7 g/dL (grams per deciliter), hematocrit of 25.9% (percent) and Red Blood Count (RBC) of 2.6 10 6/uL (microliters).On 04/09/2025 the Medical Director (MD) made an acute care visit for RI #9. The MD's note indicated that he was not aware of ongoing concerns regarding bleeding from RI #9's surgical wound. The MD also reported that he was unaware that RI #9's surgical incision was bleeding and unaware of the 04/09/2025 CBC results. The MD reported RI #9's Eliquis should have continued to be held beyond 04/10/2025.RI #9's Eliquis was resumed at 8 PM on 04/10/2025.The Orthopedic surgeon said he would have not resumed the Eliquis on 04/10/2025, but he left those decisions to the facility's Medical Director.On 04/16/2025 a repeat hemoglobin was drawn and resulted on 04/17/2025 with value of 4.9 g/dL. RI #9 was transferred to the hospital on [DATE].It was determined the facility's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.45 Drug Regimen is Free From Unnecessary Drugs.On 05/31/2025 at 7:08 PM, the interim Administrator and the Market Clinical Advisor were provided a copy of the IJ template and notified of the findings of immediate jeopardy and substandard quality of care in the area of Pharmacy Services at 757- Drug Regimen is Free From Unnecessary Drugs.The IJ began on 04/10/2025 and continued until 06/03/2025. On 06/04/2025 the immediate jeopardy was removed. F757 was lowered to the lower severity of no actual harm with a potential for more that minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revised their corrective actions as necessary to achieve substantial compliance.This deficient practice affected RI #9 one of 18 sampled residents.Findings Include:Cross Reference F580 and F841Mosby's 2025 Nursing Drug Reference 38th Edition (drug manual) indicated Apixaban (Eliquis) was classified as an Anticoagulant that was a High Alert medication. The drug manual documented:apixaban . CONTRAINDICATIONS: active bleeding. INTERACTIONS . Increase: bleeding .NURSING CONSIDERATIONS Assess: Bleeding: bleeding may occur from any body system, may be fatal if severe. Bleeding to report bleeding, bruising, confusion, weakness, numbness of limbs.RI #9 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include Unspecified Atrial Fibrillation and Displaced Intertrochanteric Fracture of Left Femur, Subsequent Encounter for Closed Fracture with Routine Healing. RI #9's Order Summary Report (Physicians Orders) revealed RI #9 had an order dated 02/26/2021 for Eliquis 5 mg (milligram) by mouth two times a day for Atrial Fibrillation.On 03/28/2025 RI #9 was readmitted to the facility post hospital stay. Licensed Practical Nurse (LPN) #68 documented RI #9 had 14 staples plus five more staples at left hip surgical incision. The LPN indicated RI #9 arrived with a surgical dressing over the site.On 05/29/2025 at 4:57 PM, an interview was conducted with LPN #101 who said that when RI #9 first came back they did not discontinue his/her anticoagulant until the CRNP did labs and gave an order to hold it. LPN #101 said that the wound had staples, but fluid was seeping out when she came in on the evening shift and a CNA reported to her that RI #9's gown, the bed, and the pad were wet from the bloody-tinged fluid. She further stated that there was a pretty good amount of drainage because she helped the CNA change the resident's bed. LPN #101 stated that she passed the information on in report to LPN #74. A review of RI #9's Progress Notes dated 04/07/2025 revealed RI #9 had bleeding from the left hip incision site. RI #9's Primary Care Provider was informed and gave an order to hold RI #9's Eliquis 5 mg for three days.RI #9's Lab Results Report revealed the lab was collected on 04/08/2025 and resulted on 04/09/2025. The results included that RI #9 had a hemoglobin of 7.7 g/dL which was low. The normal range for a hemoglobin level was 12.0 g/dL - 16.0 g/dL. RI #9's hematocrit level was 25. 9% which was also low. The normal range for a hematocrit level was 36.0% - 48.0%. RI #9's Progress notes dated 04/09/2025 7:13 by LPN #74 documented that wound care was provided to left hip surgical site and a medium amount of serous drainage was noted.A review of the MD's progress notes dated 04/09/2025 did

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure Resident Identifier (RI) #119, RI #76, and RI #9 were free of a significant medication errors. Specifically, the facility failed to ensure: 1) RI #119's monthly paliperidone (Invega) injection was administered on 01/24/2025 and 02/24/2025. RI #119 had a history of cursing and yelling in the facility and on 03/18/2025 RI #119 threatened to kill people in the facility. RI #119 was sent to the hospital for evaluation. On 04/01/2025 RI #119 hit RI #53 in the face twice with a closed fist. 2) Further the facility failed to ensure RI #76's morning medications including Imdur (Isosorbide Dinitrate), Lacosamide, Keppra, Amlodipine, and Losartan were administered on 05/06/2025 when RI #76 requested that Licensed Practice Nurse (LPN) #42 administer the medications after he/she ate breakfast. The LPN did not administer the medications. On 05/07/2025 RI #76's blood pressure was 200/97. It was determined the facility's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.45 Pharmacy Services. On 05/13/2025 at 3:30 PM, the Administrator and Director of Nursing (DON) were provided a copy of the IJ template and notified of the findings of immediate jeopardy in the area of Pharmacy Services at F760- Residents are free of Significant Med Errors. After the facility submitted the removal plan for the above non-compliance that indicated the DON conducted an audit of residents Medications Administration Records and no significant medication errors were identified, the survey team began to validate the removal plan and identified: 3) The facility failed to ensure RI #9 was free from significant medication errors when facility staff failed to administer RI #9's intravenous antibiotic Piperacillin-Tazobactam (Zosyn) as ordered. RI #9's Electronic Medication Record documented that facility staff administered 42 doses of Zosyn to RI #9. Of the 42 times, five doses were documented as administered days later on 05/14/2025 by Registered Nurse (RN) #25 who was not clocked in at the time the doses were due, two doses were documented as administered days later on 05/14/2025 by the Former Director of Nursing (FDON #2), and three doses were documented as administered by Licensed Practical Nurse (LPN) #101 who was not qualified to administer the antibiotic and reported she did not administer the medication. RI #9's scheduled dose of Zosyn 05/17/2025 at 12 AM was not administered. A total of ten of 42 doses of RI #9's scheduled Zosyn were either documented days later or documented by staff who reported it was documented in error. