STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015136	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Falkville Rehabilitation and Healthcare Center	10 West 3rd Street Falkville, AL 35622

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, facility policy review, and review of Alabama Administrative Code, Chapter 420-5-19, Advance Directives the facility failed to ensure an effective process was developed and implemented to ensure resident's end-of-life decisions were validly recorded and honored.Specifically, the facility failed to ensure do not resuscitate (DNR) forms were filled out completely and accurately, including signatures of those authorized to sign the form, and dates. The facility failed to ensure all the necessary Power of Attorney (POA), Living Will, or Surrogate paperwork to support the DNR forms were included in the residents' medical records.The facility further failed to ensure facility staff were aware of the process to follow to rescind a DNR in an emergent situation. The failure affected 13 (Residents #104, #97, #79, #116, #66, #67, #117, #82, #115, #32, #55, #64, and #77) of 36 residents reviewed for their code status. The failure created the likelihood of cardiopulmonary resuscitation (CPR) being provided or withheld against the residents' advance directive. Resident #104's Advance Directive, DNR form was signed incorrectly, and the facility did not have the necessary Surrogate paperwork. Resident #104's medical record included a care plan that directed staff to withhold life-saving measures and an invalid DNR document. On [DATE], Resident #104's condition declined. According to the facility, Resident #104's spouse, Family Member (FM) #38, who was also a resident of the facility, Resident #105, and roommate of Resident #104 verbally requested staff to help the resident and staff began providing life-saving measures. Facility staff did not verify Resident #104's code status before CPR was initiated. FM #38 said that he/she did not request staff to provide CPR. Resident #104 expired on [DATE]. This was cited as a result of the investigation of complaint number 454680.As a result of the facility initiating CPR and activating Emergency Services RI #104 was subjected to manual chest compressions and insertion of an intraosseous catheter.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 Code of Federal Regulations 483.10 Resident Rights at F578-Right to Request/Refuse/Discontinue Treatment; Formulate Advance Directives. The survey team notified the Regional Nurse Consultant, the Administrator, and the Director of Nursing (DON) of the IJ and provided the updated IJ template on [DATE] at 11:27 AM. The IJ began on [DATE] and was removed on [DATE] after the survey team performed onsite verification that the removal plan had been implemented. Noncompliance for F578 remained at a lower scope and severity of no actual harm with the potential for more than minimal harm.Additional findings were identified related to the facility failure to provide an opportunity and instructions on how to formulate an advance directive for 2 (Resident #34 and Resident #85) of 19 sampled residents.Findings included:The STATE COMMITTEE OF PUBLIC HEALTH ADMINISTRATIVE CODE, CHAPTER 420-5-19 ADVANCE DIRECTIVES included:420-5-19-.01 Advance Directives.Surrogate health care decision makers, as authorized by Act 97-187, shall complete the form attached hereto as Appendix I which, when properly completed and duly notarized, shall constitute the certification of the surrogate as required by the act and shall authorize the surrogate, including a representative of the ethics committee or another duly appointed (continued on next page)

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

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

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	committee at the facility where the patient is being treated, acting by unanimous consent as the surrogate, to make standard health care decisions for the patient as well as to make decisions regarding the providing, withholding, or withdrawal of life-sustaining treatment .420-5-19-.02 Portable Physician Do Not Attempt ResuscitationOrders.(1) Definitions.(a) Do Not Attempt Resuscitation (DNAR) Order. A DNAR order would include, without limitation, physician orders written as do not resuscitate, do not allow resuscitation, do not allow resuscitative measures, DNAR, DNR, allow natural death, . A DNAR order must be entered with the consent of the person, if the person is competent; or in accordance with instructions in an advance directive if the person is not competent or is no longer able to understand, appreciate, and direct his or her medical treatment and has no hope of regaining that ability; or with the consent of a health care proxy or surrogate functioning under the provisions of Title 22, Chapter 8A, Code of Ala. 1975; or instructions by an attorney in fact under a durable power of attorney that duly grants powers to the attorney in fact to make those decisions described in Section 22-8A-4(b)(1), Code of Ala. 1975.