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	03/19/2025

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

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F 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** 21055 Based on medical record review, interviews, and review of a facility policy titled, Change in Condition: Notification of, the facility failed to notify Resident Identifier (RI) #237's family/responsible party when RI #237's Ativan 1 mg (milligram) was decreased to 0.5 mg on 12/12/2024. This affected RI #237 one of one sampled resident reviewed for notification of change. This deficiency was cited as a result of the investigation of complaint/report number AL00042921. Finding Include: Review of a policy titled Change in Condition: Notification of, with an effective date of 11/28/2016, documented: . POLICY A Center must immediately inform the patient, . and notify, consistent with their authority, the patient's representative, where there is: . 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) . PURPOSE To provide appropriate and timely information about changes relevant to the patient's condition. RI #237 was admitted to the facility on [DATE] with a diagnoses to include Generalized Anxiety Disorder and Restlessness and Agitation. RI #237's November 2022 Order Summary Report (Physicians Orders) documented: . LORazepam Oral Tablet 1 MG . Start Date 11/04/2022 . RI #237's November 2022 Physician Orders documented: (continued on next page)

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

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	015133	A. Building B. Wing	03/19/2025

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	. Ativan Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth at bedtime for anxiety . Start Date 12/12/2022 . A review of RI #237's progress notes dated 12/12/2022 revealed RI #237's Ativan was being decreased to 0. 5 mg as a gradual dose reduction (GDR). There was no evidence in the progress notes that RI #237's family/responsible party had been notified of a decrease in the Ativan. A telephone interview was conducted with RI #237's family on 03/04/2025 at 10:31 AM. RI #237's family was asked about RI #237's Ativan order. RI #237's family reported RI #237 was admitted to the facility with an order for Ativan and she/he nor the responsible party were notified of a decrease in the Ativan. A telephone interview was conducted with RI #237's emergency contact (responsible party) on 03/12/2025 at 7:10 PM. The responsible party said he/she was not informed of RI #237's decrease in Ativan to 0.5 mg on 12/12/2022. An interview was completed with Registered Nurse (RN) #4 on 03/11/2025 at 10:36 AM. RN #4 stated RI #237 was admitted to the facility on Ativan 1 mg at bedtime. RN #4 said the progress notes dated 12/12/2022 documented the Ativan was decreased to 0.5 mg. RN #4 said the family/sponsor should be notified when there was a change in the resident's medication. RN #4 said there was no evidence in the nursing notes the family had been notified of the decrease in RI #237's Ativan. RN #4 said it was important for the family to be notified so they would be aware of changes in the resident's plan of care.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33738 Based on interviews, observation, medical record review, and facility's policies titled, Safeguarding and Storage of Health Information Records and Medication Administration, the facility failed to ensure the Electronic Medication Administration Record (eMAR) screen was closed and did not reveal personal information concerning Resident Identifier (RI) #127. This was observed on 03/03/2025 during the evening medication pass and affected RI #127, one of 134 residents residing in the facility. Findings Include: A review of a facility policy titled, Safeguarding and Storage of Health Information Records, with a revision date of 05/01/2022 revealed the followings: . POLICY The Company will maintain reasonable administrative, technical, and physical safeguards to protect the privacy of protected health information (PHI) from use or disclosure that is in violation of federal and/or state regulations. PURPOSE To limit unauthorized access of protected health information (PHI) . 3.1. Do not leave health information records unattended in public area . A review of a facility policy titled, Medication Administration, with a date of 01/2025 revealed the following: PROCEDURES . Medication Administration: .18. Resident's health information needs to remain private. Medication Administration Records containing resident health information must not be visible when not in direct use (. Electronic Health Record information hidden) . RI #127 was admitted to the facility on [DATE] with a diagnosis of End Stage Renal Disease. On 03/03/2025 at 5:15 PM, the Surveyor observed a privacy screen unlocked on the eMAR screen on top of the medication cart. The privacy screen was visible left open showing RI #127's medications. The nurse was across from the medication cart weighing a resident. On 03/03/2025 at 5:15 PM, an interview was conducted with Licensed Practical Nurse (LPN) #20. She was asked if she left the eMAR screen unlocked and visible to the public for RI #127. LPN #20 said, she did. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/2025 at 4:22 PM a follow up interview was conducted with LPN #20. LPN #20 was asked if RI #127's eMAR screen was left unlocked and visible for the public to see on 03/03/2025 during medication pass. LPN #20 said yes. When asked if RI #127's eMAR should have been left unlocked and visible for the public to see, she said no. LPN #20 further said when the nurse was away from the medication cart the eMAR screen should be locked. LPN #20 was asked why was it important for the eMAR to be closed/locked when the nurse was away from the medication cart. She said for the resident privacy.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 33738 Based on observations, interview, and the facility's document titled, YOUR RIGHT . AS A NURSING HOME RESIDENT, the facility failed to maintain a safe, comfortable, and homelike environment as evidence by: 1) Exit door at end of 100 hall was scraped, dirty with an unknown black substance. The door was in view of residents on the hall. 2) Resident Identfier's (RI) #15, RI #92, and RI #340 bathrooms' ceiling tiles were missing. This deficient practice affected the residents on the 100 hall and RI #15, RI #92, and RI #340 bathrooms. This was cited as a result of the investigation of complaint/report number AL00042921. Findings Include: A review of a facility's document titled, YOUR RIGHT . AS A NURSING HOME RESIDENT, with no effective date revealed the following: . Federal law require us .to provide . a safe, clean, comfortable and homelike environment . On 03/02/2025 at 2:51 PM, RI #340's bathroom tiles were observed to be missing from the ceiling. On 03/02/2025 at 2:55 PM, the ceiling tiles in RI #92's bathroom were observed to be missing and the RI #92 stated the tiles had been missing for about a month. On 03/04/2025 at 1:35 PM, RI #340's bathroom tiles were observed to be missing from the ceiling. On 03/05/2025 at 3:28 PM, the Surveyor observed the exit door at end of 100 hall. The door was scraped, dirty with unknown black substance. The door was in view of residents on the hall. On 03/14/2025 at 10:28 AM, RI #340's bathroom tiles were observed to be missing from the ceiling. On 03/14/2025 at 10:22 AM, the ceiling tiles in RI #92's bathroom were observed to be missing. On 03/14/2025 at 3:50 PM an interview with conducted with Assistance Maintenance Staff. The AMS was asked to describe the ceiling in the bathroom of RI #15's room. He said he had to cut the area out to actually get in the ceiling to see where the leak was coming from. He further said there was also water stain in the ceiling. The AMS was asked when did the leak occur, he said last month some time. When asked why was the area still opened, he said the facility was working on getting it covered up now. The AMS was asked if it was considered homelike, he said no. 21055

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48195 Based on observation, interviews, a review of the facility's investigative file, and a review of a facility's policy titled, Grievance/Concern, the facility failed to ensure a Grievance/Concern filed on 05/15/2024 by Resident Identifier (RI) #117 and RI #117's Resident Representative (RR) was resolved when CNA #44 went back into RI #117's room to provide care on 05/31/2024 after being instructed not to enter RI #117's room. This deficient practice affected one of 29 sampled residents. Findings include: A review of the facility policy with a revised date of 07/19/2023 titled, Grievance/Concern documented: . POLICY . The patient/resident (hereinafter patient) has the right to voice grievances to the Center or other agency or entity that hears grievances . Such grievances include those with respect to care and treatment, which has been furnished as well as that which has not been furnished, the behavior of staff and of other patients, and other concerns regarding their Center stay. PURPOSE To assure prompt receipt and resolution of patient or representative grievance/concern. RI #117 was admitted to the facility of 08/23/2023 and readmitted [DATE] with a diagnoses to include Cerebral Infarction Due to Thrombosis of Left Anterior Cerebral Artery, Chronic Obstructive Pulmonary Disease (COPD), and Hypertension. A review of RI #117's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/11/2024 revealed a Brief Interview of Mental Status (BIMS) of 15 of 15 which indicated RI #117 was cognitively intact. A review of a facility investigative file documented: . prior incident with CNA #44 was referenced . On 05/15/2024, CNA #44 was coached on (his/her) tone used during care of residents. (RI #117) was the resident that raised this concern and grievance form was completed at that time. A document dated 05/15/2024 titled, Grievance/Concern Form documented: . Resident and representative said did not like a male CNAs tone when caring for (him/her) . Grievance/ Concern resolution: CNA was educated and will not have this resident in near future . A separate form attached to Grievance/Concern form signed by RN #45 and RN #4 documented: . (RN #45 and RN #4) asked CNA #44 to not go back in to care for RI #117 due to resident and RR stating they did not like (his/her) tone while caring for resident . (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/07/2025 12:47 PM an interview with RI #117 was conducted. RI #117 recalled the incident when he/she asked CNA #44 not to return to his/her room. RI #117 said one morning early while he/she was sleeping, CNA #44 came into his/her room, yanked the covers off and told RI #117 he/she was going to provide incontinent care. RI #117 said he/she did not call for assistance and said it scared me. RI #117 said he/she felt uncomfortable, and startled as he/she did not recognize CNA #44. RI #117 asked CNA #44 to leave the room and RI #117 notified the unit manger immediately of what occurred. RI #117 said the facility made notifications to the local police and the responsible party, and he/she had not seen CNA #44 again. On 03/11/2025 at 4:14 PM an interview was conducted with the Social Service Director (SSD) who was also the Grievance Coordinator. SSD said she was not aware of the incident that occurred on 05/15/2024 where RI #117 and the RR had filed a grievance regarding CNA #44. SSD said she was aware of the second incident on 05/31/2024 when the RR came to the facility and was livid because CNA #44 had entered the room and provided care after it had been requested that CNA #44 not go back into RI #117's room. When asked if the Grievance policy was followed in this situation, SSD said no, that everyone should have been made aware of RI #117 's request not to have a male CNA in his/her room, and CNA #44 immediately removed off RI #117's section. SSD said this would have prevented the second incident on 05/31/2024 from occurring. On 03/11/2025 at 11:17 AM an interview was completed with RN #4 who was acting as the Assistant Director of Nursing on 05/15/2024. RN #4 said she recalled the incident on 05/15/2024. RN #4 said RI #117 and the RR called her down to RI #117's room and said they did not want CNA #44 back into care for RI #117. RN #4 said a grievance was filed by RN #45, and both RN #4 and RN #45 counseled CNA #44. RI #4 said CNA #44 was told at that time not to go back into RI #117's room. RN #4 said she was not aware that CNA #44 had returned to RI #117's on 05/31/2024 to provide care. RN #4 said CNA #44 should not have been assigned to RI #117's room after 05/15/2024 when grievance filed. When asked if RI #117's grievance was resolved since CNA #44 re-entered RI #117's room, RN #4 said no. When asked what the importance of resolving a grievance, RN #4 said resident satisfaction .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29671 Based on interviews, resident record reviews, review of a facility policy titled Abuse Prohibition, review of Facility Reported Incidents (FRIs) received by the State Agency, and review of the facility's investigative files, the facility failed to protect the residents' right to be free from physical, mental, and verbal abuse perpetrated by staff and residents. On 07/25/2023 around 9:15 AM Resident Identifier (RI) #60 was mentally abused by Certified Nursing Assistant (CNA) #41 and RI #287 was physically abused by RI #60 while outside at the smoking area with other residents and staff present to witness the abuse. RI #60, a resident with a history of behaviors toward staff, called CNA #41 names and CNA #41 responded by throwing a metal ashtray weighing over one pound at RI #60. The ashtray thrown by CNA #41 missed RI #60 and hit the wall behind the resident. RI #60 threw the ashtray back at CNA #41. The ashtray struck RI #287 in the head and cause injury. Staff summoned assistance and reported RI #60 hit RI #287 with the ashtray. CNA #39 witnessed the incident and failed to report that CNA #41 had instigated the incident by throwing the ashtray at RI #60. CNA #41 continued working her assigned shift on 07/25/2023 and 07/26/2023, leaving RI #60 and other residents in the facility unprotected from her during that time. Staff who respond to resident behavior by throwing heavy, metal items including ashtrays are likely to inflict serious physical harm and/or serious psychosocial harm upon residents, causing fearfulness and mental anguish. It was determined the facility's noncompliance with one or more requirements of participation had 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 at F600- Free from Abuse and Neglect. On 03/19/2024 at 6:20 PM, the Administrator and Director of Nursing (DON), were provided a copy of the Immediate Jeopardy Template and notified of the findings of substandard quality of care at the immediate jeopardy level in the area of Freedom from Abuse, Neglect, and Exploitation at F600-Free from Abuse. The immediate jeopardy began on 07/25/2023 and continued until 08/21/2023 when the facility implemented corrective actions to remove the immediacy and correct the deficient practice; thus, immediate jeopardy past noncompliance was cited. The facility further failed to ensure RI #3, RI #41, RI #487, and RI #488 were protected from physical and verbal abuse that did not rise to the jeopardy level. 2.) On 05/24/2023, RI #487 and RI #488 was verbally abused by a staff member, Dietary Aid (DA) #49, who told RI #487 and RI #488 he would whoop their ass during an argument in the kitchen and dining room. 3.) On 07/01/2023, the facility failed to protect RI #41 from physical abuse that resulted in a painful broken finger and a hospital admission, when RI #487, a resident with known behavioral health needs, twisted and broke RI #41's left ring finger. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4.) On 09/12/2024, the facility failed to protect RI #3 from physical abuse that resulted in a hospital visit when RI #339, a resident with known behavioral health needs, stabbed RI #3 in the left hand with an ink pen causing pain and bleeding. Six of 18 residents sampled for abuse were found to have been abused as determined by the investigations of facility reported incident (FRI)/complaint/report numbers AL00044967, AL00044983, AL00044322, AL00044657, and AL00048800. Findings Include: Review of the facility's abuse policy titled Abuse Prohibition with a revision date of 10/24/2022, revealed the following: POLICY Centers prohibit abuse, mistreatment, neglect . for all patients . Federal Definitions: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish . Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Verbal Abuse is any use of oral, written language that willfully includes disparaging and derogatory terms to patients or their families, or within hearing distance, regardless of their ability to comprehend, or disability . Examples of verbal abuse includes, but are not limited to: threats of harm; saying things to frightened a patient . Physical Abuse includes hitting slapping, pinching, kicking, etc. Mistreatment is defined as inappropriate treatment . of a patient . Mental Abuse includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation. Mental abuse may occur through either verbal or nonverbal conduct which causes or has the potential to cause the patient to experience humiliation, intimidation, fear, shame, agitation, or degradation. PURPOSE To ensure Center staff are doing all that is within their control to prevent occurrences of abuse . for all patients . 6. Staff will identify events . 6.1 Anyone who witnesses an incident of suspected abuse . is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1.) On 07/25/2023 at 10:35 AM the State Agency received a FRI alleging an incident of RI #60 cursing CNA #41 and throwing an ashtray towards CNA #41 and instead hitting RI #287 causing an abrasion on the scalp behind RI #287's right ear. On 07/26/2023 at 7:08 PM the State Agency received a different FRI alleging Abuse-Mistreatment had occurred when CNA #41 threw an ashtray at RI #60 and the ashtray did not make contact with RI #60. RI #60 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include: Alzheimer's Disease, Dementia with Behavioral Disturbance, Schizoaffective Disorder, Bipolar Disorder, Anxiety Disorder, and Major Depressive Disorder. RI #60's annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/06/2023 documented a Brief Interview for Mental Status (BIMS) score of 12 of 15, which indicated moderate cognitive impairment. A review of RI #60's comprehensive care plan revealed RI #60 exhibited verbal behaviors/ outburst directed towards others and had a history of cursing staff and other residents. RI #287 was admitted to the facility on [DATE]. RI #287's significant change MDS assessment with an ARD of 06/02/2023 documented a BIMS score of 14 of 15 which indicated intact cognition. RI #287's progress notes contained an entry dated 07/25/2023 at 9:25 AM signed by LPN #27 as follows: . Called to the smoke porch by a staff member stated that (RI #287) had been hit in the head with (an) ash tray by another resident, . A Skin and Body Audit contained within the facility's investigative file was labeled with RI #287's name indicated RI #287 had a raised area with an abrasion behind his/her right ear. The form was signed by LPN #27. RI #287 no longer resides in the facility. On 03/11/2025 at 3:51 PM LPN #27 was asked about the incident with the ashtray. LPN #27 said, RI #60 would curse at staff and called people names. LPN #27 said, at the time of the incident it was reported that RI #60 threw an ashtray at CNA #41, but they later found that CNA #41 was the one that threw the ashtray first. LPN #27 said, CNA #41 had worked with RI #60 before and knew how to deal with RI #60's behaviors, she was a seasoned CNA and knew how to deal with aggressive residents. LPN #27 said, CNA #41 throwing the ashtray at RI #60 was mental abuse and she triggered RI #60's behavior and it would have made RI #60 feel upset and angry. The facility investigative file contained a typed statement for RI #60 dated 07/26/2023 which documented the following: . Do you remember an incident on the smoking porch that involved an ashtray? . Yes, I threw an ashtray at that black girl and hit another (resident) with it. I didn't mean to hit (him/her) with the ashtray. I was throwing it at that bitch that threw it at me and tried to hit me with it. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/17/2025, an interview took place at 2:47 PM, with RI #60. During the interview, RI #60 was questioned regarding the event from 07/25/2023, which involved the throwing of an ashtray. RI #60 stated he/she did not remember the incident. The facility investigative file contained a handwritten witness statement dated 07/27/2023, signed by CNA #39 who witnessed the abuse, which documented: . On 7/25/23 I (CNA #39) was working west wing around 9:20 am. I was on the smoke porch with residents and another employee (CNA #41). (RI #60) was calling (CNA #41) a black bitch and stated she smoke crack and sell drugs. (CNA #41) grabs an ashtray off the table and threw it at (RI #60). it hits the wall and (RI #60) picks up the ashtray and throw it back at her (CNA #41) but it hits (RI #287) in the head (RI #60) apologize to (RI #287) saying (he/she) didn't mean to hit (him/her). Surveyors attempted and were unable to reach CNA #39 for interview during the survey. The facility investigative file contained a typed witness interview signed by CNA #40, who did not witness the abuse, but was informed of what took place by CNA #41, which documented: . On 07/25/23 at (approximately 10:00 PM) . (CNA #41) called me . She said, . I will tell you why that mother fucker, (RI #60), went out today. She then proceeded to tell me that (RI #60) was outside yelling Fuck these bitches . Then (CNA #41) told me that she asked (RI #60) who (he/she) was talking about . I am talking about you, . (CNA #41) then told me that she picked up a metal ashtray and threw it at (RI #60). She said she missed (him/her) and it hit the wall and fell on the ground beside (RI #60's) chair. She said she was throwing it at (RI #60). I asked her why in the world she would do that and she told me that she hated that mother fucking bitch. she said that (RI #60) picked that ashtray up and flung it back at her. She said that m . f . is so stupid that (he/she) missed me and hit another resident with it. On 03/18/2025 at 10:15 AM CNA #40 was asked about the incident involving RI #60 and CNA #41. CNA #40 recalled receiving a phone call from CNA #41 around 10:00 PM on 07/25/2023 when she was informed by CNA #41 that she had thrown an ashtray at RI #60. CNA #40 stated, the next morning she contacted CNA #41 to confirm what happened. CNA #40 said, CNA #41 verified for her that she had thrown an ashtray at RI #60. CNA #40 said, it was then that she reported incident to the facility. CNA #40 said, the incident would cause fear and most likely increase agitation in RI #60, who was known to exhibit behaviors, including cursing at staff. Regarding the facility's abuse policy, she stated any incidents of abuse should be reported immediately. On 03/04/2025 at 4:18 PM an interview was conducted with the Social Services Director (SSD) regarding the incident on 07/25/2023 involving RI #60 and CNA #41. SSD said, she was off that day, but did recall the incident. When asked to describe the ashtray thrown the day of the incident, SSD said they were bulky, metal, circular, and it had a piece that opened where the ashes go inside. The SSD said the ashtray was the same ashtrays used currently at the facility. On 03/17/2025 at 4:15 PM the ADM was questioned about the incident involving RI #60 and CNA #41. The ADM indicated that the report was substantiated as mistreatment and CNA #41 intended to strike RI #60 by throwing an ashtray at him/her. The ADM said prompt reporting of abuse was important for the safety of the residents. The ADM said if staff witnessed another staff member throw an ashtray at a resident, they should act to protect the resident at all times and report the incident immediately. (continued on next page)