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RI #9's pharmacy records indicated 56 doses were delivered. On 05/20/2025, 23 of the 56 delivered doses of RI #9's Zosyn were observed unused in the medication room. On 05/28/2025 at 9:37 PM, the interim Administrator (ADM), the interim DON, and the Market Clinical Advisor were provided a copy of an updated IJ template and notified of the additional findings of immediate jeopardy in the area of Pharmacy Services at F760- Residents are free of Significant Med Errors. The IJ began on 04/01/2025 and continued until 05/30/2025. On 05/31/2025 the immediate jeopardy was removed. F760 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revised their corrective actions as necessary to achieve substantial compliance. These deficient practices affected RI# 119, RI #76, and RI #9, three of three residents sampled for medication administration. Findings Include: Cross-reference F600, F658, F694, F740. Review of a facility policy titled, Medication Administration General Guideline, dated 01/25, revealed the following: POLICY . PROCEDURES . 7.1 General Guidelines . Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber. 4. Medications are to be administered at the time they are prepared. 14. Medications are administered within 60 minutes of the scheduled time . Medications should not be given at mealtimes . unless specifically ordered with meal. Documentation: 1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. 2. If a regularly scheduled medication is withheld, refused, or given at other than the scheduled time . the nurse shall be documented in either the Electronic Medication Administration Record or the paper MAR that the dose was withheld, refused, or given at other than the scheduled time, and enter an explanatory note . (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RI #119's nursing notes did not include documentation that the doctor or CRNP was notified that RI #119 refused his/her monthly injection of Invega. On 05/10/2025 at 3:30 PM an interview was conducted with CRNP #53. The CRNP said RI #119 was admitted with orders for Invega. The CRNP said RI #119's Invega was ordered for Schizophrenia and was to be given once a month. When asked, how long would someone need to be prescribed Invega, the CRNP said continuously, and she would not discontinue that medication. On 05/12/2025 at 11:31 AM a phone interview was conducted with the Pharmacy Director. The Pharmacy Director said the facility ordered and received RI #119's Invega on 01/24/2025. The Pharmacy Director said the facility did not order another dose until April 2025. The Pharmacy Director said the nurses had to call in all orders with the pharmacy because it was not on an automatic cycle because the Governing Body wanted the nurses to be responsible for the medications. The Pharmacy Director said Invega was a second-generation antipsychotic, and it was for mood stabilization. The Pharmacy Director said if Invega was not administered as prescribed to a resident who was prescribed Invega for Schizophrenia, the resident could have a full break and could start hearing voices. The Pharmacy Director continued to say the resident would not be stable at all. On 05/12/2025 at 4:36 PM an interview was conducted with the facility's Medical Director (MD). The MD said he was not made aware that RI #119 had missed doses of Invega. The MD was asked, what was the concern with RI #119 not receiving his/her ordered Invega for two months. The MD said RI #119 might have symptoms of behavior. The MD said he should be notified any when the medication is not administered as ordered. The MD said when a resident refused a medication that was prescribed to be administered once per month, he would expect the nurse to administer the medication the following day. On 05/13/2025 at 7:45 PM an interview was conducted with the Administrator (ADM) #1. The ADM said she did not know RI #119 had not received his/her Invega in January or February before the survey team informed her. 2) RI #76 was admitted on [DATE] and readmitted on [DATE] and had diagnoses that included Ileus, Epilepsy without Status Epilepticus, Hypertension, Bradycardia, Depression, and Other Specified Noninfective Gastroenteritis and Colitis. RI #76's physician's order included orders for Amlodipine 10 mg daily for hypertension, Hydralazine 100 mg three time per day for hypertension, Isosorbide Dinitrate 40 mg three times a day for heart, Lacosamide 150 mg daily for seizures, Keppra 500 mg twice daily for seizures, Losartan 100 mg daily for hypertension, 2 tablets of Bisacodyl 5 mg daily for constipation, Doxazosin Mesylate 1 mg daily for hypertension, and Aspirin 81 mg daily for anti-inflammatory. On 05/06/2025 at 9:18 AM an observation was made of LPN #42 preparing to administer medications to RI #76 to include: Amlodipine 10 mg, Hydralazine 100 mg, Isosorbide Dinitrate 40 mg, Lacosamide 150 mg, Keppra 500 mg, Losartan 100 mg, 2 tablets of Bisacodyl 5 mg daily, Doxazosin Mesylate 1 mg, and Aspirin 81 mg. On 05/06/2025 at 9:30 AM RI #76 told LPN #42 that he/she wanted his/her medications after eating breakfast. LPN #42 did not administer the medications. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's Timeline of Events for RI #9 indicated that RI #9 was transferred to the hospital on [DATE] for critical lab values. RI #9 returned on 05/02/2025 with a PICC line. A review of RI #9's hospital medical record revealed a Progress Note-Generic signed on 05/01/2025 by a hospital physician. The note included: . Medications . DAPTOmycin . 600 mg [milligram] . daily . piperacillin-tazobactam 4.5 g [grams] . q8hr [every eight hours] . Assessment/Plan: . Wound growing Pseudomonas-carbapenem resistant and VRE [Vancomycin Resistant Enterococcus] - Cont [continue] Zosyn and Daptomycin - need long term IV antibiotics - Place PICC . ID [infection disease] has give [sic] DC [discharge] antibiotic regimen - CM [Case Management] is aware - PICC ordered - pt [patient should be ready for DC in am if antibiotics arranged . RI #9's Discharge Summary created by a hospital physician on 05/02/2025 documented: . Hospital Course: . Wound growing Pseudomonas-carbapenem resistant and VRE - Cont [continue] Zosyn and Daptomycin - need long term antibiotics - PICC is in place - DC [discharge] with daptomycin and Zosyn through June 2 . The facility's Order Summary Report for RI #9 documented an order for Zosyn 4.5 gram every 8 hours with start date of 05/05/2025. RI #9 RX History Report documented 56 doses of Zosyn 4.5 g was delivered from the pharmacy to the facility for RI #9. On 05/20/2025 at 4:50 PM an interview was conducted with the Pharmacist who reported 56 doses of Zosyn were delivered to the facility for RI #9. The Pharmacist said the facility did not stock Zosyn 4.5 g. On 05/20/2025 at 1:00 PM an observation was made with LPN #28 of RI #9's remaining doses of Zosyn. 23 doses of RI #9's Zosyn 4.5 g was observed in the medication room. RI #9's EMAR indicated 42 doses of Zosyn were documented as administered to RI #9. On 05/27/2025 at 4:00 PM during a phone interview with the FDON #2, she said she was not aware RI #9 had not received his/her IV antibiotics as ordered until the survey team discussed the 12 AM doses. The FDON said she did not know how it was possible that 42 doses of Zosyn were documented as administered when the pharmacy delivered 56 doses of Zosyn for RI #9, and 23 doses were observed in the medication room. On 05/23/2025 at 12:11 PM during a follow-up interview with the FDON #2, she said the Unit manager should be looking at residents' EMARs on a daily basis. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Ridge	420 Dean Drive Gardendale, AL 35071