(b) Portable Physician DNAR Order. A DNAR order entered into the medical record by a physician using the required form designated by this rule and substantiated by completion of all applicable sections of the form.(2) Physicians intending to enter a portable physician DNAR order shall utilize the form attached hereto as Appendix 2 which, when properly completed and executed, shall constitute the portable physician DNAR order .The Alabama's State Committee of Public Health Administrative Code includes Rule 420-5-19-A2 which references the use of Appendix II Alabama Portable Physician Do Not Attempt Resuscitation Order No CPR/Allow Natural Death form for Do Not Attempt Resuscitation (DNAR) also known as Do Not Resuscitate (DNR) orders. The form includes: .This order Is valid only if Section I, II, III, OR IV is completed AND a physician has completed Section V.Section I. Patient/ Resident Consent.I, the undersigned patient/ resident, direct that resuscitative measures be withheld from me in the event of cardiopulmonary cessation. I have discussed this decision with my physician, and I understand the consequences of this decision.Section II. Incompetent Patient/ Resident with DNAR instructions in Advance Directive.The patient/ resident is not competent or is no longer able to understand, appreciate, and direct his / her medical treatment and has no hope of regaining that ability. A duly executed Advance Directive for Health Care with instructions that. no life sustaining treatment be provided was previously authorized by the patient/ resident and is part of his/her medical record.Section III. Health Care Proxy or Attorney-in-Fact Consent.I, the undersigned, am the health care proxy or attorney-in-fact designated by the patient/ resident to make decisions regarding the providing, withholding, or withdrawal of life-sustaining treatment for the patient/ resident. I hereby direct that resuscitative measures be withheld from the patient/ resident in the event of cardiopulmonary cessation. A copy of the proxy or attorney-in-fact. designation (e.g., living will, power of attorney, etc.) has been made part of the patient/ resident' s medical record.Section IV. Surrogate Consent.I, the undersigned, am the surrogate certified to make decisions, in consultation with the attending physician, regarding the providing, withholding, or withdrawal of life-sustaining treatment for the patient/ resident. After consultation with the attending physician, I hereby direct that resuscitative measures be withheld from the patient/ resident in the event of cardiopulmonary cessation. I believe that this decision conforms as closely as possible to what the patient/ resident would have wanted. I make this decision in good faith and without consideration of the financial benefit or burden which may accrue to me or to the health care provider as a result of this decision. A copy of the Certification of Health Care Decision Surrogate has been made part of the patient/ resident' s medical record.Section V. Physician Authorization.Based on the information above, I hereby direct any and all medical personnel, emergency responders, and paramedical personnel to withhold resuscitative measures, i.e., cardiopulmonary resuscitation, chest compression, endotracheal intubation and other advanced airway management, artificial ventilation, cardiac resuscitative medications, and cardiac defibrillation, in the event of cardiopulmonary cessation in the patient/ resident.I further direct the implementation of all reasonable comfort care such as oxygen, (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a DNR was the responsible party, then they had a right to change the code status. She stated she was not sure what paperwork would need to be completed. UM #13 stated that if a resident had a DNR, but a spouse was in the room asking for help, then she would provide CPR to honor the spouse's decision. During a telephone interview on [DATE] at 2:07 PM, previous Medical Records Staff (MR) #35 stated that at the time Resident #104 coded in [DATE], the DON or UM #5 was responsible for reviewing and completing the DNRs. She stated they filled out the DNR forms upon admission, and she scanned it into the electronic medical record and completed an audit to try and make sure the form was correct so that the record was correct. She stated that the UM then double checked behind her. She stated she was not provided with any education of the DNR forms and did not know the process to rescind a DNR. She stated that in [DATE], they had a code book at the nurses' station that had the residents' code status in it, and the unit manager was responsible for it.During an interview on [DATE] at 11:34 AM, UM #5 stated it was the responsibility of the interdisciplinary team (IDT) to ensure all the necessary paperwork was in the resident's medical records. She stated medical records staff obtained the initial paperwork upon admission and then she double-checked that they had all the necessary paperwork when they came to her floor. She stated that if a resident or family, if the resident was not cognitive, wanted to change their code status, then it was their right to do so. She stated it was also a resident's right to die with dignity, and they should have honored Resident #104's choice, whether the family changed their mind or not. She stated residents made that choice when they could make the choice, and it should be honored.During an interview on [DATE] at 10:44 AM, the AD stated if a resident had a DNR or a Living Will, she obtained a copy of it and uploaded it to the medical record, but she did not review the information for accuracy. She stated she had not had any specific training on the DNRs. The AD stated she was not sure of the process to rescind a DNR.During an interview on [DATE] at 1:19 PM, the Social Services Director (SSD) stated they had a clinical team that reviewed new admissions weekly, including DNRs, and medical records staff were responsible for making sure all the paperwork was in the record. She stated she had gone to a sister facility and saw how the DNR process worked there but had never received any training at the facility on DNRs. She stated she was not sure of the process to rescind a DNR because she did not do that, but she stated she thought that the physician and family would need to sign something. She stated if a resident with a DNR coded, and the spouse wanted CPR performed, she stated she thought the facility should follow what was on the DNR form. She stated the resident's code status should be presented in their profile on the computer, on their physician orders, and in the code book.During an interview on [DATE] at 2:45 PM, the Regional Nurse Consultant stated if a resident or family wanted to rescind a DNR, it could be a verbal revocation, and once the staff were aware of it, they should act on it. She stated they should involve the physician, obtain an order, and update the plan of care. The Regional Nurse Consultant stated that in the situation with Resident #104, the nurse acted upon the verbal revocation from FM #38, who was in the room. She stated she was not aware staff could not find Resident #104's code status. During an interview on [DATE] at 3:18 PM, the Administrator reviewed Resident #104's DNR form during the interview and stated it was not filled out correctly and it would not be valid. She stated they had staff training at the end of [DATE] on DNRs, to include the importance of documentation and who could revoke a DNR. She stated the facility process to rescind a DNR was that whoever signed the DNR or the resident could revoke it. During an interview on [DATE] at 1:10 PM, the Medical Director stated that in the situation of Resident #104, the nurse should do what the family said. He stated if FM #38 was alert and oriented and wanted CPR provided, then they should provide CPR, even if there was a DNR order. The Medical Director stated he expected the DNR forms to be filled out correctly and for the facility to have all the required documents.During an interview on [DATE] at 8:28 AM, the Medical Director stated if a resident's spouse initiated the DNR but then changed their mind, then the staff should perform CPR. He stated it was his understanding that if the family member was alert and oriented, then they should be able to make that decision.2. An admission Record indicated the facility admitted Resident #97 on [DATE]. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	health care representative; allow the resident, if able, to discuss their feelings regarding their Advance Directive; notify the physician of the resident's wishes regarding life prolonging procedures; and indicated that an Advance Directive could be revoked or changed if the resident and/or appointed health care representative changed their mind about the medical care they wanted delivered.Resident #116's Order Summary Report, with active orders as of [DATE], included a DNR order, dated [DATE].Resident #116's Appendix II Alabama Portable Physician Do Not Attempt Resuscitation Order No CPR/Allow Natural Death form revealed Section III. Health Care Proxy or Attorney-in-Fact Consent was signed and dated [DATE]. The form revealed Section V. Physician Authorization was signed by a physician and dated [DATE].Resident #116's medical record revealed no POA or Living Will documents to support the DNR form. Those documents were requested from DON #33 on [DATE] at 3:00 PM.Resident #116's POA document was uploaded to the resident's electronic medical record on [DATE], during the survey.5. An admission Record indicated the facility admitted Resident #66 on [DATE]. According to the admission Record, the resident had a medical