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	03/19/2025

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/18/2025 at 10:49 AM the Former Administrator (FADM) who was the Administrator at the time of the incident was questioned about the incident involving RI #60 and CNA #41 on 07/25/2023. The FADM indicated she was initially called by the Director of Nursing (DON) who reported to her that RI #60 had thrown an ashtray at RI #287 and plans were made to send RI #60 out to the hospital for evaluation. The FADM said it was not until the next day she received a call back from the DON stating RI #60 had been the one abused by CNA #41. The FADM said the facility became aware when CNA #40 called the DON and reported that CNA #41 called her on the phone and told her that she, CNA #41, was the one that threw the ashtray at RI #60. The FADM said CNA #41 was then suspended and terminated. The FADM said it was discovered through interviews that CNA #41 actually threw the ashtray a second time at RI #60. The FADM said CNA #39 and CNA #40 were both terminated also for failing to report abuse timely when it occurred. When questioned about what occurred prior to the alteration, the FADM said from what she recalled RI #60 had been cursing CNA #41, who became upset and reacted by throwing the ashtray at RI #60. When asked how staff should respond in a situation when a resident was exhibiting aggressive behavior, FADM said staff should have reported the aggressive behavior to the unit manager, but they did not. The FADM said, if staff got upset and responded by throwing an ashtray at a resident, someone could be harmed. The FADM said the incident involving CNA #41 throwing a metal ashtray at RI #60 was substantiated by the facility. CNA #41's printed time sheet documented CNA #41's last two days worked were on 07/25/2023 from 6:56 AM until 2:55 PM and on 07/26/2023 from 7:18 AM until 2:55 PM. ********** The facility took action to correct the noncompliance including: 07/25/2023, RI #60 was immediately brought into facility and placed on 1:1 with supervisor until sent out for psych evaluation 07/25/2023 - Body audits completed on both residents 07/25/2023 - Report made to ADPH 07/25/2023 - Police report filed with police department 07/25/2023 - Investigation initiated 07/25/2023 - Care Plans updated 07/26/2023 2nd report to ADPH 07/26/2023 - RI #60 seen by provider - medications adjusted for agitation 07/26/2023 - RI #287 assessed by provider - noted as stable 07/27/2023- CNA #41 was suspended until she was terminated on 08/02/2023 07/29/2023- CNA #39 was suspended until she was terminated on 08/02/2023 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	07/30/2023 - Interview: residents to rule out abuse and with staff members to ensure no unreported abuse 07/31/2023 - RI #60 seen by IBH provider - no behaviors noted; continues on IBH monthly 08/01/2023 - 100 percent of body audits completed - no concerns noted 08/01/2023-CNA #40 was suspended and terminated 08/08/2023- All staff educated on Behavior Management Education. 08/15/2023 - Monitoring behaviors and abuse through QAPI process 08/21/2023 - All staff educated on abuse and reporting abuse - completed by local ombudsman ********** After review of documentation supporting the above corrective actions, including the facility's investigation file, in-service/education records, QAPI documentation, and staff interviews, the survey team verified the facility implemented corrective actions including ongoing monitoring from 07/25/2023 to 08/21/2023 thus immediate jeopardy past non-compliance was cited. 48195 2.) On 05/24/2023 at 10:52 AM the State Agency received a Facility Reported Incident that alleged verbal abuse involving RI #488 and RI #487 and Dietary Aide (DA) #49. The FRI documented . It is reported that (DA #49) . told both these residents he would whip their ass. (DA #49) is suspended pending outcome of the investigation. RI #487 was admitted to the facility on [DATE]. RI #487's annual MDS with an ARD of 03/30/2023 documented a BIMS score of 14 of 15 which indicated intact cognition. The facility investigative file contained a typed witness statement signed by RI #487 dated 05/24/2023 in which RI #487 reported the guy in dietary said he was going to whoop RI #487's ass. RI #488 was admitted to the facility on [DATE] and had diagnoses to include: Dementia without Behavioral Disturbance and Major Depressive Disorder. RI #488's quarterly MDS assessment with an ARD of 05/17/2023 documented RI #488 scored a 13 of 15 on the BIMS which indicated intact cognition. The facility's investigative file contained a typed witness statement signed by RI #488 dated 05/24/2023, which documented: . (RI #487) came to me and said that guy in dietary . told (him/her) he would whoop (his/her) ass. (RI #487) wanted a grilled cheese sandwich and he told . (RI #487) (he/she) could not have one. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	I went to the kitchen to see why (RI #487) couldn't get a grilled cheese and then it escalated to where he (DA #49) told me he would whoop my ass and I gave him a chance. I got out of my wheelchair and he (DA #49) walked toward me and then I walked toward him and it escalated from there. He told me he was going to whoop my ass too. The facility investigative file contained a typed statement signed by Floor Tech (FT) #30, dated 05/25/2023 which documented: . Yesterday morning when the commotion was taking place in the kitchen doorway, I was coming in from the smoke porch. (DA #49) came in right before me. (RI #488) was sitting in the doorway of the kitchen. (RI #488) stood up and said, I want to see you kick my ass. (DA #49) stated You better stop playing with me before I push you back down in that wheelchair. (RI #488) . said, (RI #487) said you were going to kick my ass and I want to see you kick my ass. I got between the two of them. I was afraid they were actually going to fight. On 03/07/2025 at 9:12 AM an interview was conducted with Floor Tech (FT) #30 who witnessed the incident on 05/24/2023 between DA #49 and RI #488. The FT verified his typed statement. The FT said, when he came in from the back kitchen door, he saw DA #49 and RI #488 arguing in the doorway of the kitchen. The FT said, he saw DA #49 and RI #488 cursing one another and threatening to kick each other's ass. The FT said, the DA was visibly angry and RI #488 was red in the face and he physically got in between the two to prevent a physical altercation. The FT said, the cursing was loud and that it was a seven on a scale of one to ten and it was verbal abuse. The facility investigative file contained a final summary signed and dated 05/26/2023, by the Former Administrator (FADM) which documented . There were several staff members in or around the area when this argument was taking place. Conclusion: Unfortunately, the allegation that (DA #49) told RI #488 that he would whip (his/her) ass is substantiated. verbal abuse is substantiated. The employee (DA #49) has been terminated . ********** The facility took immediate action to correct the noncompliance including: 05/24/2023- Reporting Abuse timely and suspending DA #49 and terminated on 05/26/2023 05/25/2023 - AD Hoc Residents Rights 05/26/2023-Final summary substantiating verbal abuse and termination of perpetrator 05/29/2023 - Psychosocial Assessment for both residents 05/30/2023 - Resident Statements 06/24/2023 - Resident Rights In-Service 06/24/2023 - How to Manage Difficult People 06/24/2023 - Review Care Plans for both Residents with appropriate revisions 06/05/2023 - RI #487 seen by IBH provider, 06/23/2023, 07/01/2023, and 07/31/2023 (continued on next page)

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	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	09/26/2023 - RI #487 on Behavior Monitoring until discharge 09/28/2023- RI #488 was seen by provider without any documented complications until discharge ********** After review of documentation supporting the above corrective actions, including the facility's investigation file, in-service/education records, QAPI documentation, and staff interviews, the survey team verified the facility implemented corrective actions including ongoing monitoring from 07/25/2023 to 09/28/2023, and past non-compliance was cited. 3.) On 07/01/2023 at 10:05 AM, the State Agency received a FRI which reported and alleged an incident between RI #41 and RI #487 who had an argument. The report alleged that RI #487 bent RI #41's finger, the residents were separated, and RI #487 was placed on one-on-one. The report indicated an x-ray was to be obtained of RI #41's finger. The facility investigative file contained an undated final summary which documented . Complaint: (RI #487) became angry because (he/she) said (RI #41) yelled at (him/her) for turning on a TV and waking (him/her) up. (RI #487) walked over to (RI #41's) side of the room, where (RI #41) was in the bed, and hit (him/her) on the fist with (his/her) fist and twisted (RI #41's) left hand. Staff heard an argument in the room but did not witness the actual event. It has been determined that (RI #487) did hit (RI #41) on the fist and did twist (his/her) finger. The allegation has been substantiated. RI #41 was admitted to the facility on [DATE] with diagnoses to include End State Renal Disease, Congestive Heart Failure, and Diabetes Mellitus. RI #41's quarterly MDS assessment with an ARD date of 05/26/2023 documented a BIMS score of 14 out of 15 which indicated intact cognition. RI #41's Radiology Interpretation with an exam date of 07/01/2023 at 12:11 PM for two views of the left hand documented: . Significant Findings . There is a mildly displaced, comminuted fracture of the proximal phalanx of the ring finger. Impression: Acute fracture of the ring finger. RI #41's hospital record titled Rounds Report dated 07/01/2023 documented: . Reason for Admission: . ASSAULT . RI #487 was admitted to the facility on [DATE] and had diagnoses to include: Vascular Dementia with Behavioral Disturbance, Mood Disorder with Depressive Features, and Adjustment Disorder with Depressed Mood. RI #487's annual MDS with an ARD of 03/30/2023 documented a BIMS score of 14 out of 15 which indicated intact cognition. The MDS also documented that RI #487 had less than daily Behavioral Symptoms of verbal behaviors symptoms directed towards others. A review of RI #487's Comprehensive Behavior Care Plans with a start date of 07/12/2019 documented the following behavior problems for RI #487, but did not include what level of supervision RI #487 would require to keep residents safe. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1) . RI #487 exhibits or has the potential to exhibit verbal behaviors related to cognitive loss/Dementia. RI #487 has a history of verbal outburst. (He/She) is easily frustrated. (He/She) gets agitated, yells out, and curses because (he/she) wants to go home . 2) RI #487 exhibits or has the potential to exhibit physical behaviors related to Dementia . Date initiated 09/22/2021 . 3) RI #487 is resistive to care related to difficulty adjusting to the facility and cognitive loss/Dementia . Date initiated 04/08/2020 . The facility investigative file contained a typed statement signed by RI #487 dated 07/04/2023 which documented: . Last Saturday I was in my room with my roommate. (He/she) woke up and started cursing because I turned on the TV. (He/she) woke up and started bitching like hell and yelled at me. I went over to (his/her) bed because (he/she) was yelling at me. (He/she) had (his/her) fist drawn up and pulled back. I balled my fist up and hit (his/her) fist and then I grabbed (his/her) hand and twisted it. I had had enough of (him/her) yelling at me and I just blew up. We yell out at each other all the time but most of the time it is just playing. The facility investigative file contained a typed statement signed by RI #41 dated 07/03/2023 which documented: . This past weekend there was something that happened between me and my roommate (RI #487). I don't remember saying anything to (him/her) . (He/she . came over to my side of the room, grabbed my fingers on my left hand and started twisting them hard. I am not afraid being here and I am o.k. I just do not want (him/her) to be my roommate anymore. On 03/03/2025 at 9:45 AM RI #41 was questioned about the incident on 07/01/2023 with roommate RI #487. RI #41 recalled the incident and said he/she was lying in bed that morning and RI #487 came over and twisted his/her left ring and pinky finger. RI #41 said, he/she could not recall anything that may have triggered RI #487 to act in that manner. RI #41 said RI #487 was crazy and would do things that did not make sense. RI #41 said, he/she called the staff to report the incident, they sent RI #487 out to the hospital and transferred him/her for an X-ray which showed a fracture. RI #41 said, the pain was a 10 on a scale of 1-10. On 03/14/2025 at 11:26 AM the ADM was interviewed and questioned about the incident on 07/01/2023 between RI #41 and RI #487. The ADM said, she was not present during that time and referred to the reportable and five-day or final investigative summary submitted to the State agency. The ADM said on 07/01/2023 at 10:20 AM the State Agency was notified that roommates RI #41 and RI #487 had an argument (over the TV being turned on). RI #487 bent RI #41's finger, upon staff entrance to the the room, RI #487 admitted to twisting RI #41's finger. The ADM continued, nursing staff intervened, assessed, provided protection, an X-Ray of RI #41's left ring finger was ordered, and once a fracture was detected, RI #41 was sent out for treatment. The ADM said an investigation was conducted and it was determined that the allegation of abuse was substantiated and this was physical abuse. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/06/2025 at 12:27 PM an interview was conducted with Social Service Assistant (SSA) regarding the incident on 07/01/2023 between RI #41 and RI #487. SSA said RI #41 and RI #487 had been roommates for a few months. When asked if there had been any disagreements or issues between RI #41 and RI #487, SSA said yes, but that they had always resolved the issue between themselves. The SSA said she spoke with RI #41 after the incident, and RI #41 was very upset. When asked how this could have been prevented, SSA said possibly addressing the signs of the micro aggressive behaviors between RI #41 and RI #487. The SSA said it was physical abuse when RI #487 twisted RI #41's finger. ********** The facility took immediate action to correct the noncompliance including: 07/01/2023- RI #487 immediately placed on 1:1 Observation 07/01/2023 - RI #487 sent out to Hospital for Psychiatric Evaluation 07/01/2023 - X-Ray of RI #41's finger obtained 07/01/2023 - Body Audits to both residents 07/01/2023 through 07/04/2023 - Interviews with Staff and Residents 07/03/2023 - Interview with RI #41 07/04/2023 - Interview with RI #487 07/15/2023 and 08/15/2023 QAPI to monitor abuse and behaviors. 08/15/2023 - Behavior Antipsychotic Review 08/21/2023 - Ombudsman Abuse In- Service 07/04/2023 - Room change upon RI #487's return from the hospital 07/01/2023 and 07/31/2023 RI #487 seen by IBH Provider 09/26/2023 - RI #487 discharged home. It was recommended on discharge that resident continue IBH services RI #487 remained on Behavior Monitoring from the time of the incident (07/01/2023) until discharge 09/26/2023 RI #487 continued being followed by psychiatric services provider until discharged on [DATE]. ********** (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	After review of documentation supporting the above corrective actions, including the facility's investigation file, in-service/education records, QAPI documentation, and staff interviews, the survey team verified the facility implemented corrective actions including ongoing monitoring from 07/01/2023 through 09/26/2023, thus, past non-compliance was cited. 33738 4.) RI #3 was readmitted to the facility on [DATE] and had diagnoses that included Vascular Dementia. RI #3's admission MDS assessment with an ARD of 07/19/2024 documented long- and short-term memory problems and moderately impaired cognition. RI #339 was admitted to the facility on [DATE] with diagnoses to include Depression and Post-Traumatic Stress Disorder. RI #339's quarterly MDS assessment with an ARD of 07/17/2024 documented a BIMS score of 15 of 15 indicating intact cognition. RI #339 had a care plan initiated 08/15/2024 to address the focus area of exhibiting verbal behaviors, history of verbal outbursts directed at others, uses of abusive language, pattern of challenging/confrontational verbal behavior, but did not include what level of supervision RI #339 required to keep residents safe. Further review of RI #339's medical record revealed comprehensive care plans, progress notes, and IBH notes describing some of RI #339's behaviors leading up to the incident on 09/12/2024. RI #339's IBH notes documented behaviors on several visits. The IBH notes did not include clear recommendations or interventions to manage RI #339's behaviors and mental health symptoms. IBH notes reviewed were dated 08/23/2024 and 09/06/2024. RI #339's progress notes included documented behaviors on 07/02/2024, 08/19/2024, 09/03/2024, 09/12/2024 at 11:31 AM and 9:09 PM. The facility reported a FRI that alleged that on 09/12/2024 at 10:45 PM RI #339 stabbed RI #3 in the left hand with an ink pen causing a gash. The residents were separated, and Emergency Medical Services (EMS) were requested, and the Police were notified. The facility investigative file contained a form titled, INVESTIGATION REPORT for RI #3 dated 09/14/2024 which documented on 09/12/2024 Licensed Practical Nurse (LPN) #38 called and reported to the Administrator (ADM) and Director of Nurses (DON) that RI #339 stabbed RI #3 in the left hand. A Conclusion to the report was documented as follow: In conclusion, the facility completed an investigation and there is sufficient evidence to substantiate an allegation of physical abuse (Resident to Resident). (RI #3) transferred to the hospital on 9/12/24 for evaluation of (his/her) left hand. (RI #3) is monitored for any psychosocial changes. (RI #339) transferred to three different hospitals on 09/13/24. After the incident, the residents were separated as roommates. The facility staff was also reeducated on abuse reporting and reporting any roommate incompatibility. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of RI #3's hospital medical record indicated he/she was admitted date on 09/12/2024. The hospital medical record document titled ED (Emergency Department) Provider Documentation documented: Chief Complaint: . STABBED IN LEFT HAND/MIDDLE FINGER WITH PEN BY ROOMMATE . History of Present Illness . presents to the ER with a stab wound to . left hand. Patient is currently at a nursing home. states that (he/she) got in a fight with another resident. stabbed . in the left hand with a pen. Wash and repair the wound as necessary. Procedure Laceration repair . Laceration 1 cm (centimeters) in length . left hand . Stab wound to left hand . The facility investigative file contained a handwritten statement signed by RI #3 dated 09/13/2024 which documented: . What happened last night? (RI #339) accused me of stealing (his/her) remote control. I told (him/her) I did not have (his/her) remote control. (RI #339) was very upset. (RI #339) was screaming. (RI #339) pulled my cell phone and charger out of the garbage can and threw them at me. I was sitting in my wheelchair in close proximity to (RI #339). (RI #339) stabbed me with an ink pen in my left hand. I put my hand . up to defend myself. The nurse came in the room and placed me by her cart at the nurses station. On 03/02/2025 at 3:50 PM an interview was conducted with RI #3. RI #3 stated, RI #339 was his/her roommate and would yell out at times. RI #3 stated, on 09/12/2023 RI #339 stabbed his/her hand and he/she was sent to the hospital and r [TRUNCATED]