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. On 5/08/25, the Administrator hosted an AD HOC Quality Assurance Performance Improvement (QAPI) meeting to review the significant medication errors, medication refusals/preferences, medication administration, and notifying the Physician and/or Provider of significant medications errors. The QAPI personnel who participated included the following disciplines: Market Clinical Advisor, Clinical Lead, Administrator, Director of Nursing, and Nurse Managers 2. On 5/13/25, the Administrator hosted an AD HOC Quality Assurance Performance Improvement (QAPI) meeting to review the process to ensure medications are administered as prescribed and the Physician and/or Provider has been notified of significant medications errors. The QAPI personnel who participated included the following disciplines: Market President, Market Clinical Advisor, Clinical Lead, Administrator, Director of Nursing, Social Services, Activities Director, and Nurse Managers 3. On 5/30/25, the QAPI committee reviewed medication errors to identify medication error patterns, the significant medication errors occurred on 2 of 3 units and during day shift. The identified concerns were addressed by education with licensed nurses, monitoring of medication administration records, and rounds to provide verbal cueing/reminders on medication administration ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team verified onsite that the immediate corrective actions had been implemented the Immediate Jeopardy was removed on 05/31/2025. The scope/severity level of F760 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interviews, record review, and the Administrator's and Director of Nursing's Job Description the administration failed to provide oversight and guidance to the facility's staff to ensure policies and procedures were developed and implemented to ensure: staff knew what behaviors and abuse should be reported and communicated; residents with Mental Illness were determined to be appropriate for the facility and received the appropriate treatment and medications as ordered; staff communicated resident's needs pre-admission to ensure medications were administered as expected following a transition of care from hospital to the facility; and management staff identified medications that had not been administered. It was determined the facility's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.70 Administration. On 05/13/2025 at 3:30 PM the Administrator (ADM) and Director of Nursing (DON) were provided a copy of the IJ template and notified of the finding of immediate jeopardy in the area of Administration and at F835-Administration. On 05/19/2025, after the facility submitted the removal plan for the above non-compliance and while the removal plan was being validated, it was determined that staff had witnessed and were aware of Resident Identifier (RI) #9's behaviors of using derogatory language and roommate incompatibility. RI #9's behaviors were not communicated and addressed until RI #9 verbally abused his/her roommate on 05/17/2025 and 05/18/2025. Further, while validating the removal plan for F760 it was determined that on 05/14/2025 the DON and Registered Nurse (RN) #25 documented missed doses of Resident Identifier (RI) #9's intravenous antibiotics scheduled to be administered between 05/06/2025 and 05/13/2025 as administered. It was determined the facility's continued noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.70 Administration. On 05/28/2025 at 9:37 PM, the interim Administrator, the interim DON, and the Market Clinical Advisor were provided a copy of an updated IJ template and notified of the additional findings of immediate jeopardy in the area of Freedom from Abuse Neglect, and Exploitation at F600- Free from Abuse and Neglect. The IJ began on 04/01/2025 and continued until 05/24/2025 when the survey team verified onsite that corrective actions had been implemented. On 05/25/2025 the immediate jeopardy was removed. F835 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy to allow the facility time to monitor and/or revised their corrective actions as necessary to achieve substantial compliance. The deficient practice had the potential to affect all residents who resided at the facility. Findings Include: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Cross-reference F600, F645, F609, F610, F740, F658, F760, F835, and F867. The Administrator's job description documented the Administrator's responsibilities as follows: REPORTED TO: Market President and/or Regional Administrator . POSITION SUMMARY: Create an environment where staff members are highly engaged and focused on providing the highest level of clinical care . to residents . Responsible for assuring that the center operates in full compliance with Federal and State regulations while Doing the Right Things, which will result in high levels of performance . The Administrator is responsible for planning and is accountable for all activities and departments of the Center subject to rules and regulations promulgated by government agencies to ensure proper health care services to residents. The Administrator administers, directs, and coordinates all activities of the Center to assure that the highest degree of quality of care is consistently provided to residents. ESSENTIAL FUNCTIONS Business Excellence 1. Assures that the QAPI Process is understood and utilized by all members of the Center Leadership Team to continually improve all aspects of Center performance . 2. Oversees and assures an efficient Refer to Admit Process which maximizes Center occupancy. Staff Excellence . 3. Works in close collaboration with the Director of Nursing and department heads to assure professional development and career goals are met. Clinic Excellence 1. Is highly visible throughout the Center on all shifts and days of the week to develop positive relationships with residents, patients, family members and staff to assure that the needs of all are being met. 2. Works in close collaboration with the Director of Nursing, Medical Director . to assure high quality clinical outcomes, appropriate level of hospital readmissions, acceptable survey results and the best possible 5 Star rating. 3. Assures that staffing levels in all departments are appropriate to meet the needs of all patients and residents. 