history that included a diagnosis of chronic obstructive pulmonary disease with acute exacerbation.An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #66 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment.Resident #66's Care Plan Report included a focus area dated [DATE], that indicated the resident had an Advance Directive that included a DNR. Interventions initiated [DATE] directed staff to discuss Advance Directives with the resident and/or appointed health care representative; allow the resident, if able, to discuss their feelings regarding their Advance Directive; and indicated that an Advance Directive could be revoked or changed if the resident and/or appointed health care representative changed their mind about the medical care they wanted delivered.Resident #66's Order Summary Report, with active orders as of [DATE], included a DNR order, dated [DATE].Resident #66's Appendix II Alabama Portable Physician Do Not Attempt Resuscitation Order No CPR/Allow Natural Death revealed Section I. Patient/Resident Consent was signed by the resident and dated [DATE]. The form revealed Section V. Physician Authorization included a physician signature but was not dated.6. An admission Record indicated the facility admitted Resident #67 on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of cerebral infarction (a stroke) and hemiplegia (weakness of one side of the body) affecting the right dominant side.An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #67 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment.Resident #67's Care Plan Report included a focus area dated [DATE], that indicated the resident had an Advance Directive that included a DNR. Interventions initiated [DATE] directed staff to discuss Advance Directives with the resident and/or appointed health care representative; allow the resident, if able, to discuss their feelings regarding their Advance Directive; and indicated that an Advance Directive could be revoked or changed if the resident and/or appointed health care representative changed their mind about the medical care they wanted delivered.Resident #67's Order Summary Report, with active orders as of [DATE], included a DNR order, dated [DATE].Resident #67's Appendix II Alabama Portable Physician Do Not Attempt Resuscitation Order No CPR/Allow Natural Death form revealed Section IV. Surrogate Consent was signed by two nurses that indicated that consent was obtained by a family member, FM #39, via telephone and was dated [DATE]. The form revealed Section V. Physician Authorization included a physician signature but was not dated.Resident #67's record revealed no Surrogate documents in the resident's record to support the DNR form. Those documents were requested from DON #33 on [DATE] at 3:00 PM.Resident #67's Surrogate document was uploaded to the resident's electronic medical record on [DATE], during the survey.7. An admission Record indicated the facility admitted Resident #117 on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of nonrheumatic aortic (va[TRUNCATE

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	015136	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, facility policy review, and a review of the American Heart Association's Summary of High-Quality CPR [cardiopulmonary resuscitation] Components for BLS [Basic Life Support] Providers, the failed to ensure staff provided BLS in accordance with accepted guidelines. Specifically, the facility failed to ensure rescue breaths were provided while performing CPR to Resident #104 on [DATE].Failure of the facility to provide high-quality CPR that included chest compressions and rescue breaths during an attempted resuscitation created the likelihood of failed resuscitation efforts and death. Continued failure created the likelihood that the CPR attempts would be unsuccessful, which could cause serious harm, injury, impairment, or death to other residents.Further the facility failed to ensure staff verified Resident #104's code status before initiating CPR. The facility further failed to ensure staff did not provide CPR to a resident believed to have a do-not-resuscitate (DNR) order. Staff also failed to communicate the resident's understood DNR status to emergency medical services (EMS) staff. CPR was provided to Resident #104 by facility staff on [DATE] until EMS arrived. EMS staff provided CPR for approximately 20 minutes, started an intraosseous line, and administered emergency drugs before Resident #104 was pronounced deceased .This affected 1 (Resident #104) of 36 residents reviewed for code status and was cited as a result of the investigation of complaint number 454680.It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, serious harm, serious impairment or death to residents. The Immediate Jeopardy (IJ) was related to 42 Code of Federal Regulations (CFR) 483.24 Quality of Life at F678-Cardiopulmonary Resuscitation (CPR). The survey team notified