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	015133	A. Building B. Wing	03/19/2025

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055 Based on interviews, record review, review of facility policies titled, Medication Administration Controlled Substances and Abuse Prohibition, review of the facility's investigative file and review of information from the Alabama Department of Public Health's (ADPH) Online Reporting System, the facility failed to ensure Resident Identifiers (RI) #'s 15, 21, 40, 76, 79, 103, 108, and 113 were free from misappropriation of property when the resident's controlled substances were unable to be accounted for after Registered Nurse (RN) #33 removed the resident's controlled substances from the medication cart on 11/13/2024 on the 7 PM to 7 AM shift. This deficient practice affected RI #'s 15, 21, 40, 76, 79, 103, 108, and 113 eight of 11 residents reviewed for misappropriation of property, and affected two of two medications carts on the Rehab Hall. This deficiency was cited as a result of the investigation of a facility reported incident/complaint/report number AL00049756. Findings Include: The facility policy titled Medication Administration Controlled Substances, dated 2007 and 01/2025, revealed the following: . CONTROLLED SUBSTANCES POLICY Controlled Medications are substances that have an acceptable medical use (medications which fall under U. S. (United States) Drug Enforcement Agency (DEA) Schedules 11-V), have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. These medications are subject to special handling, storage, disposal, and record keeping at the nursing care center, in accordance with federal and state laws and regulations. PROCEDURES . 3. Controlled medications are obtained from the locked cabinet or safe, or medication cart. 4. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record when removing dose from controlled storage . a. Date and time of administration b. Amount administered c. Signature of the nurse administering dose (continued on next page)

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	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Administer the controlled medication and document dose administration on the MAR (Medication Administration Record) . The facility policy titled Abuse Prohibition, with a revision date of 10/24/2022, revealed the following: POLICY Centers prohibit . misappropriation of resident/patients . property . Federal Definitions: . Misappropriation of patient property is defined as the deliberate misplacement, . or wrongful, temporary or permanent use of a patient's belongings . without the patient's consent . A review of an ADPH Online Facility Reported Incident dated 11/14/2024, revealed the following: . Incident Type . Select Category: . Abuse - Misappropriation of Resident Property . Incident Detail . Name of alleged perpetrator(s): (name of RN #33) . Narrative summary of incident: Resident states (he/she) did not get (his/her) pain medication. Action(s) taken by the facility in response to the incident. Investigation immediately initiated. Review of the facility's INVESTIGATIVE REPORT, dated 11/19/2024, revealed the following: . Allegations Details: . (RN #35) , informed . (the Director of Nursing (DON)) that the residents on the Rehab Unit stated; they did not receive their pain medication as requested on 11/13/2024 on the 11-7 shift. The name of the resident involved . (RI #15) . Investigation Details . (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The investigation revealed that the nurse (RN #33) had signed out the narcotics for 8 PM, 9 PM and 10 PM on the Controlled Drug Record but failed to administer the narcotic medications to the residents. (RN #33) stated she did not give any narcotic medications prior to her unplanned departure at 9:26 pm. She stated she placed the pills in a cup with the residents' name on the cup and locked them in the medication cart. (RN #33) pulled the routine narcotics, as well as, PRN (as needed) for administration (this is not the facility protocol for medication administration); however, the residents stated they did not get the medicine. In addition, the relieving nurses and medication aide did not observe the medications in the cart and the residents informed them of the missed doses of narcotics. The narcotic medications could not be located and hasn't been to date. Conclusion: In conclusion, the facility completed an investigation and could not determine where the narcotic medications were placed; therefore, Misappropriation of Residents Property cannot be substantiated . Although we are unable to determine what happened to the narcotic medication, the facility can establish that the Medication Administration Policy and Procedure was violated causing this occurrence . (1) RI #15 was admitted to the facility on [DATE]. RI #15 had diagnoses that included Low Back Pain and Other Chronic Pain. A review of RI #15's November 2024 Order Summary Report (Physician Orders) revealed an order for Oxycodone 10 mg (milligrams) 1 tablet by mouth every 12 hours as needed (PRN) for pain. RI #15's Controlled Drug Record revealed RN #33 signed the Controlled Drug Record that she removed one Oxycodone 10 mg tablet on 11/13/2024 at 8 PM. RI #15's November 2024 MAR revealed that Oxycodone 10 mg was not administered to RI #15 on 11/13/2024. (2) RI #21 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #21 had diagnoses that included Other Chronic Pain and Chronic Pain Syndrome. A review of RI #21's November 2024 Physician Orders revealed an order for Gabapentin 600 mg 1 tablet by mouth three times a day for pain. RI #21's Controlled Drug Record revealed RN #33 signed the Controlled Drug Record that she removed one Gabapentin 600 mg tablet on 11/13/2024 at 9 PM. RI #21's November 2024 MAR revealed that the 10:00 PM scheduled dose of Gabapentin 600 mg was not administered on 11/13/2024. On 03/06/2025 at 11:11 AM an interview was conducted with RI #21. RI #21 said he/she remembered not receiving his/her pain medication in on 11/13/2024. (3) RI #40 was admitted to the facility on [DATE]. RI #40 had diagnoses that included Pain in Right Toes and Pain in Left and Right Hands. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RI #40's November 2024 Physician Orders revealed an order for Hydrocodone-Acetaminophen 5-325 mg every 8 hours for pain. RI #40's Controlled Drug Record revealed RN #33 signed the Controlled Drug Record that she removed one Hydrocodone-Acetaminophen 5-325 mg tablet on 11/13/2024 at 10 PM. RI #40's November 2024 MAR revealed that the 10:00 PM scheduled dose Hydrocodone-Acetaminophen was not administered on 11/13/2024. (4) RI #76 was admitted to the facility on [DATE]. RI #76 had diagnoses that included Epilepsy. A review of RI #76's November 2024 Physician Orders revealed an order for Lacosamide 150 mg one tablet by mouth two times a day for seizures. RI #76's Controlled Drug Record revealed RN #33 signed the Controlled Drug Record that she removed one Lacosamide 150 mg tablet on 11/13/2024 at 9 PM. RI #76's November 2024 MAR revealed that the 8:00 PM scheduled dose of Lacosamide was not administered on 11/13/2024. (5) RI #79 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #79 had diagnoses that included Pain, Unspecified and Pain in Unspecified Joint. A review of RI #79's November 2024 Physician Orders an order for Neurontin (Gabapentin) 300 mg 1 capsule by mouth two times a day for pain. RI #79's Controlled Drug Record revealed RN #33 signed the Controlled Drug Record that she removed one Gabapentin tablet on 11/13/2024 at 8 PM. RI #79's November 2024 MAR revealed that the 9:00 PM scheduled dose of Gabapentin was not administered on 11/13/2024. (6) RI #103 was admitted to the facility on [DATE]. RI #103 had diagnoses that included Pain in Right Fingers, Pain in Left Shoulder and Other Chronic Pain. A review of RI #103's November 2024 Physician Orders revealed an order for Hydrocodone-Acetaminophen 5-325 mg by mouth every 6 hours as needed for pain. RI #103's Controlled Drug Record revealed RN #33 signed the Controlled Drug Record that she removed one Hydrocodone tablet on 11/13/2024 at 9 PM. RI #103's November 2024 MAR revealed that Hydrocodone was not administered on 11/13/2024. (7) RI #108 was admitted to the facility on [DATE] RI #108 had diagnoses that included Chronic Pain. A review of RI #108's November 2024 Physician Orders revealed an order for Ultram 50 mg give 1 tablet by mouth every 12 hours as needed for pain. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RI #108's Controlled Drug Record revealed RN #33 signed the Controlled Drug Record that she removed one Ultram tablet on 11/13/2024 at 8 PM. RI #108's November 2024 MAR revealed that Ultram was not administered on 11/13/2024. (8) RI #113 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #113 had diagnoses that included Anxiety Disorder. A review of RI #113's November 2024 Physician Orders revealed an order for Ativan 0.5 mg 1 tablet by mouth every 4 hours for anxiety/agitation. RI #113's Controlled Drug Record revealed RN #33 signed the Controlled Drug Record that she removed one Ativan 0.5 mg tablet on 11/13/2024 at 9 PM. RI #113's November 2024 MAR revealed the 9:00 PM schedule dose of Ativan was not administered on 11/13/2024. Contained within the facility's investigative file was a Witness Statement, dated 11/14/2024, given by RN #33. The following was documented: . Please give your statement in detail: Employee was told by LNHA (Licensed Nursing Home Administrator) and (and) DON (Director of Nursing) that there is an allegation that narcotics were not given to some of the residents on the rehab unit last night. (RN #33) stated via (by way of) phone I pulled all of my narcs and locked them in the top drawer. I also locked the cart . My practice is to pull all the medications. I told (LPN [Licensed Practical Nurse] #20) they were pulled and labeled with the residents' name on them . (LPN #20) would have given the meds . On 03/06/2025 and 03/07/2025 unsuccessful attempts were made to contact RN #33. Contained within the facility's investigative file was a Witness Statement, dated 11/14/2024, given by LPN #20. The following was documented: . Please give your statement in detail: 1) When you took the cart on rehab from (RN #33) did you see any medication in cups with resident's name on it? No, neither cart 2) Were you able to give meds to residents on rehab during your time there? I gave to all residents who were on the call lights stating they did not get their medication and I signed off on the MARS. 3) Did you give any NARCS (narcotics) on rehab? Yes I signed them off on the NARC Book and the MAR . (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/06/2025 at 5:59 PM an interview was conducted with LPN #20. LPN #20 said she was asked to count the controlled medications with RN #33 because she was leaving. LPN #20 said there were no discrepancies and the count was accurate. LPN #20 said she did not observe any prepared medications with residents' names on the cups in the top medication drawer. LPN #20 said when the residents complained that they did not get their pain narcotic medications, she looked at the narcotic sheet (Controlled Drug Record) and RN #33 had signed the residents' medications out. LPN #20 said nurses should sign out on the narcotic sheet when the medication was pulled and then sign on the MAR that it had been given. LPN #20 said the facility's policy was that medications should be given as soon as they were prepared by the person who prepared them. Contained within the facility's investigative file was an unsigned and undated Witness Statement, given by RN #35. The following was documented: . Please give your statement in detail: Last night on 11-13-2024 there were no 2000 (8 PM) or 2200 (10 PM) meds given. All narcotics were signed out on patients but not given or left anywhere . RI #40 and RI #15 said they didn't get their pain medications . Narcotics were signed out on the book but not given and not found . On 03/08/2025 at 1:08 PM, a telephone interview was conducted with RN #35 who said there were not any pills already prepared and in medication cups with the resident's name on them in the top drawers on either medication cart when she counted the controlled medications on 11/13/2024. RN #35 said she found out residents had not received their controlled drugs when RI #40 and RI #15 came into the hall asking about their medications. On 03/11/2025 at 12:08 PM a telephone interview was conducted with the facility's Medical Director (MD). The MD said it was considered misappropriation of the residents' property when controlled drugs were signed out on the Controlled Drug Record, but not signed as administered on the MAR and were not able to be located. On 03/12/2025 at 4:11 PM, an interview was conducted with the Director of Nursing (DON). The DON said when she was made aware of the residents' concerns, her initial first concern was the residents' comfort and getting their medicine to them. The DON said when she realized it affected more than one resident, and the facility could not account for the medication she had the nurses to look for the medication. The DON said the medications were the residents' property and could not be located. On 03/13/2025 at 8:44 AM during a follow-up interview the DON said missing controlled drugs was misappropriation of the resident's property. On 03/13/2025 at 4:14 PM, a telephone interview was conducted with the Consultant Pharmacist (CP). The CP said the facility did inform her about narcotics not being administered and a nurse pre-pulling medications. The CP said it was definitely diversion when a controlled medication was signed out on the Controlled Drug Record, not signed out on the MAR as being administered, and the resident informed other staff that they had not received their medication.