4. Confers with consultants to various departments concerning problem areas and utilizes the Q.A.P.I. Process to improve performance. 5. Creates an environment that is focused on patient and staff safety. Customer Excellence (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. Create a culture of Service Excellence which focuses on the patient experience and is responsive to patients/families concerns and grievances. Compliance . 2. Complies with and promotes adherence to applicable legal requirements, standards, policies and procedures including but not limited to those within the Compliance and Ethics Program, Standard/Code of Conduct, Federal False Claims Act and HIPAA. 3. As the center Compliance Liaison, provides leadership and support for the Compliance and Ethics Program within management area. 4. Attempts to resolve any compliance issues brought to his/her attention and report all significant compliance issues to the Compliance Officer, and assist in their resolution in any way necessary. 6. Ensures that staff participates in orientation and training programs including but not limited to all required compliance courses and relevant policies and procedures, and that such training is properly documented. Participates in compliance and other required training programs. 7. Provides open lines of communication regarding compliance issues within management area and access to the Integrity Line, and ensures that retaliation against staff who report suspected incidences of non-compliance does not occur. Promptly reports concerns and suspected incidences of non-compliance to supervisor, Compliance Liaison or to the Compliance Officer. 8. Participates in education, monitoring and auditing activities and investigations, and implementing quality assurance and performance improvement processes, as required. The Director of Nursing job description included: POSITION TITLE: Clinical POD Leader- DON (PDON) . DEPARTMENT: NURSING ADMINISTRATION . POSITION SUMMARY: . is responsible for overseeing clinical aspects for the assigned POD, in addition to the responsibilities outlined for the Director of Nursing . The Director of Nursing leads the Center clinical team . This position has overall accountability for providing leadership, direction, and administration of day-to-day operations associated with direct patient care activities, nursing practice, and clinical education and development . RESPONSIBILITIES/ACCOUNTABILITIES: . 7. Develops, collaborates with and supervises the Nurse Practice Educator to assure her/his effective, ongoing development of nurse practice and engagement through education, training, and frontline coaching; . CLINICAL EXCELLENCE: 1. Maintains a working knowledge if current clinical practice and the regulatory requirements . (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	2. Determines the workforce/staffing model for the Nursing department necessary to meet the nursing needs of the patients; 3. Oversees the implementation and evaluation of the staffing model to assure high-quality . care; 4. Implements, evaluates, and develops an effective nursing practice model to meet the needs of diverse patient populations; . 6. Ensure there are safe, coordinated and thorough admission and discharge planning processes in place; 7. Organizes and leads effective clinical meetings, rounds, shift to shift communication and huddles to assumes effective patient/resident outcomes. CUSTOMER EXCELLENCE: . 4. Ensures that patient's attending physician and family or responsible party are promptly notified of any significant change in the patient's health condition; . 6. Actively develops relationships and strategies for collaboration with hospitals/health systems . to promote value based care delivery. BUSINESS EXCELLENCE 1. Contributes to creating an environment that has a reputation for high ethical standards; 2. Implements the QAPI [Quality Assurance and Performance Improvement] process to assure quality, safety, and efficient clinical outcomes; . 6. Provides oversight and approves nursing department schedules . 1.3.1 Determines the staffing needs of the Nursing Department necessary to meet the nursing needs of the patients; . On 05/12/2025 at 6:46 PM an interview was conducted with the DON (FDON #2). FDON #2 reported she had worked at the facility since July of 2024 and her job duties included providing oversight to the nursing department, staffing, and day-to-day operations. FDON #2 said she provided oversight to licensed and non-licensed (nursing) staff. FDON #2 was asked how she provided oversight. FDON #2 said, daily the facility had charge nurses and administrative staff the helped with that responsibility. FDON #2 said the nurse managers reviewed residents Electronic Medication Administration Records (EMARs) for missed doses Monday through Fridays. FDON #2 said she did not know two of RI #119's monthly injections of Invega was not administered in January or February of 2024 until the current survey team identified the missed doses. FDON #2 said she did not know when she became aware of RI #119's behaviors. FDON #2 said all behaviors should be documented by staff. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 05/27/2025 at 4:00 PM during a follow-up interview with FDON #2, regarding behavior management, FDON #2 said all behaviors should be documented and if staff were not documenting residents' behaviors it would be hard to develop the correct interventions which would result in ineffective behavior management. FDON #2 was asked, how did that provide a safe, homelike environment for residents. FDON #2 said if that was the case it would be difficult. FDON #2 said she was responsible to ensure the documentation and monitoring occurred and to ensure the correct medication was administered. On 05/12/2025 at 7:47 PM an interview was conducted with the Administrator (ADM #1). The Administrator said she did not know when she first became aware of RI #119's behaviors. The ADM was asked if she was aware of RI #119's behaviors before the incident on 03/18/2025. The ADM said she was not going to be able to answer that on this big of a home. The ADM said staff were trained to document in the nursing notes and the Cardex. The ADM said all behaviors should be documented. The ADM was asked, what was her responsibility to ensure residents who had behaviors were managed, tracked, supervised, and monitored for appropriate interventions and improvement in behaviors. The ADM said her responsibility was to ensure the staff were trained and doing the stuff that they were required to do. The ADM said she provided oversight to everyone, and it was a collaborative effort to ensure residents who had behaviors were managed, tracked, supervised, and monitored for appropriate interventions and improvement in behaviors. The ADM said the oversight was provided by having clinical meetings, stand-up meetings, behavior management, behavior monitoring weekly, and