the Regional Nurse Consultant, the Administrator, and Director of Nursing (DON) #33, who replaced the DON during the survey, of the IJ and provided the IJ template on [DATE] at 2:15 PM. The IJ began on [DATE] when staff provided CPR for Resident #104 and it was determined that proper CPR procedures were not followed. The IJ was removed on [DATE] after the survey team performed onsite verification that the removal plan had been implemented. Noncompliance for F678 remained at a lower scope and severity of no actual harm with the potential for more than minimal harm.Findings included: A facility policy titled, Cardiopulmonary Resuscitation (CPR), dated [DATE], indicated, It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement guidelines regarding cardiopulmonary resuscitation (CPR). The policy revealed, 1. The facility will follow current American Heart Association (AHA) guidelines regarding CPR. 2. If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and: a. In accordance with the resident's advance directives, or b. In the absence of advance directives or a Do Not Resuscitate order; and c. If the resident does not show obvious signs of clinical death (e.g. [exempli gratia; for example], rigor mortis, dependent lividity, decapitation, transection, or decomposition). The policy continued, 3. CPR certified staff will be available at all times. 4. Staff will maintain current CPR certification for healthcare providers through a CPR provider whose training includes a hands-on session either in a physical or virtual instructor-led setting in accordance with accepted national standards.The American Heart Association's Summary of High-Quality CPR Components for BLS Providers, dated 2020, indicated the Compression-ventilation ratio without advanced airway with one or two rescuers was 30 compressions, with compressions at least 2 inches in depth, with two hands on the lower half of the breastbone.An admission Record indicated the facility admitted Resident #104 on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of vascular dementia, diabetes mellitus, heart failure, and unspecified convulsions.Resident #104's Care Plan Report included a focus area initiated [DATE], that indicated the resident had an Advance Directive (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	that included a DNR. Interventions initiated [DATE] directed staff to discuss Advance Directives with the resident and/or their appointed health care representative; allow the resident, if able, to discuss their feelings regarding their Advance Directive; notify the physician of the resident's wishes regarding life prolonging procedures; and indicated that Advance Directives could be revoked or changed if the resident and/or appointed health care representative changed their mind about the medical care they wanted delivered.Resident #104's Appendix II Alabama Portable Physician Do Not Attempt Resuscitation Order No CPR/Allow Natural Death indicated that the resident's code status was to be DNR, however, Section I. Patient/Resident Consent was signed by Resident #104's family member (FM), FM #38, making the order invalid (see F578). Additionally, had FM #38 signed the appropriate section as a health care surrogate, there were no surrogate documents in the resident's records.Resident #104's Progress Notes revealed a Nursing Note, dated [DATE] at 2:38 AM, that indicated that on [DATE] at approximately 10:15 PM, staff were notified that the resident had fallen. The note indicated that upon entering the room, Resident #104 was observed lying on the floor and was assisted up, taken to the bathroom, then back to bed. The note indicated the resident became diaphoretic [excessive sweating] with decreasing oxygen saturations and was continuing to decline. The note indicated FM #38 asked the staff to help the resident and indicated that life saving measures were started until paramedics arrived. The note indicated that paramedics worked with resident but were unable to revive them.There was no other documentation of the resuscitation efforts included in Resident #104's medical record.During an interview on [DATE] at 2:34 PM, Resident #104's Responsible Party (RP), RP #28, stated the facility provided CPR for the resident and stated, They should not have done CPR, [Resident #104] was a DNR.During an interview on [DATE] at 11:38 AM, FM #38 stated Resident #104's code status was DNR and they remembered signing the DNR paperwork.During an interview on [DATE] at 12:53 PM, Licensed Practical Nurse (LPN) #27 stated that as best as she could recall, Resident #104 had fallen, and when she talked to the resident's family on the phone, staff came to tell her the resident's color did not look good. She stated that when she got to the room, the resident went unresponsive and FM #38, who was in the room, was asking her to help Resident #104, so she started doing chest compressions on the resident. She stated the manual