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	015133	A. Building B. Wing	03/19/2025

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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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48195 Based on interviews, resident record reviews, review of a facility policy titled Abuse Prohibition, review of Facility Reported Incidents (FRIs) received by the State Agency, and review of the facility's investigative files, the facility failed to ensure allegations of abuse were reported immediately by staff to a supervisor or the Administrator so action could be taken to investigate abuse and protect residents. Specifically, on 07/25/2023, a Certified Nursing Assistant (CNA) #39 failed to immediately report that she witnessed CNA #41 throw a metal ashtray weighing over one pound at RI #60. Further, CNA #40 failed to report the allegation of abuse immediately on 07/25/2023 around 10:00 PM when CNA #41 made a telephone call to tell CNA #40 she had thrown an ashtray at RI #60. CNA #40 failed to report what CNA #41 told her until the next day on 07/26/2023. Because CNA #39 failed to report abuse immediately, CNA #41 remained in the facility and continued working until almost 3:00 PM when her shift ended on 07/26/2023. Because CNA #39 failed to immediately report witnessed abuse and CNA #40 failed to immediately report alleged abuse, residents were left unprotected when CNA #41 continued to work and have access to RI #60 and other residents. This was likely to result in further abuse and/or serious psychosocial harm, causing fearfulness and mental anguish. It was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect and Exploitation at F609-Reporting of Alleged Violations. On 03/19/2024 at 6:20 PM, the Administrator and Director of Nursing (DON), were provided a copy of the Immediate Jeopardy Template and notified of the findings of substandard quality of care at the Immediate Jeopardy level in the area of Freedom from Abuse, Neglect, and Exploitation at F609-Reporting of Alleged Violations. The IJ began on 07/25/2023 and continued until 08/21/2023 when the facility implemented corrective actions to correct the identified deficient practice and prevent recurrence; thus, immediate jeopardy past noncompliance was cited. This deficiency was cited as a result of a Facility Reported Incident/Complaint/Report Number AL00044983. Findings include: Cross-reference F600. Review of the facility's abuse policy titled, Abuse Prohibition, with a revision date of 10/24/2022, revealed the following: POLICY Center prohibit abuse . for all patients . (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Center will implement an abuse prohibition program through the following: . Identification of possible incidents or allegations which need investigation; Investigation of incidents and allegations; Protection of patients during investigations; Reporting of incidents, investigations, and Center response to the results of their investigations. Federal Definitions: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . PROCESS . 6. Staff will identify events- such as . occurrences . that may constitute abuse . 6.1 Anyone who witnesses an incident of suspected abuse . is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately, regardless of shift worked. 6.1.1 The notified supervisor will report the suspected abuse immediately to the Administrator . RI #60 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include: Alzheimer's Disease, Dementia with Behavioral Disturbance, Schizoaffective Disorder, Bipolar Disorder, Psychosis, Anxiety Disorder, and Major Depressive Disorder. RI #60's annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/06/2023 documented a 12 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated RI #60 was moderately cognitively impaired. The Online Incident Reporting System Report submitted to the State Agency on 07/26/2023 at 7:08 PM documented: . Incident Type . Abuse - Mistreatment . Name(s) of resident(s) involved: (RI #60) . Name of alleged perpetrator(s): (CNA #41) Date and time of when staff became aware of the incident: 07/26/2023 Time: 05:10 PM (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Name of staff member who became aware of the incident: (DON) Date and time of when administrator was notified of the incident: 07/26/2023 Time: 06:00 PM . Date and time of incident or alleged incident: 07/26/2023 Time: 09:30 PM Narrative summary of incident: It was reported that the Nursing Assistant, (CNA #41), threw an ashtray at resident, (RI #60). the ashtray did not make contact with (RI #60). Who made the allegation (unless it was reported anonymously), and their relationship to the alleged victim: (CNA #40) What was reported and to whom or which agency/entity: (CNA #40) reported to (DON) that (CNA #41) threw an ashtray at (RI #60) and stated that the ashtray did not make contact with the resident. The facility's investigative file contained a typed statement dated 07/27/2023 signed by CNA #39, who was present and witnessed the abuse, that documented: . On 07/25/23 did you witness (CNA #41) throw an ashtray at (RI #60)? . Yes . Do you know what caused her to throw the astray at (RI #60)? . Yes, (he/she) . was cursing at her calling her a Black Bitch. (RI #41) said to (him/her) who are you calling a bitch? Then she threw the ashtray at (him/her). Did you report to anyone that (RI #41) threw an ashtray at (RI #60)? No . Why did you not report this? . I guess I was scared. On 03/18/2025, at 10:15 AM, a telephone interview was conducted with CNA #40. During the interview, CNA #40 stated CNA #41 called her around 10:00 PM on 07/25/2023 and informed her she had thrown an ashtray at RI #60. CNA #40 said, she was not fully awake when she received the call the night of 07/25/2023, so she contacted CNA #41 the next morning to confirm what she had heard. It was not until after the second phone call with CNA #41 that CNA #40 reported the incident to the facility. Regarding the facility's abuse policy, CNA #40 stated, any incidents of abuse should be reported immediately. On 03/12/2025 at 11:26 AM an interview was conducted with the Administrator (ADM) Abuse Coordinator. The ADM was asked when CNA #39 witnessed CNA #41 throwing an ashtray at RI #60 when should she have reported the incident of alleged abuse. The ADM said CNA #39 should have reported it immediately. She further stated the timeframe for reporting an allegation of abuse was within two hours. The ADM said CNA #39 did not follow the abuse policy for reporting. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/18/2025 at 10:49 AM the former Administrator (FADM), who was the Administrator at the time of the incident on 07/25/2023, was asked about the incident. The FADM said, she was at the beach when it occurred and was notified by the DON of the initial report on 07/25/2023. The FADM said, it was the next afternoon on 07/26/2023 when she was made aware CNA #41 had thrown the ashtray first at RI #60. The FADM said the DON became aware when CNA #40 reported that CNA #41 was the one that threw the ashtray at RI #60.The FADM said, CNA #41 had continued to work in the facility on 07/26/2023 because they did not know initially what she had done. CNA #41's printed time sheet documented CNA #41's last two days worked were on 07/25/2023 from 6:56 AM until 2:55 PM and on 07/26/2023 from 7:18 AM until 2:55 PM. ********** The facility took immediate action to correct the noncompliance including: 07/25/2023, immediately brought into facility and placed on 1:1 with supervisor until sent out for psych evaluation 07/25/2023 - Body audits completed on both residents 07/25/2023 - Report made to ADPH 07/25/2023 - Police report filed with police department 07/25/2023 - Investigation initiated 07/25/2023 - Care Plans updated 07/26/2023 2nd report to ADPH 07/26/2023 - RI #60 seen by provider - medications adjusted for agitation 07/26/2023 - RI #287 assessed by provider - noted as stable 07/27/2023- CNA #41 was suspended 07/29/2023- CNA #39 was suspended 07/30/2023 - Interview: residents to rule out abuse and with staff members to ensure no unreported abuse 07/31/2023 - RI #60 seen by IBH provider - no behaviors noted; continues on IBH monthly 08/01/2023 - 100 percent of body audits completed - no concerns noted 08/01/2023-CNA #40 was suspended and terminated 08/02/2023- CNA #41 and #39 were terminated (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	08/08/2023- All staff educated on Behavior Management Education. 08/15/2023 - Monitoring behaviors and abuse through QAPI process 08/21/2023 - All staff educated on abuse and reporting abuse - completed by local ombudsman ********** After review of documentation supporting the above corrective actions, including the facility's investigation file, in-service/education records, QAPI documentation, and staff interviews, the survey team verified the facility implemented corrective actions including ongoing monitoring from 07/25/2023 to 08/21/2023 thus immediate jeopardy past non-compliance was cited. 29671 33738

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	015133	A. Building B. Wing	03/19/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39580 Based on observations, interviews, resident record review, and review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Resident Assessment Instrument 3.0 Manual, the facility failed to ensure Minimum Data Set (MDS) assessments were coded accurately. 1.) Resident Identifier (RI) #69's quarterly Minimum Data Set assessment dated [DATE] was coded to reflected RI #69 was receiving tracheostomy care, invasive mechanical ventilator and non-invasive mechanical ventilator, when RI #69 was not receiving those special services. 2.) RI #60's annual MDS assessment dated [DATE] section A1500 was not coded accurately to reflect RI #60's Preadmission Screening and Resident Review (PASRR) Level II and Serious Mental Illness. These deficient practices had the potential to affect RI #69 and RI #60 two of 29 sampled residents whose MDS assessments were reviewed. Findings include: 1.) The A review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2024, section O, revealed: .Intent: the intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specified time periods . RI #69 was readmitted to the facility on [DATE] and had diagnoses to include: Cerebrovascular Disease, Chronic Kidney Disease, Dementia, and Diabetes Mellitus. RI #69's quarterly MDS with an Assessment Reference Date (ARD) of 12/10/2024 was coded in section O to reflect RI #69 had received special treatments to include: tracheostomy care, invasive mechanical ventilator, and non-invasive mechanical ventilator. On 03/03/2025 at 11:19 AM RI #69 was observed in bed without a ventilator being used and there was not a tracheostomy in place. On 03/05/2025 at 10:00 AM RI #69 was observed in bed without a ventilator being used and there was not a tracheostomy in place. On 03/05/2025 at 03:49 PM an interview was conducted with the Clinical Reimbursement Coordinator (CRC). CRC #21 was asked about RI #69's MDS assessment and if RI #69 was on a ventilator and if RI #69 had a tracheostomy. CRC #21 stated, RI #69's MDS assessment was coded incorrectly. CRC #21 said, RI #69 being coded as receiving tracheostomy care, invasive mechanical ventilator, and non-invasive mechanical ventilator on the quarterly MDS assessment dated [DATE] was a coding error and the assessment was not an accurate assessment. 2.) Review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2024, revealed the following: (continued on next page)

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	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. A1500: Preadmission Screening and Resident Review (PASRR) . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition RI #60 was readmitted to the facility on [DATE] with a diagnosis of Major Depressive Disorder, Anxiety Disorder, and Dementia with Behavioral Problem. RI #60's medical record contained a PASRR Level II Service Determination dated 05/08/2019 that indicated RI #60 had a Serious Mental Illness. RI #60's annual MDS with an Assessment Reference Date of 06/06/2023 was marked No for the question if resident currently was considered by the state level II PASRR process to have a Serious Mental illness. On 03/11/2205 at 04:43 PM an interview was conducted with CRC #21. When asked what should have been coded in the section A1500, the CRC said, RI #21's MDS should have been coded yes. When asked the importance of accurate coding, the CRC #21 said, to reflect the best picture of the resident overall because it directed their plan of care. 34019 48195

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	015133	A. Building B. Wing	03/19/2025

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33738 Based on interview, medical record review, and review of the Preadmission Screening and Resident Review (PASRR), the facility failed to submit a new Level I for Resident Identifier (RI) #339 when a new diagnosis of Post Trauma Stress Disorder (PTSD) was given on 08/30/2024. This deficient practice affected RI #339, one of 29 residents PASRR reviewed. Findings include: RI #339 was admitted to the facility on [DATE] with a diagnosis of Depression. RI #339's medical record documented a PTSD diagnosis with an onset date of 08/30/2024. On 03/07/2025 04:56 PM, while reviewing the residents medical record, a new Level I was not found. On 03/11/2025 at 5:11 PM, an interview was conducted with SSD (Social Service Director). SSD said she was responsible for completing a new PASSR when a resident had a significant change. SSD said when RI #339 was given a diagnosis of PTSD on 08/30/2024, he/she required a new Level I PASSR to be completed, but a new Level I PASSR was not done.

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	015133	A. Building B. Wing	03/19/2025