care plans. The ADM said behavior monitor should continue and interventions on the care plan should be changed based on the need on the individual when a resident continued to have behaviors affecting others over several months. The ADM was asked who reviewed residents' records for missed doses of medications. The ADM said she was not clinical and could not answer. The ADM said she did not know RI #119 had missed doses of his/her antipsychotic medication. The ADM said she was not sure if RI #119's Invega was discussed in the morning clinical meeting because she could not be a voice for other staff and she could only be a voice for herself. The ADM was asked, what were her responsibilities to residents at the facility. The ADM said to make sure they were cared for properly and they were safe and out of harm's way. On 05/27/2025 at 4:00 PM during a follow-up interview with FDON #2, she said the admission Liaison (AL) was responsible for assessing residents at the hospital and communicating with the hospital before residents were admitted to the facility. FDON #2 said the AL communicated with the admission Director (AD) regarding resident needs including intravenous (IV) antibiotic. FDON #2 said she did not recall being aware before RI #9 was admitted that RI #9 needed IV antibiotics. FDON #2 was asked, who reviewed to ensure treatment and medications were administered and documented per facility policy and standards of practice. FDON #2 said Unit Managers reviewed the MARs and the Treatment Administration Records (TARs) and they had another check during the clinical meeting for all MARs and TARs. Regarding the facility's process to ensure sufficient staffing to administer RI #9's IV antibiotics, FDON #2 said a Registered Nurse was in the building to administer the 8 AM, 12 PM, and 4 PM doses. FDON #2 said RN #25 would administer the 12 AM dose. FDON #2 said there was nothing written, just verbal. FDON #2 was asked, what education was provided regarding IV antibiotics. FDON #2 said no training was documented. FDON #2 said there was no specific training provided regarding IV flushes, PICC assessment, care, or dressing changes. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 05/23/2025 at 12:11 PM during a follow-up interview with FDON #2 was asked why RI #9's Zosyn was documented as administered on 05/14/2025 that were days past due their scheduled time for administration. FDON #2 said, because that was when she identified the doses had not been documented as administered. FDON #2 said the Unit manager be looking at residents' EMARs on a daily basis. FDON #2 said RI #9's Zosyn doses that were past due and not documented as administered should have been included on the facility's initial removal plan for F760 and she was not sure why they were not. FDON #2 was asked, what evidence did they have that RI #9's Zosyn was administered considering that 42 doses of the medication were administered and only 33 doses had been used from the residents' medication supply. FDON #2 said she did not have anything other than the EMAR. FDON #2 was asked, how was RI #9's EMAR accurate. FDON #2 said RI #9's EMAR might not be accurate. On 05/23/2025 at 3:29 PM during a follow-up interview with FDON #2 she was asked about her involvement in the audit of mediations for removal plan for F760. FDON #2 said she would look at the EMAR and validate the omission or not. FDON #2 was asked, what prompted her to review these medications on 05/14/2025 when RI #9's Zosyn was documented on the EMAR. FDON #2 said she was just doing a regular check with the EMARS. FDON #2 said she understood the purpose of the audit was to validate that medications were administered and to look for omissions. FDON #2 said RN #62 and the Market Clinical Advisor provided her the instructions for performing the audit for the removal plan for Medication Administration. FDON #2 said she made the decision to document omissions on 05/14/2025 as administered rather than investigate to ensure the medication had been administered as ordered. FDON #2 said she had not investigated to determine whether RI #9's IV antibiotics were administered as ordered. FDON #2 was asked what knowledge she had of other nurses documenting missed doses of RI #9's Zosyn as administered on 05/14/2025 during the audit. FDON #2 said that she just suggested that the nurses check their EMARs. On 05/24/2025, a notification of change in Administrator and Director of Nursing was provided to the surveyor team onsite. ********** The facility submitted an acceptable plan to remove the immediacy of the identified deficient practice that included: ********** The Market Operations Advisor educated the Administrator on OPS300 Abuse Prohibition Policy on 5/13/25 to ensure the Administrator understands her role in operationalizing and overseeing policies within the Center, specifically the Abuse Prohibition Policy. Effective 5/24/25, a notification of change in Administrator and Director of Nursing was provided to the surveyor on site. Effective 5/24/25, a notification of change in Administrator and Director of Nursing was provided to the surveyor on site. In-services (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. On 5/13/25, the Market Operations Advisor educated the Nursing Home Administrator on: NSG206 Behaviors: Management of Symptoms and the role of the Administrator to ensure the staff are aware of what behaviors and abuse should be reported and communicated to the Abuse Prevention Coordinator. The education emphasized patients exhibiting behavioral symptoms will be individually evaluated by the Interdisciplinary team to determine the behavior. Additionally, the interdisciplinary team will identify underlying medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes that contribute to the patient's behavior and develop a person-centered plan of care. The Administrator was educated on the following responsibilities: a. Participating in and providing input to the facility staff to ensure the behavior management program is executed, and staff know what behaviors should be reported promptly to determine if the behavior rises to a potential abuse occurrence. The Administrator will be responsible for reporting and investigating all allegations of abuse to APDH in a timely manner as needed. i. The Administrator will be responsible for ensuring that the Behavior Management Program will be carried out to include daily review of Behavior Monitoring Report, a weekly behavior meeting to include a review of behaviors, care planning and education as needed to ensure Behavior Monitoring is occurring and interventions are implemented as needed. The Administrator will provide oversight and guidance to the facility staff to ensure a behavior management program was developed and implemented, staff know what behaviors and abuse should be reported and communicated ii. The Administrator will document the daily reviews, actions and recommendations on the Morning Meeting Sheet. The weekly audit includes a sign -in sheet for the weekly behavior meeting. 