respirator was not fitting the mask correctly, so she could not say for sure that rescue breaths were being given. LPN #27 stated the resident did have blood coming out of their mouth, but she could not recall if the resident was suctioned or not.During an interview on [DATE] at 5:27 PM, Certified Medication Aide (CMA) #21 stated FM #38 had initiated a call light and when she entered the room, the resident was lying on their side on the floor, stating they needed to go to the bathroom. She stated LPN #27 assessed the resident, then she and the nurse took the resident to the bathroom. She stated the resident walked to the bathroom, sat on the toilet, and did not have any complaints at that time. She stated that they walked the resident back to the bed, and they started to complain about shortness of breath and having a hard time breathing. She stated she stayed with the resident, and the nurse went and got oxygen and brought it back and put it on the resident. She stated the nurse was going to send the resident to the hospital, so she went to do the paperwork, but the resident was having more complaints of shortness of breath and did not look well, so she told one of the certified nurse aides (CNAs) to go get the nurse. She stated the nurse was in the room a minute or two later, and the resident went unresponsive. CMA #21 stated LPN #27 started doing chest compressions on the resident, and she (CMA #21) attempted to give the resident breaths, but the resident had blood coming out of their mouth. She stated a nurse from another floor came into the room and brought a cart with supplies needed to manage a life-threatening emergency (crash cart). She stated that they tried to put the mouth guard in place, but she could not say that rescue breaths were given. She stated the nurse did not stop compressions until EMS staff took over. She stated they were not able to find the resident's code status in the facility's electronic system. She stated the order was not entered correctly in the electronic medical record for it to be displayed under the resident's name. She stated they did have a code book at the nurses' station, but with the resident (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	being a newer admission, she did not think it was in the book. She stated if they had known the resident's code status, they would not have provided CPR and would have just explained it to FM #38.During a telephone interview on [DATE] at 5:48 PM, LPN #29 stated that when the code was called for Resident #104, she went to that floor and heard FM #38 requesting help for the resident and requesting that the resident be saved. She stated LPN #27 was giving chest compressions when she walked in the room, but she could not say if rescue breaths were being given. She stated she thought she brought the crash cart to the room, but she did not recall getting a mouth guard out and she did not provide rescue breaths. She stated if she had known the resident had a DNR, she would have kept FM #38 comfortable and let the rest of the family know the resident's condition.During a telephone interview on 08//26/2025 at 8:32 AM, CNA #37 stated Resident #104 had fallen on the floor. She stated that staff got the resident up and assisted them to the bathroom. She stated the resident started passing out and became unresponsive. She stated LPN #27 was providing chest compressions, and CMA #21 was assisting her, but she did not recall rescue breaths being administered.Resident #104's EMS report revealed EMS was notified of the incident at 10:48 PM on [DATE], and EMS staff arrived at 11:02 PM on [DATE]. According to the report, a facility healthcare provider (non-911 responder) was the first to initiate CPR and nursing facility staff were doing manual compressions when EMS arrived. The EMS report revealed the primary symptom was cardiac arrest and that the resident was unresponsive, had no vital signs of life, was cool, and pupils were fixed and dilated. Per the report, EMS started an intraosseous (IO) infusion, administered emergency medications (epinephrine, sodium bicarbonate, and calcium chloride) via the IO line, and provided CPR for approximately 20 minutes before calling their medical director and calling Resident #104's time of death at 11:20 PM on [DATE]. The EMS report revealed no documentation that the facility's staff provided rescue breaths or that EMS was informed by facility staff of Resident #104's DNR code status.During an interview on [DATE] at 8:34 AM, Unit Manager (UM) #5 stated that if a resident was designated as a DNR, staff were to respect their wishes and allow them to die with dignity.During an interview on [DATE] at 2:45 PM, the Regional Nurse Consultant stated proper CPR procedure included chest compressions with rescue breaths with a manual respirator at a ratio of 30 compressions to 2 breaths.During an interview on [DATE] at 3:18 PM, the Administrator stated if CPR was administered, she expected it to be done according to the recommendations by the AHA and how they were trained in a CPR class.