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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 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** 21055 Based on interviews, record review, review of facility policies titled Medication Administration General Guidelines and Medication Administration Controlled Substances and review of the facility's investigative file, the facility failed to ensure Resident Identifier (RI) #'s 15, 21, 40, 76, 79, 103, 108 and 113 received their on the 7 PM to 7 AM shift on 11/13/2024 as ordered by the physician. This deficient practice affected eight of 11 residents residing on the Rehab unit reviewed for not receiving their medications as ordered by the physician. Findings Include: Cross-Reference F 602. Review of a facility policy titled, Medication Administration General Guidelines, dated 2007 and 01/2025, revealed the following: . GENERAL GUIDELINES . PROCEDURES . 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. 5. The person who prepares the dose for administration is the person who administers the dose . Documentation: 1. The individual who administers the medication dose, records the administration on the resident's MAR (Medication Administration Record) immediately following the medication being given . Review of a facility policy titled, Medication Administration Controlled Substances, dated 2007 and 01/2025, revealed the following: . CONTROLLED SUBSTANCES . PROCEDURES . 5. Administer the controlled medication and document dose administration on the MAR . Review of the facility's INVESTIGATIVE REPORT, dated 11/19/2024, revealed the following: . Investigation Details . (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with (RN #35) via (by way of) phone-(RI #35) stated; when she arrived for her 11-7 shift on 11/13/24, none of the 2000 (8 PM) or 2200 (10 PM) medications had been given . The investigation revealed that the nurse (RN #33) had signed out the narcotics for 8 PM, 9 PM and 10 PM on the Controlled Drug Record but failed to administer the narcotic medications to the residents. (RN #33) stated she did not give any narcotic medications prior to her unplanned departure at 9:26 pm. the residents stated they did not get the medicine . Conclusion: . Although we are unable to determine what happened to the narcotic medication, the facility can establish that the Medication Administration Policy and Procedure was violated causing this occurrence . 1) RI #15 was admitted to the facility on [DATE] and had diagnoses to include Depression, Mixed Hyperlipidemia, Epilepsy, Unspecified and Hyperglycemia. A review of RI #15's November 2024 Order Summary Report (Physicians Orders) revealed RI #15 had orders for Atorvastatin Calcium Oral tablet 10 mg (milligrams) by mouth at bedtime for Hyperlipidemia, Insulin Glargine 11 units subcutaneous two times a day for Diabetes, Sertraline HCl (Hydrochloric Acid) Oral tablet 50 mg by mouth two times a day for Depression, and 4 capsules of Valproic Acid Oral capsule 250 mg by mouth two times a day for Seizure Disorder. RI #15's November 2024 MAR revealed on 11/13/2024, Atorvastatin Calcium Oral tablet 10 mg, Insulin Glargine 11 units, Sertraline HCl Oral tablet 50 mg, and 4 capsules of Valproic Acid Oral capsule 250 mg were not administered at 8:00 PM as ordered by the physician. 2) RI #21 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include Parkinson's Disease, Mixed Hyperlipidemia, Chronic Pain, and Chronic Pain Syndrome. RI #21's November 2024 Physician Orders revealed RI #21 had orders for Atorvastatin Calcium Oral tablet 80 mg at bedtime for Mixed Hyperlipidemia, Carbidopa-Levodopa Oral tablet 25-100 mg by mouth three times a day for Parkinson's Disease, and Gabapentin Oral tablet 600 mg by mouth three times a day for Pain. RI #21's November 2024 MAR revealed on 11/13/2024 the following medications were not administered as ordered: Atorvastatin Calcium Oral tablet 80 mg at 9:00 PM; Carbidopa-Levodopa Oral tablet 25-100 mg at 10:00 PM; and Gabapentin Oral tablet at 10:00 PM. 3) RI #40 was admitted to the facility on [DATE] and had diagnoses to include Chronic Pain Syndrome, Hypotension, Depression, and Constipation. RI #40's November 2024 Physician Orders revealed RI #40 had orders for Cilostazol Tablet 50 mg by mouth two times a day for symptoms of intermittent claudication, Glycolax Powder 17 grams by mouth two times a day for constipation, Hydrocodone-Acetaminophen Oral tablet 5-325 mg every 8 hours for chronic pain, Midodrine HCl tablet 5 mg 2 tablets by mouth three times a day for hypotension, Senna Oral tablet 8.6 mg 2 tablets by mouth at bedtime for constipation, and Trazodone HCL Oral tablet 75 mg by mouth at bedtime for depression. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #40's November 2024 MAR revealed on 11/13/2024 the following medications were not administered to RI #40 as ordered: Cilostazol Tablet 50 mg at 8:00 PM; Glycolax Powder 17 grams at 8:00 PM; Senna Oral tablet 8.6 mg at 8:00 PM; Trazodone HCL Oral tablet 75 mg at 8:00 PM; Hydrocodone-Acetaminophen Oral tablet 5-325 mg at 10:00 PM; Midodrine HCl tablet 5 mg at 10:00 PM. 4) RI #76 was admitted to the facility on [DATE] and had diagnoses to include Epilepsy, Hyperlipidemia, Essential Hypertension, and Pain. RI #76's November 2024 Physician Orders revealed RI #40 had orders for Atorvastatin Calcium Oral tablet 40 mg by mouth one time a day for Hyperlipidemia, Carvedilol Oral tablet 12.5 mg by mouth two times a day for Hypertension, Isosorbide Dinitrate Oral tablet 40 mg by mouth three times a day for Chest Pain prevention, Lacosamide Oral tablet 150 mg by mouth two times a day for Seizures and Levetiracetam Oral tablet 500 mg by mouth two times a day for Seizures. RI #76's November 2024 MAR revealed on 11/13/2024 the following medications were not administered as ordered by the physician at 8:00 PM: Atorvastatin Calcium Oral tablet 40 mg; Carvedilol Oral tablet 12.5 mg; Isosorbide Dinitrate Oral tablet 40 mg; Lacosamide Oral tablet 150 mg; and Levetiracetam Oral tablet 500 mg. 5) RI #79 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include Unspecified Atrial Fibrillation (A-Fib), Angina Pectoris, Pain, Essential Hypertension, Chest Pain and Irritable Bowel Syndrome with Diarrhea. RI #79's November 2024 Physician Orders revealed RI #79 had orders for Carvedilol Tablet 25 mg by mouth two times a day for Hypertension, Eliquis Oral tablet 5 mg by mouth two times a day for A-Fib, Florajens3 Oral capsule by mouth at bedtime for Diarrhea/IBS (Irritable Bowel Syndrome), Neurontin Oral capsule 300 mg by mouth two times a day for Pain, Primidone Oral tablet 50 mg by mouth at bedtime for Tremors/Spasms, and Ranolazine ER (Extended Release) Tablet 500 mg by mouth two times a day for Angina. RI #79's November 2024 MAR revealed the following medications were not administered as ordered on 11/13/2024: Carvedilol Tablet 25 mg at 8:00 PM; Eliquis Oral tablet 5 mg at 8:00 PM; Florajens3 Oral capsule at 8:00 PM; Primidone Oral tablet 50 mg at 8:00 PM; Ranolazine ER Tablet 500 mg at 9:00 PM; and Neurontin Oral capsule 300 mg at 9:00 PM. 6) RI #103 was admitted to the facility on [DATE] and had diagnoses to include Seizures, Type 1 Diabetes with Hyperglycemia, Hyperlipidemia, Constipation, and Chronic Pain. RI #103's November 2024 Physician Orders revealed RI #103 had orders for Atorvastatin Calcium Oral tablet 40 mg by mouth at bedtime for HDL (High-Density Lipoprotein), Divalproex Sodium Oral tablet 500 mg 2 tablets by mouth two times a day for Seizures, Humalog Insulin injection per sliding scale before meals, Ibuprofen Tablet 800 mg by mouth two times a day for Inflammation, Glargine Insulin 36 units at bedtime for Diabetes and Sennosides Tablet 8.6 mg by mouth two times a day for Constipation. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #103's November 2024 MAR revealed on 11/13/2024 the following medications were not administered as ordered: Atorvastatin Calcium Oral tablet 40 mg at 8:00 PM; Divalproex Sodium Oral tablet 500 mg 2 tablets at 8:00 PM; Glargine Insulin 36 units at 8:00 PM; Sennosides Tablet 8.6 mg at 8:00 PM; and Ibuprofen Tablet 800 mg at 9:00 PM. 7) RI #108 was admitted to the facility on [DATE] with diagnosis to include Primary Insomnia and Hyperlipidemia. RI #108's November 2024 Physician Orders revealed RI #108 had orders for Atorvastatin Calcium Oral tablet 20 mg by mouth at bedtime for HDL and Melatonin Tablet 5 mg by mouth at bedtime for Insomnia. RI #108's November 2024 MAR revealed the following medications were not administer as ordered on 11/13/2024: Atorvastatin Calcium Oral tablet 20 mg at 8:00 PM and Melatonin Tablet 5 mg at 8:00 PM. 8) RI #113 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Anxiety Disorder and Vascular Dementia with Other Behavioral Disturbance. A review of RI #113's November 2024 Physician Orders revealed RI #113 had orders for Ativan Oral tablet 0.5 mg by mouth every 4 hours for Anxiety/Agitation. A review of RI #113's November 2024 MAR revealed the Ativan Oral tablet 0.5 mg was not administered as ordered on 11/13/2024 at 9:00 PM. Contained within the facility's investigative file was an unsigned and undated Witness Statement, given by Registered Nurse (RN) #35. The following was documented: . Please give your statement in detail: Last night on 11-13-2024 there were no 2000 (8 PM) or 2200 (10 PM) meds given. All narcotics were signed out on patients but not given or left anywhere . Looking back all meds 8 p and 10 pm were in the red; not charted . On 03/06/2025 and 03/07/2025 unsuccessful attempts were made to contact RN #33. On 03/08/2025 at 1:08 PM a telephone interview was conducted with RN #35 who said on 11/13/2024 the residents were coming into the hall asking about their medications. RN #35 said when she looked on the computer on the eMAR (electronic Medication Administration Record) everything was in red showing the medications had not been given, both controlled drugs and other medications. RN #35 said the standard of practice nurses should use when administering medications was to pop the pill from the medication card, give it to the resident, and sign the MAR that they administered the medication. RN #35 said the standard of practice nurses should use when administering a narcotic medication was to pop the pill, sign the narcotic sheet, administered the medication to the resident, and sign the MAR that it had been administered. RN #35 said the facility's Medication Administration policy indicated that medications should be administered when removed from the pill pack and the person that prepared the medication should administer it. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/12/2025 at 4:11 PM, an interview was conducted with the DON. The DON said the standard of practice nurses use when administering medications was to make sure: the right patient, right medicine, right time, right route; obtain the medication, and stay and with the resident to ensure the resident took the medication. The DON said staff documented on the MAR after the resident took the medication. The DON said the standard of practice nurses used when administering controlled drugs was the same but with narcotic medications staff signed out on the narcotic sheet when staff pulled the medication, administer the medication, and stay with the patient until the patient took the medication, then sign the MAR that the resident took the medication.

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	015133	A. Building B. Wing	03/19/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29671 Based on interviews, medical record review, and review of facility policies titled, OPS111 Elopement of Patient, and OPS100 Accidents/Incidents, facility failed to ensure Resident Identifier (RI) #48 was supervised in a manner that staff knew of his/her whereabouts and that he/she did not leave the facility without staff knowledge. The facility failed to have a system to ensure residents were unable to exit the facility without staff's knowledge and without supervision. The facility further failed to ensure the Physical Therapy Assistant (PTA) did not leave RI #48 in an unsafe area without taking measures to ensure the resident's safety when he observed RI #48 off the facility property on 02/01/2025. On 02/01/2025 around 8:40 AM, the PTA observed RI #48 in his/her wheelchair near the road, across the street from the facility. The PTA did not take immediate action, but instead parked his vehicle in the facility parking lot and entered the facility to report RI #48's whereabouts to nursing staff. The facility's investigation concluded that RI #48 exited through the facility's secured doors before the Receptionist's shift began and was unable to determine who opened the door to allow RI #48 to exit. This deficient practice affected RI #48, one of three sampled residents reviewed for elopement. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.25(d) Free of Accident Hazards/Supervision/Devices at a scope and severity of J. On 03/13/2025 at 6:09 PM, the Administrator (ADM) and the Director of Nursing (DON) were provided a copy of the Immediate Jeopardy (IJ) Template and notified of the findings of substandard quality of care at the Immediate Jeopardy level at F689 Free of Accidents Hazards/Supervision/Devices. The IJ began on 02/01/2025 and continued until 03/14/2025. On 03/15/2025 the Immediate Jeopardy was removed, F689 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 deficiency was cited as a result of the investigation of facility reported incident (FRI)/complaint/report number AL00050249. Findings include: Review of a facility policy titled, OPS111 Elopement of Patient, with a revision date of 10/24/2022, documented: . POLICY . Elopement is defined as any situation in which a patient leaves the premises or a safe area without the facility's knowledge and supervision, if necessary . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2.1 Staff witnessing a confused patient or an identified elopement risk patient attempting to leave the Unit and/or Center unaccompanied will intervene as appropriate to redirect the patient to a safe area and prevent elopement . Review of a facility policy titled,OPS100 Accidents/Incidents, with a revision date of 03/01/2024, documented: . POLICY . An incident is defined as any occurrence not consistent with the routine operation of the Center or normal care of the patient . 1. Response: . 1.1 If an employee witnesses a patient accident/incident within or outside the center premises, the employee will: 1.1.1 Provide immediate assistance and remove the individual from immediate harm . 1.1.2 Stay with the individual and summon help . RI #48 was admitted to the facility on [DATE], with diagnoses including cerebral infarction, depressed mood, psychotic disorder with delusions and muscle weakness. Review of RI #48's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 01/04/2025 revealed RI #48 had a Brief Interview for Mental Status (BIMS) score of 14, indicating he/she was cognitively intact. On 02/03/2025 at 8:48 PM, the facility report to the Alabama State Survey Agency an incident of elopement. According to the initial report, RI #48 left the facility unsupervised by staff. He/She was observed by staff and then escorted back into the facility. The facility INVESTIGATION REPORT dated 02/07/2025 documented: . Allegation Details: On February 1, 2025 (RI #48) self-propelled in (his/her) wheelchair out of the facility. Conclusion: . (RI #48) was assessed . (he/she) was confused. (he/she) stated; (he/she) was going to work . (He/she) self-propels throughout the facility at times . At the time of the occurrence (he/she) had started treatment for Urinary Tract Infection . On 03/10/2025, at 6:43 PM, the Administrator (ADM) and the Market Clinical Advisor, measured and determined that RI #48 was found 49 feet off the facility property on 02/01/2025. On 03/02/2025, at 3:30 PM, an interview was conducted with RI #48 who was unable to remember the incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/06/2025, at 4:42 PM, an interview was conducted with LPN (Licensed Practical Nurse) #43 who said that upon her arrival at work around 7 AM, she observed RI #48 seated in the hallway. At approximately 8:30 AM, she was informed by a PT staff that he had seen RI #48 outside the building upon his arrival to work. LPN #43 and LPN #42 went outside, found RI #48 in his/her wheelchair about 100 feet from the property line, and brought RI #48 inside the facility. LPN #43 said she was unaware of how he/she had exited. An interview was conducted with LPN #42 on 03/06/2025 at 5:53 PM. LPN #42 reported that at approximately 8:30 AM on 02/01/2025, she was informed by a staff member from the PT department that RI #48 was outside the facility. LPN #42 said that LPN #43 and herself went outside and found RI #48 off the facility's premises. LPN #42 said that upon reaching RI #48, the resident expressed an intention to go to work and appeared to be confused. LPN #42 said RI #48 was assisted back to the facility and assessed for injury. An interview with the PTA was conducted on 03/11/2025 at 12:32 PM. The PTA said that on 02/01/2025, at approximately 8:30 AM, he observed RI #48 in a wheelchair on the road near the stop sign. The PTA stated he recognized RI #48 as a resident of the facility and he slowed his vehicle down, but he did not stop to check on RI #48's condition. The PTA said he parked his vehicle, entered the building, and then notified a nurse that he observed a resident off the facility's premises. The PTA said that it was important for staff to stop when a resident was seen of the facility's premises to ensure the resident's safety, as the resident might not be in a normal state of mind. He acknowledged that he should have stopped to ensure RI #48's safety. An interview with the ADM took place on 03/11/2025 at 4:48 PM. The ADM stated that RI #48 had not been identified as an elopement risk and had never attempted to leave the facility previously. The ADM said the facility's investigation concluded that RI #48 exited through the front door. The ADM said the front door was secured and locked at the time RI #48 exited. The facility's investigation did not determine who let RI #48 outside. The ADM said RI #48 normally went outside. The ADM said the PTA should have stopped to check on the resident when he saw RI #48 in the wheelchair off of the facility's property. The ADM said the expectation was that staff should remain with residents and notify the facility if they observed a resident off property. A follow-up interview with the ADM was conducted on 03/13/2025 at 3:11 PM. During the interview, she was questioned about how a confused resident managed to leave the facility in a wheelchair without the staff's knowledge. The ADM indicated that to her knowledge, RI #48 either followed someone out or was permitted to exit by a staff member. When asked about the root cause of the incident, she confirmed the investigation revealed RI #48 had left the building and was off the property. Since the doors were locked, it was concluded that either a staff member or a visitor facilitated the exit. However, it remained unclear who specifically allowed RI #48 to leave the building. The ADM said there was no signage at the front door alerting staff and visitors to not allow residents to exit. The ADM said she had been the Administrator of the facility for about 11 months and it had been the facility's policy to allow residents to exit the facility to the front porch unsupervised. The ADM said residents identified as elopement risk in the elopement book at the desk were not allowed to go outside. The ADM said the Receptionist normal day started at 9:00 AM and the Receptionist would open the front door to allow visitors and residents to enter and exit the building. The ADM said the Receptionist was not working when RI #48 exited on 02/01/2025. The ADM said staff were trained to allow residents to exit the facility and go outside on the porch unsupervised unless the resident was in the elopement book. (continued on next page)

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	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	********** On 03/14/2025, the facility submitted the following as their removal plan for the identified Immediate Jeopardy: ********** Assessments: 1. Licensed Nurse completed an assessment, obtained vital signs, and completed a skin audit on RI#48 on February 1, 2025, and no injury, distress, or fatigue was noted. The Physician and Responsible Party were notified and 1:1 supervision was initiated. 2. Licensed Nurse received and executed an order for STAT CMP and CBC with diff for RI#48 on February 1, 2025. 3. The Nurse Manager and Licensed Nurses completed a 100% head count on February 1, 2025, to verify all residents were accounted for, and no additional concerns were identified. 4. Nurse Manager and/or designee completed a new Elopement Assessment on RI #48, placed a wander guard bracelet, and revised the plan of care on February 3, 2025. The Director of Nursing Services and/or designee completed an Elopement Risk Identification form for RI #48 and placed the form in the Elopement binders on February 3, 2025. Audits: 5. Licensed Nurses completed an Elopement Assessment on all residents on February 3, 2025, to identify other residents at risk for Elopement. No additional concerns were identified. The care plans were reviewed and updated as needed. 6. The Director of Nursing Services and Nurse Managers reviewed the elopement binders on February 3, 2025, to validate at risk residents had an Elopement Risk Identification form completed. 7. The Maintenance Assistant inspected 14 of 14 exit doors on February 3, 2025 to ensure doors were operational. 14 of 14 doors functioned properly with maglock keypad in place. Keypads were checked for proper opening and closing and no concerns were identified with security and/or alarms of the doors. In-services: 8. Administrator and/or designee completed one on one education with the Physical Therapist Assistant on February 4, 2025, on the Elopement Policy with emphasis on immediate actions to take if a resident is observed off the facility premises. Education included remaining with the resident, notifying the center staff by phone, and assisting the resident back into the center. Additional education was completed on Resident Safety/Supervision and Change of Condition. 9. The Nurse Practice Educator and/or designee educated all active employees on February 3, 2025, on the Elopement Policy. Education consisted of the following subcategories and topics: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Assessment/Evaluation: Licensed Nurses will complete an Elopement Risk Assessment to identify resident elopement risk upon admission, re-admission, quarterly, or with a significant change in condition. b. For residents identified as at risk; an interdisciplinary elopement prevention patient-centered care plan will be developed by a Licensed Nurse. A Licensed Nurse and/or designee will obtain a current photograph of the resident and complete the Elopement Risk Identification form to alert staff of residents considered at risk of elopement. The Elopement Risk Identification form will be place in a binder that is easily accessible to staff in designated area(s). c. Staff witnessing a confused patient or an identified elopement risk patient attempting to leave the Center unaccompanied will intervene as appropriate to redirect the resident to a safe area and prevent elopement. If staff observe a resident off the Center premises, remain with the resident, notify the center staff by phone, and assist the resident to a safe area. Unwitnessed Elopement: Staff will notify the Supervisor that the patient is missing. The Supervisor will alert all staff of the missing resident with an announcement to activate a missing resident protocol. Staff will search the interior of the Center and the exterior building perimeter and grounds. If the patient is not found after the search of the Center and grounds, law enforcement will be contacted, and Center staff will follow directions and guidance offered by law enforcement until the resident is located. Once the resident is found, a Licensed Nurse will perform a physical examination. The Licensed Nurse will notify the Physician/Advanced Practice Provider (APP) of any changes from baseline. The Licensed Nurse and/or designee will notify all parties previously contacted (resident representative, law enforcement, etc.) to inform them of the resident return or status. The nurse will document the elopement in the Nurses Notes including date, time, place, notification, and other pertinent information. d. The Nurse Practice Educator and/or designee educated all active employees on February 3, 2025, on Change in Condition and Active Infections that may contribute to cognitive changes. The team determined that when an active infection exists that results in a change in cognition a new Elopement Assessment will be completed. If the resident is identified as at risk for an elopement, the Licensed Nurse will complete an Elopement Risk Identification form and add to the elopement binders. The plan of care will be updated to alert staff of the change in elopement status by a Licensed Nurse. Active employees and employees on leave of absence (FMLA), vacation, or PRN staff who have not been educated, will be trained prior to returning to duty by the Nurse Practice Educator. Education was completed on February 5, 2025 with 106 employees; 5 employees were identified as not educated due to leave of absence, vacation or PRN status. Porch Process: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	015133	A. Building B. Wing	03/19/2025