2. The Market Operations Advisor educated the Administrator on the Administrator's job description and to include, but not limited to, ensuring the Administrator administers, directs, and coordinates all activities of the center. To attain and maintain the highest practicable physical, mental and psychosocial well-being of the residents as part of the facility governing body on 5/13/25. The Administrator educated on the following responsibilities: a. Tracking and trending the following areas in the monthly QAPI meetings and assisting with the development of performance plans in the areas: significant medication errors, behavior management trends, allegations of abuse, and pre-admission screening. The reviews will be documented on the monthly QAPI form and maintained in the Administrator's office. 3. The Market Operations Advisor educated the Administrator on OPS300 Abuse Prohibition Policy on 5/13/25 to ensure the Administrator understands her role in operationalizing and overseeing policies within the Center, specifically the Abuse Prohibition Policy. The Administrator plays a vital role in ensuring staff are properly trained on what behaviors and abuse should be reported and communicated. The Administrator educated on the following responsibilities: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	a. Leading in the investigation process and following up with outstanding activities needed for a thorough investigation. The Investigation checklist will be used which includes but not limited to the following: initial report, resident/ staff interviews signed and dated, Resident care plans pertaining to the investigation, Record of training after incident, Nurses notes, Social and Psych notes if applicable, documentation of resident's behaviors, resident's outcome and corrective actions taken by the facility. A copy of the investigation checklist will be placed in all abuse allegation files. b. Ensuring that each reportable event is taken to the QAPI committee monthly for thorough review of completion, deliberation on investigation findings, and development of appropriate actions to take regarding elimination of future recurrence. c. Hosting an ADHOC QAPI to identify root cause analysis for each reportable and implement proper interventions. The ADHOC QAPI will take place within one week if a reportable event occurs. 4. On 5/13/25, the Market Operations Advisor educated the Administrator on SS105- Pre-admission Screening for Mental Disorder and/or Intellectual Disability on oversight and guidance to ensure that all patients are screened for Mental Disorders and/or Intellectual Disability prior to admission. In addition, individuals identified with Mental Disorder or Intellectual Disability are evaluated and receive care and services in the most integrated setting appropriate to their needs. The Administrator was educated on the responsibility of the following: a. Reviewing the audits completed by the Social Service Director and/or Admissions' Director to validate all residents are screened prior to admission and evaluations needed upon admission are promptly submitted for a Determination. The review will be completed after each admission to the Center. The results will be documented on a PASSAR monitoring tool. 5. On 5/15/25, the Administrator was educated by the Market Clinical Advisor and Market Clinical Lead on communicating to the governing body any concerns identified with regarding Abuse Prohibition and Behavior Monitoring. The Administrator will promptly report any allegations of abuse to the governing body for oversight and assistance. Additionally, the Administrator will track performance improvement plans in the monthly QAPI and report findings to the governing body. 6. On 5/24/25, the Market Clinical Advisor educated the new Administrator on everything the previous Administrator was educated on with a focus on the Administrator's role in the Behavior Management process to include review of behavior rounds, trends, input into causative factors and corrective actions monthly in QAPI. Education conducted on validating admissions have a pre-admission screen and evaluations are acted upon promptly. Additionally, education was conducted on reviewing the medication administration audit tools to add input and provide guidance and oversight through the QAPI process. Quality Assurance (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. The Nursing Home Administrator /designee was educated on 05/13/25 by the Market President to report findings monthly to the Quality Assurance Performance Improvement Committee for any additional follow up and/or in servicing until the issue is resolved and randomly thereafter as determined by the QAPI committee. ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team verified onsite that the immediate corrective actions had been implemented the Immediate Jeopardy was removed on 05/25/2025. The scope/severity level of F835 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Based on interviews, record reviews, and the job description for Center Sr. Executive Director the Governing Body failed to provide oversight to ensure residents were free from abuse, neglect, and significant medications errors. Further the Governing Body failed to ensure the facility staff responsible for administering medications and parenteral fluids via PICC were trained on the standards of practice. The Governing Body further failed to ensure facility staff were trained on proper resident care for residents with a PICC. It was determined the facility's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.70 Administration. On 05/28/2025 at 9:37 PM, the interim Administrator (ADM), the interim Director of Nursing (DON), and the Market Clinical Advisor were provided a copy of the IJ template and notified of the findings of immediate jeopardy in the area of Administration and at F837-Governing Body. The IJ began 05/02/2025 and continued until 05/29/2025. On 05/30/2025 the immediate jeopardy was removed. F837 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revised their corrective actions as necessary to achieve substantial compliance. This deficient practice had the potential to affect all residents who resided at the facility. Findings Include:Cross-Reference F600, F609, F610, F740, F658, F694, F835, F867.A review of the job description for Center Sr. Executive Director, documented, . REPORTS TO: Regional [NAME] President and/or Regional Executive Director.POSITION SUMMARY: Create an environment where staff members are highly engaged and are focused on providing the highest level of clinical care and compassion to patients, residents and families. Responsible for assuring that the center operates in full compliance with Federal and State regulations while Doing the Right Things, which will result in high levels of performance in each of the (company name) Strategic Focus Areas. ESSENTIAL FUNCTIONSBusiness Excellence 1.Assures that the QAPI Process is understood and utilized by all members of the Center Leadership Team to continually improve all aspects of Center performance as measured by the Center Performance Scorecard. Clinic Excellence . 