**********The facility submitted a removal plan that indicated the following:********** F678 Removal Plan[DATE]. Immediate action(s) taken for the resident(s) found to have been affected:Resident identified expired at the time of the event on [DATE].2. How did you identify residents affected or likely to be affected:On [DATE], the Regional Director of Health Services (RDHS) educated the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Staff Development Coordinator (SDC) on the facility's code procedures and proper Cardiopulmonary Resuscitation (CPR) technique including chest compressions and when to provide rescue breathsXXX[DATE], as of 3:00 PM education was initiated by the DON, the ADON, the RDHS, and the SDC for all licensed nursing staff and MACs on the facility's code procedures and proper Cardiopulmonary Resuscitation (CPR) technique including chest compressions and when to provide rescue breaths. 16 staff members of 25 total who are BLS certified were educated (11 in person and 5 via phone). As of 3:00 PM on [DATE], staff members who have not been in-serviced will not be allowed to work until they are in-serviced by the DON, ADON, or SDC.The DON was educated by the RDHS that she is responsible for monitoring the schedule every day to identify scheduled staff who have not been in-serviced on the process and ensure the staff are trained before beginning their scheduled shift.On [DATE], an audit was completed by the Medical Records and Regional Assessment Compliance Coordinator to verify accuracy of each resident wishes about advanced (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	death was pulmonary embolism.2. Education provided to the DON, Assistant Director of Nursing (ADON)/Infection Preventionist (IP), and Staff Development Coordinator (SDC) on the facility's code procedures and proper CPR was verified by a review of signatures on the sign-in sheet and through interviews.Education to all licensed nursing staff was verified with the names on the sign-in sheet with the staff roster, and the education provided was reviewed with no concerns.Copies of the assignment sheet were obtained and compared with the in-service sign-in sheets to verify that all staff were educated on proper CPR protocol prior to working.Interviews with staff including one certified medication aide (CMA); 13 licensed practical nurses (LPNs), including the Medical Records Director, the Minimum Data Set (MDS) Coordinator, a respiratory LPN, a restorative LPN, a treatment LPN, and the SDC; four registered nurses (RNs), including the ADON/IP, a weekend supervisor, and one unit manager; and the social worker verified that they had received the education. The survey team reviewed the facility's audit records for resident code status, which indicated the facility confirmed each resident had a physician's order for code status; if DNR, had a signed and dated order that was uploaded in the resident's electronic medical record; and that each residents' code status was verified in the resident's profile and care plan. A statement from the Regional MDS Coordinator revealed she performed a house wide audit of code status on [DATE].The survey team reviewed the facility's in-service and training sign-in sheets, which indicated staff were educated on [DATE] regarding staff responsibility for honoring residents' wishes for DNR or a full code, code status order entry and location, and the facility's emergency protocol.The survey team interviewed the facility medical director, who confirmed the facility notified them of the IJ. 3. Education provided to the DON to verify the validity of each newly admitted resident's advance directives/code status was verified by a review of a sign-in sheet and through interview. Education provided to the DON to audit newly admitted residents to verify advance directive/code status reflects and was correlated in the electronic medical record was verified through a review of a sign-in sheet and through interview. The form being used for the audit was reviewed with no concerns. Education provided to the DON and SDC on completing actual code/mock code drills was verified through a review of a sign-in sheet and through interviews. The code drill form was reviewed and verified that a mock code drill was completed on [DATE] on the first shift and on [DATE] on the second shift. This was verified through interviews with the DON and the SDC. Interviews with most of the staff, including one CMA; 13 LPNs, including the MRD, the MDS Coordinator, a respiratory LPN, a restorative LPN, a treatment LPN, and the SDC; four RNs including the ADON/IP and a weekend supervisor; and one unit manager confirmed that they had participated in a code status drill. Eight CNAs were interviewed regarding emergency response.The audit to verify CPR certification and