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	015133	A. Building B. Wing	03/19/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	16. The Administrator hosted an AD HOC Quality Assurance Performance Improvement (QAPI) meeting on March 13, 2025, with the Interdisciplinary Team members to include the following disciplines: Director of Nursing Services, Regional Clinical Lead, and Nurse Mangers to review additional recommendations to prevent elopement and ensure resident safety. The facility alleges all immediate correction actions were implemented on March 14, 2025. ********** After reviewing the facility's information provided in their Removal Plan and verifying the immediate corrective actions had been implemented the Immediate Jeopardy was removed on 03/15/2025. The scope/severity level of F689 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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	015133	A. Building B. Wing	03/19/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39580 Based on observation, interview, record review, and review of the facility's policy titled, PROCEDURE - RESPIRATORY EQUIPMENT/SUPPLY CLEANING/DISINFECTING the facility failed to ensure Resident Identifier (RI) #94's Oxygen (02) concentrator water bottle was not empty during the administration of oxygen. This affected one of one sampled resident identified with humidified oxygen. Findings Include: A review of the facility's policy titled, PROCEDURE - RESPIRATORY EQUIPMENT/SUPPLY CLEANING/DISINFECTING with a revised date of 07/15/21, revealed the following: . 5. Schedule for Supply Changes: . Item . Oxygen Humidifiers . Frequency . Every 7 days . PRN . For soiling . RI #94 was readmitted to the facility on [DATE], with diagnoses including: Chronic Respiratory Failure with Hypoxemia, Chronic Obstructive Pulmonary Disease and Chronic Respiratory Failure. A review of RI #94's 14-Day Assessment Minimum Data Set (MDS) dated [DATE] revealed RI #94's Brief Interview for Mental Status score was 10 of 15 which indicated RI #94 had moderate cognitive impairment. A review of RI #94's March 2025 Physician's Orders revealed the following: . Start Date . 11/29/24 Oxygen at 4 Liters/Minute Nasal Cannula continuously . On 03/05/2025 at 09:24 AM, during the tour, RI #94's oxygen (O2) concentrator's humidification bottle was observed empty during administration of oxygen. The humidification bottle was dated 02/24/2025. The oxygen tubing was dated 03/03/2025. On 03/03/2025 at 11:11 AM, during the initial tour, RI #94's oxygen (O2) concentrator's humidification bottle was observed empty during administration of oxygen. On 03/05/2025 at 11:54 AM, an interview with the Director of Nursing (DON) was conducted. RI #94's oxygen humidification bottle was observed with the DON. The DON said the humidification bottle was dated 02/24/2025. The DON said the humidification bottle should be changed every 7 days when oxygen tubing was changed. The DON said the nurse that changed the oxygen tubing on 03/03/2025 did not follow the facility's policy because they did not change the oxygen humidifier bottle on 03/03/2025. The DON said oxygen infusing without humidification could dry out the resident's mucus membranes and cause bleeding.

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	015133	A. Building B. Wing	03/19/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48195 Based on interviews, resident record review, and review of a facility policy titled Behavioral Health Care Services, the facility failed to ensure staff utilized and implemented behavior management care plan approaches to manage Resident Identifier (RI) #60's verbal behaviors, outbursts, and cursing. Specifically, on 07/25/2023 RI #60 was outside in the smoking area with other residents (RI #287 and RI #488) and staff Certified Nursing Assistant (CNA #39 and CNA #41). RI #60 was cursing and calling staff names. CNA #41 failed to respond to RI #60 calmly and gently, and instead, CNA #41 picked up an ashtray and threw it at RI #60. The ashtray did not hit RI #60 but caused RI #60's behavior to escalate. RI #60 picked up the ashtray and threw it back at CNA #41. The ashtray did not hit the CNA, but the ashtray did hit another resident, RI #287 on the head and caused injury. It was determined the facility's noncompliance with one or more requirements of participation had cause, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 443.40 Behavioral Health Services. On 03/19/2024 at 6:20 PM, the Administrator and Director of Nursing (DON), were provided a copy of the Immediate Jeopardy Template and notified of the findings of substandard quality of care at the immediate jeopardy level in the area of Behavioral Health at F740-Behavioral Health Services. The immediate jeopardy began on 07/25/2023 and continued until 08/21/2024 when the facility implemented corrective actions to remove the immediacy; thus, immediate jeopardy past noncompliance was cited. The facility failed to manage other residents' behavioral concerns to prevent physical and verbal abuse in instances not rising to the immediate jeopardy level. 2.) Specifically, on 05/24/2023 RI #487, a resident with a history of behaviors had an altercation with a staff member which resulted in RI #487 being verbally abused by a staff member. Following the incident on 05/24/2023, the facility did not review RI #487's care plan to determine whether additional interventions were needed to manage RI #487's behaviors. On 07/01/2023 RI #487 had an altercation with his/her roommate, RI #41, which resulted in a fractured left finger. 3.) On 09/12/2024 RI #339 stabbed his/her roommate RI #3 with a pen causing pain and bleeding and RI #3 had to be transported to the hospital for evaluation. RI #339's care plans did not include the level of supervison required to ensure the safety of RI #339's roommate or other residents in the facility and did not include any focus areas, interventions, approaches, or guidance to staff to address physical aggression, throwing things, night terrors, flashbacks, or sleeplessness. RI #60, RI #487, and RI #339 were three of four residents sampled for behavioral concerns. The facility's failure to manage RI #60's, RI #487's, and RI #339's behaviors resulted in injury of RI #41, RI #287, and RI #3, three of 29 residents sampled. Findings include: (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Cross-reference F600 A facility policy titled Behavioral Health Care and Services with a review date of 10/24/2022 documented: POLICY Each patient/resident . must receive and the Center must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a patient's whole emotional and mental well-being, . PURPOSE To provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. To provide comprehensive. collaborative, and integrated behavioral health care and services to patients utilizing an interdisciplinary care approach. PRACTICE STANDARDS . 1.2 Ensuring that direct care staff interact and communicate in a manner that promotes mental and psychosocial well being; . 1.4 Providing an environment and atmosphere that is conducive to mental and psychosocial well being; . 1.) RI #60 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include: Alzheimer's Disease, Dementia with Behavioral Disturbance, Schizoaffective Disorder, Bipolar Disorder, Anxiety Disorder, and Major Depressive Disorder. RI #60's annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/06/2023 documented a Brief Interview for Mental Status (BIMS) score of 12 of 15 indicating moderate cognitive impairment. RI #60's care plan with a focus area of . exhibits verbal behaviors related to: History of verbal outbursts directed toward others. history of cursing staff and other residents. had an initiated date of 06/26/2018 and a revision date of 03/09/2022 and included interventions initiated on 06/26/2018 that guided all staff to . Remove resident/patient from environment, if needed. Gently guide the resident from the environment while speaking in a calm, reassuring voice. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #60's progress notes contained an entry dated 07/25/2023 at 9:25 AM signed by Licensed Practical Nurse (LPN) #27 as follows: . Called to smoke porch . it was alleged . (RI #60) had thrown (an) ash tray at a staff member and it hit (RI #287) on the right side of (his/her)head and ear . (he/she) continue to curse at staff and was place on one on one and was in (his/her) room. (RI #60) came out of the room again was cursing out loud at unseen people, the DON tried to assist (RI #60) back to (his/her) room with the assisted cna, (RI #60) left the room again and the cna was following (him/her) at this time (he/she) was uneasy to redirect, the DON was trying to (assist) (RI #60) back to (his/her) room, . assisted to the shower by the cna then (he/she) (cursed) her out and told her to get out and don't come back . On 03/11/2025 at 3:51 PM LPN #27 was asked about RI #60's behavior. LPN #27 said, RI #60 would curse at staff and called people names. LPN #27 said, at the time of the incident staff reported that RI #60 threw an ashtray at CNA #41, but they discovered that CNA #41 was the one that threw the ashtray first. LPN #27 said, RI #60 did talk to people not present and might have been talking to the voices in his/her head. LPN #27 said, if RI #60 was talking to the staff member on the porch and calling her names, she should have brought RI #60 inside. LPN #27 said, she triggered him/her. LPN #27 said, CNA #41 had worked with RI #60 before and knew how to deal with RI #60's behaviors, she was a seasoned CNA and knew how to deal with aggressive residents. LPN #27 said, CNA #41 was familiar with RI #60's behaviors and knew how to approach RI #60. LPN #27 said, CNA #41 throwing the ashtray at RI #60 was mental abuse and she triggered RI #60's behavior, and it would have made RI #60 feel upset and angry. On 03/18/2025 at 10:15 AM an interview was held with CNA #40. CNA #40 said someone in the situation of being confronted by a caregiver who had thrown an ashtray would cause fear and most likely increase agitation. CNA #40 said RI #60 was known to exhibit behaviors, including cursing at staff. CNA #40 said, everyone knew to ignore those behaviors. CNA #40 said, the protocol was to walk away, ignore the behavior, and report it to the nurse. On 03/05/2025 at 3:45 PM the Nurse Educator/Registered Nurse (RN) #18 was asked about the incident on 07/25/2023 with RI #60. RN #18 said, the staff should have walked away if they were getting upset and certainly should not have acted aggressive back toward the resident and thrown anything. RN #18 said, it was not an appropriate way to respond. RN #18 said, the harm was potential for physical injury to the resident or anyone around. RN #18 said the staff was aggravating the situation and made it worse by escalating the behavior and overall situation. RN #18 said, it would frighten the resident and make them more upset if they were already agitated. RN #18 said, an employee who was feeling frustrated with a resident should tell their supervisor they are feeling burned out and ask for a reassignment. On 03/17/2025, at 4:15 PM, an interview was held with the Administrator (ADM). During the interview, the ADM was questioned about the incident involving RI #60 and CNA #41. The ADM indicated that the report was substantiated as mistreatment and CNA #41 intended to strike RI #60 by throwing an ashtray. The ADM said, it was an inappropriate response to the resident's behavior and if staff witnessed another staff member throw an ashtray at a resident they should act to protect the resident at all times and report the incident immediately. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/18/2025 at 10:49 AM an interview with the Former Administrator (FADM) was conducted. During the interview, the FADM was questioned about what occurred prior to the incident, the FADM said, from what she recalled RI #60 had been cursing CNA #41 who became upset and reacted by throwing the ashtray. When asked how staff should respond in a situation when a resident was exhibiting aggressive behavior, the FADM said, staff should report the aggressive behavior to the unit manager. The FADM said, staff failed to report to the unit manager. The FADM said, staff failed to report to the unit manager. The FADM said someone could get hurt when staff became upset and responded by throwing an ashtray at a resident. ********** The facility took immediate action to correct the noncompliance including: 07/25/2023, immediately brought into facility and placed on 1:1 with supervisor until sent out for psych evaluation 07/25/2023 - Body audits completed on both residents 07/25/2023 - Report made to ADPH 07/25/2023 - Police report filed with police department 07/25/2023 - Investigation initiated 07/25/2023 - Care Plans updated 07/26/2023 2nd report to ADPH 07/26/2023 - RI #60 seen by provider - medications adjusted for agitation 07/26/2023 - RI #287 assessed by provider - noted as stable 07/27/2023- CNA #41 was suspended 07/29/2023- CNA #39 was suspended 07/30/2023 - Interview: residents to rule out abuse and with staff members to ensure no unreported abuse 07/31/2023 - RI #60 seen by IBH provider - no behaviors noted; continues on IBH monthly 08/01/2023 - 100 percent of body audits completed - no concerns noted 08/01/2023-CNA #40 was suspended and terminated 08/02/2023- CNA #41 and #39 were terminated 08/08/2023- All staff educated on Behavior Management Education. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	08/15/2023 - Monitoring behaviors and abuse through QAPI process 08/21/2023 - All staff educated on abuse and reporting abuse - completed by local ombudsman ********** 2) RI #487 was admitted to the facility on [DATE] with a diagnosis to include Vascular Dementia with Behavioral Disturbance, Mood Disorder Due to Known Physiological Disorder with Depressive Features, Adjustment Disorder with Depressed Mood. A review of RI #487's Annual MDS with an ARD of 3/30/2023 documented a score of 14 of 15 on the BIMS which indicated RI #487 was cognitively intact. Section E0200 Behavioral Symptoms- Presence and Frequency was coded 2 for Verbal behaviors symptoms directed towards others (e.g. threatening others, screaming at others, cursing at others. Section D0100 Resident Mood Interview documented feeling down, depressed or hopeless 7 out of 11 days in the past two weeks of this assessment period. A review of RI #487's Comprehensive Behavior Care Plans included a Focus of . (RI #487) exhibits or has the potential to exhibit verbal behaviors related to cognitive loss/Dementia. (RI #487) as a history of verbal outburst. (He/She) is easily frustrated. (He/She) gets agitated, yells out, and curses because (he/she) wants to go home . Date Initiated: 07/12/2019 . Revision on: 10/04/2022 . Interventions . Social Services visits to provide support as needed, and/or as requested . On 05/24/2023 at 10:52 AM the State Agency received a FRI alleging verbal abuse involving RI #487, RI #488, and a Dietary Aide (DA) #49 occurred when it was reported that DA #49 told both these residents he would whip their ass. On 05/24/2023 a hand written document from Dietary Manager Assistant (DMA) documented, On this day (05/24/23) RI #487 came to me about not getting a grill cheese sandwich. I turns (RI 487) curse me calling me the (B) work. I (DMA) said you don't have to say all of that . (RI # 487) said yes (B) cause you can't read I (DMA) just fixed the toast and gave it to him/her (RI #487) and went on my way . A review of RI #487's behavior monitoring document revealed RI #487 exhibited behaviors nine out of 31 days in May 2023. Further review of RI #487's Comprehensive Care Plan including behavioral care plans indicated no updates were made after the incident on 05/24/2023. On 07/01/2023 at 10:05 AM, the State Agency received a Facility Reported Incident (FRI) that documented . Roommates (RI #487) and (RI #41) had an argument and (RI #487) bent (RI #41)'s finger Was there serious bodily injury? Yes . The facility immediately separated the residents, assessed for injuries, made notifications, and initiated an investigation. A review of a hospital record date 07/1/2023 of RI #41 documented, . Reason for Admission: ASSAULT . A review of a hospital X- Ray record of RI #41's Left hand documented, Significant Findings . Impression: Acute fracture of the ring finger . (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's final summary dated 07/03/2023 documented . Complaint: (RI #487) became angry because (he/she) said (RI #41) yelled at (him/her) for turning on a TV and waking (him/her) up (RI #487) walked over to (RI #41's) side of the room, where (RI #41) was in the bed, and hit (him/her) on the fist with (his/her) fist and twisted (RI #41's) left hand . The document stated the incident was not witnessed; however, staff heard an argument in the room prior to the incident. A review of the Integrated Behavioral Health (IBH) documentation indicated that Resident RI #487 was seen on 03/06/2023, for a follow-up concerning agitation and depression. The records indicated that RI #487 exhibited irritability and was uncooperative with staff. On 04/24/2023, RI #487 was again seen by IBH for a follow-up regarding the same issues of agitation and depression. The resident continued to display signs of agitation, used excessive profanity, and remained uncooperative with the staff. On 05/11/2023, IBH conducted another follow-up for RI #487 concerning agitation and depression. During this visit, RI #487 expressed frustration with his/her stay at the facility, used profanity, and reported experiencing poor sleep due to noise disturbances from his/her roommate. On 03/06/2025 at 11:55AM the Social Services Assistant (SSA) #19. The SSA said RI #487 had behaviors that included verbal and physical aggression. The SSA said RI #487's became physically aggressive when he/she got to a point of anger. The SSA said RI #487 exhibited verbal aggression almost daily that included cursing, and he/she had an angry personality in general. When asked what would provoke RI #487, the SSA said it would have to be a situation that got him/her fired up and start to curse; he/she was easily angered. The SSA said interventions included for staff would try to redirect him/her and he/she was a smoker so staff would try to take him to smoke. The SSA said staff should redirect, calm, and remove from RI #487 the situation. The SSA said she vaguely remembered RI #487's behavioral incident on 05/24/2023 when RI #487 went into the kitchen, asked for a grilled cheese, and got into an argument with staff. The SSA said the incident should have been documented in RI #487's care plan and nurses' notes, but she did not see it documented in the nursing notes or the care plan. The SSA did not see any specific interventions following the incident in May 2023. The SSA said it was important to document incidents so staff would know how to handle his/her care and what may trigger him/her. The SSA said knowing how to handle resident's care and potential triggers was important so staff could avoid potential future situations that may impact a resident. The documentation would also support the need to send the resident for inpatient services. The SSA said RI #487's care plan was not updated following the 05/24/2023 incident, but it should have been, and she did not know why it was not. The SSA said had the incident on 05/24/2023 been documented appropriately it could have possibly prevented the incident on 07/01/2023. The SSA said not communicating or documenting behaviors could lead to other behaviors and aggression that may impact residents. The SSA added, when new staff came in they need to be aware of the resident behaviors for protection of all. On 03/14/2025 at 11:53 AM an interview was conducted with the Social Worker (SW) #17. The SW said RI #487 had care plans for verbal and physical behaviors. The SW said she was not aware of RI #487 being involved in the incident on 05/24/2023 and was only aware of the incident that occurred on 07/01/2023. The SW said she was not aware of any prior altercations between RI #487 and RI #41. The SW said the unit managers should let her know if there were any concerns. The SW said if she had been made aware and the facility was unable to come up with a resolution then a room change would be initiated. The SW said a room change was not offered until after the 07/01/2023 incident. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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The facility took immediate action to correct the noncompliance including:

07/01/2023- RI #487 immediately placed on 1:1 Observation

07/01/2023 - RI #487 sent out to Hospital for Psychiatric Evaluation

07/01/2023 - X-Ray of RI #41's finger obtained

07/01/2023 - Body Audits to both residents

07/01/2023 through 07/04/2023 - Interviews with Staff and Residents

07/03/2023 - Interview with RI #41

07/04/2023 - Interview with RI #487

06/24/2023 - Review Care Plans for both Residents

07/15/2023 - QAPI

08/15/2023 - Behavior Antipsychotic Review

07/04/2023 - Room change upon RI #487's return from the hospital 315A

06/05/2023, 06/23/2023, 07/01/2023, and 7/31/2023 RI #487 was seen by IBH Provider

08/15/2023 - Monitoring behaviors and abuse through QAPI process

08/21/2023 - All staff educated on abuse and reporting abuse - completed by local ombudsman

May 2023 until 09/26/2023 RI #487 remained on Behavior Monitoring until discharge 09/26/2023

RI #487 continued being followed by psychiatric services until discharged on [DATE].