4.Confers with consultants to various departments concerning problem areas and utilizes the Q.A.P.I. Process to improve performance.A review of the job description for Market Clinical Advisor documented, . REPORTS TO: Market ops Advisor and Market Leader . RESPONSIBILITIES/ACCOUNTABILITIES: . Leadership: .Provide clinical leadership in resident-centered initiatives that focus on enhancing resident's lives, periodically participating in activities to provide actionable feedback .Work collaboratively with the team to fully implement QAPI to maximize current and future clinical performance .Collaborate with the interdisciplinary team at the market and facility level to instill accountability in all departmental components tied to resident wellness. Clinical Market Management:Provide open lines of communication regarding compliance issues, operating with a deep commitment to preventing, identifying, and addressing such issues .Ensure education, training, and experience are effectively deployed to best serve our patients .**********The facility submitted an acceptable plan to remove the immediacy of the identified deficient practice that included:**********Effective 5/24/25, a notification of change in Administrator and Director of Nursing was provided to the surveyor onsite. 1.On 5/29/25, the Senior Market President educated the Market Clinical Advisor, Market Clinical Lead, Administrator, and Director of Nursing on ensuring the facility QA committee review allegations of abuse allegations within one week after occurrence to identify causative factors, ensure a thorough investigation has been completed, and verify the development and implementation of corrective actions. Education was provided not to admit and/or re-admit IV hydration or IV medication via PICC. The governing body will review the facility's reported allegations to ensure a thorough investigation has been conducted after the facility's five-day investigation. If a thorough investigation has not been completed, the governing body will provide additional guidance and appropriate corrective actions will be implemented. 2. The Administrator hosted an AD HOC QAPI on 5/29/25 to review allegations of abuse to include causative factors and/or root cause, barriers to comprehension of education, identification of abuse, reporting, investigation, and proactive strategies/corrective actions to prevent abuse and abuse allegations. Any identified concerns will be addressed with prompt education and QAPI evaluation for the development and implementation of new interventions to ensure residents are free from abuse. Participants included the Administrator, Director of Nursing, Nurse Managers, Director of Memory Support, MDS Nurse, a Licensed Nurse, and a Certified Nursing Assistant3. Effective 5/25/25, the facility will not accept patients receiving IV

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	015133	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Ridge	420 Dean Drive Gardendale, AL 35071

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

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F 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. (continued on next page)

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F 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, medical record review, and review of a facility policy titled, Genesis Physician Services, the facility's Medical Director (MD) failed to ensure the appropriateness and quality of Resident Identifier (RI) #9's medical care. On 04/07/2025 a change of condition was noted in RI #9's medical record related to bleeding from a surgical incision. The CRNP (Certified Registered Nurse Practitioner) was notified, and orders were obtained to hold RI #9's Apixaban (Eliquis) 5 milligrams (mgs), ordered twice daily, for three days. RI #9's Eliquis was held on 04/07/2025 at 8 PM until 04/10/2025 at 8PM.On 04/09/2025 the MD (Medical Director) made an acute care visit for RI #9. The MD's note indicated that he was not aware of ongoing concerns regarding bleeding from RI #9's surgical incision and RI #9's current lab results. The lab results documented on the MD's note dated 04/09/2025 were not the most current results. The MD reported RI #9's Eliquis should have continued to be held, but he expected the specialist, RI #9's Orthopedic Surgeon, to discontinue the medication.RI #9's Eliquis was resumed at 8 PM on 04/10/2025.The Orthopedic surgeon said he would have not resumed the Eliquis on 04/10/2025, but he left those decisions to the facility's Medical Director.On 04/16/2025 a repeat hemoglobin was drawn and resulted on 04/17/2025 with value of 4. 9 g/dL. RI #9 was transferred to the hospital on [DATE].It was determined the facility's noncompliance with one or more requirements of participation has cause, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.70 Administration is Free from Unnecessary Drugs.On 05/31/2025 at 7:08 PM, the interim Administrator and Market Clinical Advisor were provided a copy of the IJ template and notified of the findings of immediate jeopardy and substandard quality of care in the area of Administration at F841- Responsibilities of the Medical Director.The IJ began on 04/07/2025 and continued until 06/04/2025 when the survey team verified onsite that corrective actions had been implemented. On 06/05/2025 the immediate jeopardy was removed. F580 was lowered to the lower severity of no actual harm with a potential for more that minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revised their corrective actions as necessary to achieve substantial compliance.This deficient practice had the potential to affect all residents who resided at the facility.Findings Include:Cross Reference F580 and F757.Review of a facility policy titled, Genesis Physician Services, with a revision date of 07/26/2023 revealed the following:POSITION TITLE: Medical Director .POSITION SUMMARY: The Medical Director partners with the Regional Medical Director to promote the delivery of clinical services in a manner that fulfills the Genesis Physician Services (GPS) mission of achieving the highest levels of clinical quality, efficiency, and outcomes .RESPONSIBILITIES: . Coordination of Medical Care - Direct and coordinate facility-wide medical care. Resolve issues related to continuity of care and transfer of medical information between the facility and other care settings. Review individual resident cases as requested or indicated .ESTABLISHES STRATEGIC FOCUS AND EFFICIENCY AT THE CENTERreadmission Avoidance - Co-lead the Center's strategy to minimize avoidance readmission with the DON (Director of Nursing), through readmission review and