09/26/2023 - RI #487 discharged home. It was recommended on discharge that resident continue IBH services.

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After review of documentation supporting the above corrective actions, including the facility's investigation file, in-service/education records, QAPI documentation, and staff interviews, the survey team verified the facility implemented corrective actions including ongoing monitoring from May 2023 to 09/26/2023, and past non-compliance was cited.

29671

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3.) On 09/13/2024 the State Agency received a FRI alleging physical abuse occurred the day before on 09/12/2024 at 10:45 PM when RI #339 stabbed RI #3 in the left hand with an ink pen causing a gash, the residents were separated, and Emergency Medical Services (EMS) were requested and the Police were notified. RI #3 was readmitted to the facility on [DATE] and had diagnoses to include: Vascular Dementia. RI #3's admission MDS assessment with an ARD of 07/19/2024 documented long and short term memory problems and moderately impaired cognition. RI #339 was admitted to the facility on [DATE] with diagnoses to include Depression and Post-Traumatic Stress Disorder. RI #339's quarterly MDS assessment with an ARD of 07/17/2024 documented a BIMS score of 15 out of 15 indicating intact cognition. Further review of RI #339's medical record revealed comprehensive care plans and progress notes describing some of RI #339's behaviors leading up to the incident on 09/12/2024. RI #339 had a care plan initiated 08/15/2024 to address the focus area of exhibiting verbal behaviors, history of verbal outbursts directed at others, use of abusive language, pattern of challenging/confrontational verbal behavior. RI #339's care plans did not include any focus areas, interventions, approaches, or guidance to staff to address physical aggression, throwing things, night terrors, flashbacks, or sleeplessness; and did not address the level of supervision required to ensure RI #339's roommate and other residents were safe in the facility. RI #339's progress notes included documented behaviors as follows: 07/02/2024 Resident has had increased yelling and cursing staff members. Refusing medications at times, refusing . care . 08/19/2024 Resident threw (his/her) phone at CNA . Gave the unit manager the middle finger and said f@@k you. 09/03/2024 Hell no I'm not taking a shower. 09/12/2024 at 11:31 AM .up in (wheelchair) .stated, (roommate) took my remote. cursing this writer and another resident in the hallway. Attempts to redirect (RI #339) are unsuccessful. 09/12/2024 at 9:09 PM Resident refused to go to bed after telling the CNA (he/she) was ready to go to bed. Cursed and yelled at the CNA and then went back outside. The behavior documented at 9:09 PM occurred less than two hours prior to RI #3 being stabbed with the pen. RI #339's IBH note dated 08/23/2024 documented: (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Reason for Appointment 1. Initial encounter for psychiatric evaluation for medication management . Caregivers report that patient threw a phone across (his/her) room. frequent episodes of cursing at staff. patient stays awake late at night . (RI #339) Endorses some irritability (related to) living in the facility. (He/she) states that (his/her) cellphone wasn't working, and (he/she) did throw it across (his/her) room. (He/she) states that (he/she) got in a fuss with some people this morning, just messing with me. Reports trouble staying asleep at night, . Endorses night terrors . flashbacks . terrors are through my lens shooting people. Assessments 1. Post-traumatic stress disorder . 2. Depression . RI #339's IBH report dated 09/06/2024 documented: Reason for Appointment 1. (follow-up) for depression and PTSD . Describes mood as irritable. Endorses irritability due to not sleeping well at night. Endorses nightmares of past combat . no longer nightly. monitor for improvement in night terrors. IBH reports recommended treatment should include non-pharmacological interventions and coping strategies, but the reports did not specify any examples or discussion of these with RI #339. The facility investigative file contained a form titled, INVESTIGATION REPORT for RI #3 dated 09/14/2024 which documented on 09/12/2024 Licensed Practical Nurse (LPN) #38 called and reported to the Administrator (ADM) and Director of Nurses (DON) that RI #339 stabbed RI #3 in the left hand. A Conclusion to the report documented: . the facility completed an investigation and there is sufficient evidence to substantiate an allegation of physical abuse (Resident to Resident). (RI #3) transferred to the hospital on 9/12/24 for evaluation of (his/her) left hand. (RI #3) is monitored for any psychosocial changes. (RI #339) transferred to three different hospitals on 09/13/24. After the incident, the residents were separated as roommates. The facility staff was also reeducated on abuse reporting and reporting any roommate incompatibility. On 03/02/2025 at 3:50 PM an interview was conducted with RI #3. RI #3 stated, RI #339 was his/her roommate and would yell out at times. RI #3 stated, on 09/12/2023 RI #339 stabbed his/her hand and he/she was sent to the hospital and required three stitches. RI #3 further stated that he/she tried to defend himself/herself from the roommate. RI #3 stated his/her hand was hurt and bleeding. RI #3 stated, at the time of the incident he was scared. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility investigative file contained a handwritten statement signed by RI #339 dated 09/12/2024 which documented: . (RI #3), my roommate said something about a phone charger while we were on the smoking patio earlier today. I looked for my notepad and my remote control. They were missing. After we came from the smoking patio, I got (RI #3's) phone and charger out of the garbage can and threw both of them at (him/her). I accused (RI #3) of stealing my stuff. I told (him/her) I will kill (him/he) if (he/she) goes through my stuff. (RI #3) rolled (his/her) wheelchair towards me and I stabbed (him/her) in the hand. On 03/07/2025 at 9:33 AM Social Services Assistant (SSA) #19 said, she was aware that occasionally RI #3 and RI #339 would have a disagreement. SSA #19 said, RI #339 had diagnoses to include PTSD, Depression, and was seen by IBH/psychiatric on 08/23/2024 and 09/06/2024 because behaviors were getting worse, he/she was cursing more and refusing treatment. ********** The facility took immediate action to correct the noncompliance including: 09/12/2024- Separated the residents 09/12/2024- One on One observation with RI #339; RI #339 sent to inpatient psych services for evaluation. 09/12/2024- RI #339 did not return to facility after this incident. 09/12/2024- Body Audit Completed 09/12/2024- Police Notified 09/12/2024- Sent RI #3 to ER for evaluation 09/12/2024-Investigation initiated/Reported to ADPH/Ombudsman 09/13/2024- Employees Training on Abuse Policy Education, Roommate Incompatibility, Early Identification of residents concerns. Roommate Incompatibility reviewed on 09/13/2024 conducted by IDT during Stand up. Roommate Incompatibility monitoring continued weekly during the Partner Round program. 09/17/2024 - Employee Training on Behavior Management 09/23/2024- ADHOC QAPI-Completed 10/04/2024-Town Hall Meeting with all Staff. After review of documentation supporting the above corrective actions, including the facility's investigation file, in-service/education records, QAPI documentation, and staff interviews, the survey team verified the facility implemented corrective actions including ongoing monitoring from 09/12/2024 to 10/04/2024 and past non-compliance was cited.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20304 Based on observation, interview, the facility's policies for Menus and Portion Control, the facility's Fall/Winter Menu for Week 3, and the Portion Control Chart posted in the facility's kitchen; the facility failed to ensure the correct food portions were served to residents for Mandarin Orange Sections at Supper on 03/02/2025 and for Puree [NAME] Stew without Corn, Puree Bread, Puree Tomato Soup, Mashed Potatoes, Tossed Salad, and Shredded Lettuce Salad served at Lunch on 03/04/2025. This had the potential to affect 132 of 132 residents receiving meals from the facility's kitchen. Findings include: The facility's policy for Menus, undated, included the following: . Policy Statement Menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance with established national guidelines. Procedures . 5. A Registered Dietitian/Nutritionist (RDN) . reviews and approves the menus. The RDN . will adjust the individual meal plan . as appropriate. 6. Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. 7. A menu substitution log will be maintained on file. The facility's policy for PORTION CONTROL, undated, included the following: Menus and recipes are built with specific portions to meet resident's needs. Portions must be followed during all phases of food production and service. The following is the portion/scoop conversion for most items served. Scoop Number (#)* Measure Weight in Fluid Ounces (fl oz) 2 . 1 cup (C) 8 fluid ounces . 6 . 2/3 C 6 fl oz 8 . 1/2 C 4 fl oz 10 . 3/8 C 3.2 fl oz (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	12 . 1/3 C 2.6 fl oz 16 . 1/4 C 2.0 fl oz . * Scoop number is based on the number of portions/quart (portions per quart). The facility's Fall/Winter 2024-2025 Menu for Week 3 included the following for Sunday (Day 15) Dinner on 03/02/2025: The Diet Guide Sheet identified one serving of Peach Cobbler with Whipped Topping or a #8 scoop of Puree Peach Cobbler or 1/2 cup of Sliced Peaches to be served for dessert, depending upon the diet type. The Menu Substitution Log for 03/02/2025 identified Fruit to be substituted for Peach Cobbler. On 03/02/2025 at 5:25 PM, the delivery of Dinner trays to residents on the East Hall was observed. Although the menu listed Peach Cobbler with Whipped Topping for dessert, either Mandarin Orange Sections or Applesauce were being served instead. The Applesauce was served in 4-ounce commercial packages. The Mandarin Orange Sections were served in a clear plastic fluted dessert bowl, but the portion size in each bowl appeared to be 1/4 cup (2 ounces). In an interview on 03/02/2025 at 5:30 PM, the Dietary Manager said the Mandarin Orange Sections had been added to the substitute list. The Dietary Manager measured the amount of Mandarin Orange Sections being served and found only two ounces of Mandarin Orange Slices in the dessert bowl. A 2-ounce spoodle was used to check the serving size and the Mandarin Orange Sections fit inside the spoodle without any overflow. The Dietary Manager said two ounces of Mandarin Orange Slices was not enough for a serving. The facility's Diet Guide Sheet for the Fall/Winter 2024-2025 Menu for Week 3, Tuesday (Day 17) at Lunch on 03/04/2025 indicated the following serving portions: 8 ounces of Puree [NAME] Stew without Corn, a #8 scoop of Puree Bread, a #6 scoop of Puree Tomato Soup, 1/2 cup of Mashed Potatoes, one cup of Tossed Salad, and one cup of Shredded Lettuce Salad. On 03/04/2025 at 12:14 PM, trayline service for Lunch was observed. The Tossed Salad and Shredded Lettuce were being held on the trayline over ice. Each salad had a #8 scoop as the serving utensil. (continued on next page)

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	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/04/2025 at 12:35 PM, the Dietary Manager was on the line serving Tossed Salad and Shredded Lettuce into 6-ounce insulated, plastic bowls. The Dietary Manager said an 8-ounce scoop was being used to serve each salad. The Dietary Manager then displayed the scoop's number 8 metal imprint. It was a #8 scoop (1/2 cup or 4 ounces). On 03/04/2025 at 1:00 PM, the AM [NAME] was observed using a #8 Scoop (grey handle), which was not quite filled, to put Pureed [NAME] Stew without Corn atop Mashed Potatoes. The Mashed Potatoes were served with a #12 Scoop (green handle). The Puree Tomato Soup was served with a #10 Scoop (white handle). The Puree Bread was served with a #12 Scoop (green handle). The numbers on the scoops were verified with AM Cook. On 03/04/2025 at 1:25 PM, a copy of the Portion Control Chart posted in the kitchen was requested. On 03/04/2025 at 2:00 PM, the AM [NAME] was interviewed. The AM [NAME] was asked to identify the scoops used for specific Puree items during Lunch. The AM [NAME] said Pureed [NAME] Stew without Corn was served with an 8-ounce scoop, Pureed Tomato Soup was served with a 10 scoop, Puree Bread was served with a 12 scoop, and Mashed Potatoes with a 12 scoop. The AM [NAME] said she knew how much to serve by looking at the menu and the production sheet. The AM [NAME] was given a copy of the menu and asked how much Pureed [NAME] Stew without Corn should be served. The AM [NAME] looked at the Diet Guide Sheet for Tuesday (Day 17) Lunch on the Fall/Winter 2024-2025 Menu for Week 3 and said, One cup. Upon further questioning, it was revealed that the AM [NAME] believed the #8 scoop held 8 ounces, when it actually only held 4 ounces (1/2 cup). When asked for the amount of Mashed Potatoes to be served according to the menu, the AM [NAME] said, It should be one-half cup. The AM [NAME] was given a copy of the Portion Control Chart that had been posted in the kitchen and asked how much a #12 scoop provided. The AM [NAME] said, one-third cup. The AM [NAME] further said that is a little less than half a cup. When asked how this could affect the residents, the AM [NAME] said, They can lose weight. On 03/05/2025 at 4:21 PM, the Dietary Manager was interviewed. The Dietary Manager said the proper serving size for a portion of Mandarin Orange Sections was 4 ounces. The Dietary Manager said serving food in amounts less than listed on the menu would affect the resident's diet and could cause weight loss. On 03/05/2025 at 5:00 PM, the Registered Dietitian (RD) was interviewed. The RD said the proper serving size for a portion of Mandarin Orange Sections was one-half cup (4 ounces). The RD said serving food in amounts less than listed on the menu would result in not enough calories and nutrients. The RD further said it could also cause weight loss.