center-based clinical meeting, as well as collaboration with hospital and home health agencies . DIRECTS PATIENT CAREDirect the medical care of Center residents who are assigned to the Medical Director as the Attending Physician .RI #9 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include Unspecified Atrial Fibrillation and Displaced Intertrochanteric Fracture of Left Femur, Subsequent Encounter for Closed Fracture with Routine Healing. RI #9's face sheet identified the MD as RI #9's Primary/Attending physician.A Progress Note dated 04/01/2025 indicated RI #9's Orthopedic follow-up appointment was pending.Progress Notes for RI #9 dated 04/07/2025, revealed a SBAR (Situation Background Assessment Recommendation) Summary for Providers that documented:Situation: The Change in Condition/s reported on this CIC [Change in Condition] are/were: Bleeding (other than GI [gastrointestinal]) . Nursing observation, evaluation, and recommendations are: Bleeding at incision site left hip . The note indicated that the Primary Care Provider was notified and ordered RI #9's Eliquis 5 mg (milligram) to be held for three days, a hemoglobin and hematocrit to be obtained on 04/08/2025, and apply three drops of Afrin to 4x4 gauze and apply left hip.A Lab Results Report for RI #9 revealed the lab was collected on 04/08/2025 and was reported on 04/09/2025 at 10:41 AM. The results indicated RI #9 had a hemoglobin of 7.7 which was low. The normal range for a hemoglobin level was 12.0 - 16.0. RI #9's hematocrit level was 25.9 which was also low. The normal range for a hematocrit level was 36. 0 - 48.0. On 04/09/2025 MD made rounds and documented in RI #9's record: Nursing staff voices no new

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	015133	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Ridge	420 Dean Drive Gardendale, AL 35071

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. (continued on next page)

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	015133	A. Building B. Wing	06/05/2025

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of a facility policy titled, Center Quality Assurance Performance Improvement (QAPI) Process, the facility's QAPI committee failed to identify that appropriate corrective actions had not been taken and no interventions were developed to ensure RI #53 was protected from RI #119 after RI #119 hit RI #53 in the face twice with a closed fist on 04/01/2025. RI #119 continued to have access to RI #53 until 05/08/2025 after a staff intervened to separate the residents when RI #119 was observed yelling, cussing, and behaving aggressively toward RI #53. RI #119 was placed on 1 to 1 supervision, resident RI #119 room assignment was changed to an alternate unit and room on the [NAME] Wing. It was determined the facility's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.75 Quality Assurance and Performance Improvement.On 05/15/2025 at 5:00 PM the Administrator (ADM) and the Director of Nursing (DON) were provided a copy of the IJ template and notified of the findings of immediate jeopardy in the area of Quality Assurance and Performance Improvement and at F867-QAPI/QAA Improvement Activities. The IJ began on 04/01/2025 and continued until 05/29/2025 when the survey team verified onsite that corrective actions had been implemented. On 05/30/2025 the immediate jeopardy was removed. F867 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy to allow the facility time to monitor and/or revised their corrective actions as necessary to achieve substantial compliance. This deficient practice had the potential to affect all residents who resided at the facility.Findings Include:Cross-Reference F600, F609, F610, F835, F760.The facility's Policy titled, Center Quality Assurance Performance Improvement Process, with a revision date of 10/24/2022, documented, POLICY Centers are committed to incorporating the principles of Quality Assurance and Performance Improvement (QAPI) into all aspects of the Center work processes, service lines, and departments. QAPI activities will be integrated across all care and service areas and include clinical care, quality of life, and patient/resident (hereinafter patient) choice.PURPOSE To standardize the Center's approach to QAPI culture and processes by implementing the following key elements.QAPI principles will drive the decision making within each Center. The Administrator leads the Center's QAPI processes and involves all departments, staff, and stakeholders-balancing a culture of safety, quality, and patient centeredness.The QAPI processes and improvements are based on evidence, drawing data from multiple sources, prioritizing improvement opportunities, and benchmarking results against developed targets.Improvement Activities (IAS) and Performance Improvement Projects (PIPS) are the structure and means through which identified problem areas are addressed with data analysis, process improvements, and ongoing monitoring whenever necessary using an interdisciplinary team. PROCESS1. The Administrator, along with the Director of Nursing, directs the development and documentation of the Center QAPI Plan and is responsible for development, maintenance, and ongoing evaluation of an active and effective Quality Assessment and Assurance (QAA) Committee.2. The QAA Committee: 2.1 Functions under the authority of the Administrator and the Governing Body and is composed of: . 2.8 Assesses, evaluates, and identifies potential improvement opportunities based on: . 2.8.2 All current regulatory on-site assessments, including plans of correction, both state/federal surveys and peer review surveys including a review of the plan of correction.2.8.3 Adverse events since the past meeting including prevention opportunities, investigation, and corrective actions.On 04/01/2025 at 3:40 PM the State Agency received a FRI alleging physical abuse occurred when RI #119 hit RI #53 in the face with his/her hand and the residents were separated. Licensed Practical Nurse (LPN) #57, the Administrator, and the Director of Nursing (DON) were made aware of the incident.On 05/12/2025 at 12:45 PM an interview was conducted with the Director of Nursing (FDON #2) who reported the 04/01/2025 incident involving RI #119 and RI #53. FDON #2 reported the incident was reviewed by QAPI Committee on 04/30/2025. FDON #2 said the facility conducted a root cause and offered to bring survey team a copy of the documentation.The DON provided the QAPI documentation of the 04/30/2025 QAPI meeting. The root cause of the incident was identified on the documentation as onset of delusions secondary to Vascular Dementia and Schizophrenia as evidenced by the resident was tearful and referenced working in the cotton fields since she was [AGE] years old and said a white [man/woman] was sitting on the porch. The facility's IMMEDIATE PLAN included interventions completed on 04/01/2025. The interventions included one-on-one with RI #119 until he/she was transferred