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	015133	A. Building B. Wing	03/19/2025

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20304 Based on observation, interview, the facility's policies for Food Storage: Cold Foods and Meal Distribution, the facility's Labeling and Dating Inservice, and the United States (U.S.) Food and Drug Administration (FDA) 2022 Food Code; the facility failed to prevent possible cross-contamination by allowing meat to thaw on a shelf 3.5 inches from the floor, incompletely covered meal plates to be delivered on an open cart to residents throughout the facility on [DATE] for Supper, and a damaged Handwashing Sink with a draining issue and no cold water to be used by staff. The facility further failed to ensure Use By dates were used for sandwiches prepared for residents' snacks. This had the potential to affect 132 of 132 residents receiving meals from the facility's kitchen. Findings include: The facility's undated policy for Food Storage: Cold Foods, included the following: . Policy Statement All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code. Procedures 1. All food items will be stored 6 inches above the floor . The facility's policy for Meal Distribution, undated, included the following: . Policy Statement Meals are transported to the dining locations in a manner that . protects against contamination, . Procedures . 3. All foods that are transported to dining areas that are not adjacent to the kitchen will be covered. The facility's Labeling and Dating Inservice, undated, included the following: . 'Use By' Dating Guidelines . All Ready-to-Eat, Time/Temperature Control for Safety (TCS) foods that are to be held for more than 24 hours at a temperature of 40 F or less, will be labeled and dated with a 'prepared date' (Day 1) and a 'use by date' (Day 7). The 2022 FDA Food Code included the following: (continued on next page)

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	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	XXX,d+[DATE].11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination . ,d+[DATE].11 Food Storage. (A) . FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. ,d+[DATE].11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts ,d+[DATE] - ,d+[DATE] . ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) . refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. ,d+[DATE].12 Handwashing Sink, Installation. (A) A HANDWASHING SINK shall be equipped to provide water at a temperature of at least 29.4 C (85 F) through a mixing valve or combination faucet. ,d+[DATE].11 Using a Handwashing Sink. (A) A HANDWASHING SINK shall be maintained so that it is accessible at all times for EMPLOYEE use. During the initial kitchen tour on [DATE] at 1:48 PM, nine sandwiches, individually packaged in plastic wrap and each labeled [DATE], were observed in Walk-in Cooler #2. The Dietary Manager said these sandwiches were for residents' snacks and for adding to meal trays. The Dietary Manager asked the staff working on the trayline, when were the sandwiches made. Diet Aide #6 said she made them yesterday. The Dietary Manager reminded the staff that the use-by date had to be on the sandwich, not the date they were made. During the initial kitchen tour on [DATE] at 1:55 PM, Walk-in Cooler #3 had food thawing on a bottom shelf that was approximately three inches from the floor. The thawing food items included: 5 boxes of Frankfurters, 1 box of Ground Beef, and 2 boxes of Pork. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 5:10 PM, the residents' Dinner trayline was observed. Most plates had a scoop of cold chicken salad atop a stack of two bread slices. Also, on the same plate was a scoop of coleslaw, pickle garnish, and an uncovered bowl of hot Minestrone Soup. The entire plate was then covered with an insulated dome. There was a one inch gap between the insulated dome and the top of the plate on several trays leaving food uncovered. On [DATE] at 5:25 PM, the delivery of Dinner trays to residents on the East Hall was observed. The resident meal trays were being transported on an open cart. Several trays had gaps of approximately one inch between the dome lid and the top of the plate, therefore exposing the food so it was not covered. In an interview on [DATE] at 5:30 PM, the Dietary Manager said the soup bowls not covered because there were no bowl lids at the facility. During a kitchen observation on [DATE] at 11:09 AM, the handwashing sink between the 3-Compartment Sink and the entrance to the Dishwashing Room was observed to be tilted downward from the wall, so that dirty water could not go down the drain. Also, cold water was not dispensed when the knob was turned on, so the water was extremely hot when running from the faucet. On [DATE] at 5:50 PM, the shelf in Walk-in Cooler #3, which had thawing meats on [DATE], was still in the same position. The distance from the floor was measured with the Regional Dietary Manager. The distance from the floor to the top of the shelf was three and one-half inches. On [DATE] at 11:00 AM, the PM [NAME] was asked how long the handwashing sink between the 3-Compartment Sink and the entrance to the Dishwashing Room had been broken. The PM [NAME] said it had been broken for at least a month. On [DATE] at 11:15 AM, the Dietary Manager was observed using the broken handwashing sink to wash her hands. On [DATE] at 11:25 AM, the AM [NAME] was observed washing her hands at the broken handwashing sink. On [DATE] at 11:28 AM, the AM [NAME] said the handwashing sink had been broken about three months. On [DATE] at 11:30 AM, the Dietary Manager was again observed using the broken handwashing sink to wash her hands. When asked if the cold water was available, the Dietary Manager turned the cold water knob to show that the cold water connection was not working. On [DATE] at 12:40 PM, Diet Aide #13 was observed making Ham Sandwiches for Resident Bedtime Snacks. Using a black fine-point marker, he had marked all of the plastic wrapped sandwiches with , d+[DATE]. Diet Aide #13 said he had worked at the facility for just under a year. Diet Aide #13 said he did not know about Use By dates. Diet Aide #13 said the date he made the sandwiches, was the date he wrote on the plastic wrap. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 12:45 PM, Diet Aide #14 was observed making Peanut Butter and Jelly Sandwiches for Resident Bedtime Snacks. Diet Aide #14 said he had been working at the facility for 2 or 3 months. Using a black fine-point marker, he had marked all the plastic wrapped sandwiches with PB ,d+[DATE]. Diet Aide #14 said the date was for today's date. He further said, Each day I make them, I put the date that I made them. On [DATE] at 4:21 PM, the Dietary Manager was interviewed. The Dietary Manager said about a month ago, someone leaned on the sink and caused it to come off the wall. The Dietary Manager said it was bent down so the water was not going down the drain the correct way. When asked about the cold water, the Dietary Manager said the Health Department was there last month and Maintenance had to turn off the cold water in that area because there was a leak in the pipes under the 3-Compartment Sink that needed to be fixed. It was fixed, but the cold water to the hand sink had not been turned back on yet. When asked the problem with washing one's hands in a handwashing sink that was not draining dirty water down the drain, the Dietary Manager said possible cross-contamination due to back splash. When asked the problem with washing one's hands in a handwashing sink that had only hot water and no cold water, the Dietary Manager said the water can be too hot for washing one's hands the full 20 seconds. When asked the problem with storing food less than 6 inches from the floor; the Dietary Manager said rodents, not being able to clean underneath properly, and possible cross-contamination. When asked the problem with sending incompletely covered plates of food on open carts to serve residents on the halls; the Dietary Manager said loss of temperature and possible air-borne cross-contamination. Upon being asked the problem with food not being marked with a Use by Date, the Dietary Manager said staff would not know the right day to discard it. On [DATE] at 5:00 PM, the Registered Dietitian (RD) was interviewed. The RD said possible contamination was the problem with washing one's hands in a handwashing sink that was not draining dirty water down the drain. When asked the problem in using a handwashing sink that had only hot water and no cold water, the RD said the water temperature could not be adjusted so it could cause a burn and one may not wash their hands long enough. When asked the problem with storing food less than 6 inches from the floor; the RD said bugs, splash from cleaning products, dust, and possible contamination. When asked the problem with sending incompletely covered plates of food on open carts to serve residents on the halls, the RD said possible contamination. Upon being asked the problem with food not being marked with a Use by Date, the RD said staff would not know when they expired.

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	015133	A. Building B. Wing	03/19/2025

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 29671 Based on record review, interview, and Payroll Based Journal (PBJ) Report, the facility failed to report accurate staffing data from July 01, 2024 until September 30, 2024, to Centers for Medicare & Medicaid Services (CMS). This affected one quarter of data reviewed during the survey. Findings include: The PBJ report generated for the quarter of 07/01/2024 through 09/30/2024 documented: . This Staffing Data Report identifies areas of concern that will be triggered . Metric . Excessively Low Weekend Staffing . Triggered = Submitted Weekend Staffing data is excessively low . On 03/10/2025 at 11:37 AM, a review of PBJ report revealed it triggered for excessively low weekend staffing for the 4th quarter of 2024. An interview took place with the Administrator (ADM) on 03/10/2025, at 12:05 PM. During the interview, the ADM was questioned regarding the PBJ report that indicated low weekend staffing for the fourth quarter of 2024. The ADM clarified that the facility did not experience low weekend staffing during that period. She explained that administrative staff were on call during weekends and were expected to provide direct patient care if scheduled staff failed to report for duty. However, when this occurs, their time was not recorded as direct patient care, which led to the report reflecting low weekend staffing. The ADM said it was important to send accurate data to CMS to ensure the staffing report was correct.

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	015133	A. Building B. Wing	03/19/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39580 Based on observations, interviews, and review of facility policies titled, Personal Clothing Handling, the facility failed to ensure staff provided care to residents and handled supplies and linen in a manner to prevent the possibility for cross-contamination of residents and their environment. This deficient practice had the potential to affect 134 of 134 residents observed for infection control. Findings include: Review of a facility policy titled, Personal Clothing Handling, with a revision date of 03/01/2024 revealed the following: POLICY Resident/Patient . clothing that is process by the service location is cleaned and processed by the service location is cleaned and returned to the patient in a timely fashion. PURPOSE To ensure patient's personal clothing is properly laundered and processed to meet the needs of the patients . On 03/05/2025 at 11:32 AM, an observation was made of Laundry Staff (LS) #47 on the East unit, front hall passing out residents' personal clothes. Clothes were on hangers on the clothes rack and were not covered. On 03/05/2025 at 11:32 AM an interview was conducted with LS #47 who said, clothes on the rack should be covered when brought down the hall. LS #47 said the rack did not have a cover like the old one did. She further said, she guessed she could have covered the rack with a sheet. LS #47 said germs could get on the clothes when brought to the halls when not covered. On 03/05/2025 at 4:07 PM an interview was conducted with the District Manager for Environmental Services (DMES). He said that when the clothes from laundry should have a drape over them when they were delivered to the residents. The DMES further said when the resident's clothes were transported without a drape or cover on them, there was a potential for cross-contamination. 21055

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	03/19/2025

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20304 Based on observation, interview, and the United States (U.S.) Food and Drug Administration (FDA) 2022 Food Code; the facility failed to ensure: 1.) the air filters for two of two Ice Machines were cleaned as recommended by the manufacturer; 2.) an in-use Handwashing Sink in the kitchen was repaired; 3.) a new fuse was obtained for the Dishwashing Machine; 4.) a Plate Lowerator (one of one), which would help keep food warm for the residents, was repaired. This had the potential to affect 132 of 132 residents receiving meals from the facility's kitchen. Findings Include: The U.S. FDA 2022 Food Code included the following: . 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair . During the initial kitchen tour on 03/02/2025 at 1:58 PM, the Dietary Manager (DM) said the dishwashing machine was normally a hot sanitizing rinse machine, but it had been temporarily converted to a chemical sanitizing machine. On 03/03/2025 at 11:21 AM, the Dietary Manager said the dishwashing machine's heated final rinse was not working because it needed a replacement fuse for the fuse box. The blown fuse was discovered in September 2024. The Dietary Manager said the previous Maintenance Director left about October 2024, but the (Senior) Regional Maintenance Director was currently at the facility. During the initial kitchen tour on 03/02/2025 at 1:45 PM, the ice machine in the kitchen had two air filters located on the front of the machine, which needed to be cleaned or replaced. There was a thick grey residue on the exposed areas of the filters. The DM agreed the filters needed to be cleaned. On 03/02/2025 at 2:15 PM, the ice machine on East Wing was observed with Certified Nursing Assistant (CNA) #7. The ice machine had two very dirty air filters on the front of the machine. A thick grey residue was built-up on the air filters. Each frame holding an air filter on the ice machine had the following directive: Clean Air Filter Twice A Month. CNA #7 agreed the filters were dirty. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/03/2025 at 1:31 PM, the Senior Regional Maintenance Director was actively working on repair of the East Wing's ice machine. When asked about the air filters located on front of the ice machine, he said the maintenance of the ice machine air filters should be regulatory for them. The Senior Regional Maintenance Director additionally said those filters were cleanable. When asked about the fuse for the dishwashing machine, the Senior Regional Maintenance Director said he was not aware of that problem. During a kitchen observation on 03/03/2025 at 11:09 AM, the handwashing sink between the 3-Compartment Sink and the entrance to the Dishwashing Room was observed to be tilted downward from the wall which prevented dirty water from going down the drain properly. Also, cold water was not dispensed when the knob was turned on, so the water was extremely hot when running from the faucet. The sink was loose from the wall. The sink was one of three handwashing sinks observed in the kitchen. The Dietary Manager said the broken handwashing sink had not yet been reported to Maintenance. On 03/03/2025 at 3:20 PM, the Administrator was asked about the status of a fuse for the dishwashing machine. The Administrator said an Assistant Maintenance person was supposed to have contacted their vendor in mid-January 2025 about supplying one. However, that Assistant Maintenance person terminated employment with the facility last week. The Administrator said she planned to get the Senior Regional Maintenance Director to check on that for her. On 03/04/2025 at 11:00 AM, the PM [NAME] was asked how long the handwashing sink between the 3-Compartment Sink and the entrance to the Dishwashing Room had been broken. The PM [NAME] said it had been broken for at least a month. On 03/04/2025 at 11:15 AM, the Dietary Manager was observed using the broken handwashing sink to wash her hands. On 03/04/2025 at 11:25 AM, the AM [NAME] was observed washing her hands at the broken handwashing sink. On 03/04/2025 at 11:28 AM, the AM [NAME] said the handwashing sink had been broken about three months. The AM cook further said she did not like leaning over so far to wash her hands, because it hurt her back. On 03/04/2025 at 11:30 AM, the Dietary Manager was again observed using the broken handwashing sink to wash her hands. When asked if the cold water was available, the Dietary Manager turned the cold water knob to show that the cold water connection was not working. The Dietary Manager said she told Maintenance about the broken handwashing sink on Monday (03/03/2025). On 03/04/2025 at 11:35 AM, a plate lowerator was observed on the left side of the steam table, but it was not plugged in and did not seem to be in use, as there were no plates in it. The plate lowerator seems to be in use as a counter with the meal temperature sheet, eyeglasses, and a bi-metallic stemmed thermometer laying on top. On 03/04/2025 at 1:25 PM, the Dietary Manager was asked about the plate lowerator. The Dietary Manager said the plate lowerater had been broken since she had started working at the facility, about one and a half years ago. (continued on next page)

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	015133	A. Building B. Wing	03/19/2025

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/05/2025 at 4:21 PM, the Dietary Manager was interviewed. The Dietary Manager said Maintenance was usually alerted of problems and broken equipment by TELS, a computer system. The Dietary Manager also said they can call if it is an emergency. The Dietary Manager further said right now they only had a Maintenance Assistant. The Dietary Manager said she alerted Maintenance about the handwashing sink on Monday, March 3, 2025. The Dietary Manager said about a month ago, someone leaned on the sink and caused it to come off the wall. The Dietary Manager said it was bent down so the water was not going down the drain the correct way. When asked about the cold water, the Dietary Manager said the Health Dept was here last month and Maintenance had to turn off the cold water in that area because there was a leak in the pipes under the 3-Compartment Sink that needed to be fixed. It was fixed, but the cold water to the hand sink has not been turned back on yet. When asked the problem with washing one's hands in a handwashing sink that was not draining dirty water down the drain, the Dietary Manager said possible cross-contamination due to back splash. When asked the problem with washing one's hands in a handwashing sink that has only hot water and no cold water, the Dietary Manager said the water can be too hot for washing one's hands the full 20 seconds. The Dietary Manager said she alerted Maintenance about the broken plate lowerator when she started working at the facility, about a year and a half ago. The Dietary Manager said the plate lowerator was broken when she arrived at the facility. The Dietary Manager said she alerted Maintenance about the fuse for the dishwashing machine in September 2024. The Dietary Manager said about 5 months ago, the service company came to check the dishwashing machine and found that the red fuse was blown and the facility had to order it. On 03/05/2025 at 5:00 PM, the Registered Dietitian (RD) was interviewed. The RD said possible contamination was the problem with washing one's hands in a handwashing sink that was not draining dirty water down the drain. When asked the problem in using a handwashing sink that had only hot water and no cold water, the RD said you cannot adjust the water temperature so it could cause a burn and one may not wash their hands long enough. On 03/05/2025 at 5:31 PM, the Maintenance Assistant was interviewed. The Maintenance Assistant said he routinely went to the Kitchen, Monday through Friday, to check the fire equipment and that he was notified of problems or broken equipment via the work orders sent through the TELS computer system. The Maintenance Assistant said he just heard about the handwashing sink yesterday. He further said they did put a work order in, but we have been so busy this week that I have not had a chance to look at the work orders. The Maintenance Assistant did not know how the handwashing sink had been broken and he did not know about the cold water not working for the handwashing sink. The Maintenance Assistant said, if washing in a sink that is not draining dirty water down the drain, then hands are not getting clean. The Maintenance Assistant said he had not been notified about the plate lowerator. The Maintenance Assistant said he thought the fuse had been ordered for the dishwashing machine and it should have been received by now. On 03/05/2025 at 5:47 PM, the Senior Regional Maintenance Director was interviewed. He said TELS was their guide for regular preventative maintenance and it was how Maintenance was alerted of problems and broken equipment. The Senior Regional Maintenance Director said the life of the ice machine was affected by the maintenance of things like the air filters. The Senior Regional Maintenance Director said the handwashing sink in the kitchen was bent and had a screw loose. He further said it was unsanitary to wash one's hands in a sink that is not draining dirty water down the drain. He had not been notified about the plate lowerator. The Senior Regional Maintenance Director said he had found an electrical vendor to supply a replacement fuse for the dishwashing machine. (continued on next page)

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	03/19/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow-up interview on 03/06/2025 at 4:13 PM, the Senior Regional Maintenance Director said the ice machine's air filters need to be kept clean to help keep the compressor mechanics cool. The Senior Regional Maintenance Director further said it was an expensive machine and this would help make it last longer, it should last 10 or [AGE] years. The Senior Regional Maintenance Director also said the ice machines have a notation on the front to clean the air filters every two weeks.