completion of an actual code or mock code was reviewed and confirmed that all CPR certifications were current, and the next one was due to expire [DATE]. During an interview with the Regional Nurse Consultant, the CPR instructor, said the class was already scheduled. Completion of the audit was verified through an interview with the DON. Four random staff member CPR cards were sampled to verify they were in place and current, with no concerns identified. Education provided to the DON on completing a monthly audit to verify advance directives were in place and accurate was verified through a review of the audit tool to be used and verified through a review of sign-in sheets and through interviews. The QAPI meeting was verified by reviewing the sign-in sheet that included signatures of the Administrator, the DON, the Medical Director via telephone, the ADON/IP, SSD, the Regional Nurse Consultant, two unit managers, the MRD, a treatment nurse, and a restorative nurse. Interviews with the Administrator, DON, Medical Director, ADON/IP, SSD, one unit manager, the MRD, a treatment LPN, and a restorative LPN verified they were part of the QAPI discussion related to DNRs and their responsibility in the process.The survey team reviewed the facility's Code Drill documents for [DATE], which indicated staff correctly followed the facility's protocol during two code drills.A facility document titled CPR Compliance Audit 2025 indicated facility staffs' CPR had a valid date and was not expired. The survey team also reviewed Licensed Nurse/Medication Assistant, Certified Questionnaire that the facility had (continued on next page)

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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** Based on observation, interview, record review, facility policy review, and review of Occupational Safety and Health Administration (OSHA) guidelines, the facility failed to provide adequate supervision and an environment free of potential fire hazards by failing to ensure a resident complied with the facility's vaping policy for 1 (Resident #3) of 6 residents reviewed for smoking/vaping safety. The failure had the likelihood to create a fire hazard or explosion, leading to serious harm/injury/impairment or death.It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, serious harm, serious impairment, or death to residents. The Immediate Jeopardy (IJ) was related to 42 CFR 483.25, Quality of Care.On 07/26/2025 at 9:38 AM the survey team provided the IJ template and notified the Administrator of the findings of substandard quality of care at the immediate jeopardy level at F689. The IJ began on 10/16/2024 and was removed on 07/27/2025, after the survey team performed onsite verification that the removal plan had been implemented. Noncompliance for F689 remained at a lower scope and severity of no actual harm with the potential for more than minimal harm.The facility also failed to ensure 1 (Resident #60) of 6 residents reviewed for smoking safety was assessed for the safe use of smokeless tobacco.Findings included:1. A facility policy titled, Vaping Policy, revised 09/01/2024, revealed, Purpose: To ensure the safety, health, and well-being of all residents, staff, and visitors by regulating the use of electronic cigarettes (e-cigarettes) or vaping devices on the skilled nursing facility property. This policy aims to reduce fire hazards, prevent secondhand vapor exposure, and support a clean, smoke-free environment. Policy Statement - Vaping and the use of e-cigarettes are only permitted in designated areas on the skilled nursing facility property and must comply with all local, state, and federal regulations. Unauthorized vaping in non-designated areas is prohibited to maintain the health and safety of residents and staff. Policy Guidelines:1. Definitions- Electronic Cigarette (E-Cigarette): Any electronic device designed to deliver nicotine, THC [tetrahydrocannabinol, a cannabinoid], or other substances to the user through inhalation of vapor.- Vaping: The act of inhaling vapor produced by an e-cigarette or similar device.2. Designated Areas for Vaping- Designated Smoking/Vaping Area: E-cigarette use, or vaping may only be permitted in an area specifically designated for smoking and vaping, located outside and away from resident care areas, entrances, and ventilation systems.- Indoor Restrictions: Vaping is strictly prohibited in all indoor areas, including resident rooms, communal spaces, hallways, and administrative areas.3. Resident Use of vaping Devices- Assessment and Consent: Residents who wish to use e-cigarettes must be assessed for safe use. This includes ensuring they are cognitively capable of operating the device safely and storing it securely.- Storage: All vaping devices and associated materials must be safely stored with nursing staff.- Supervised Use: For residents with cognitive or physical limitations that could impair safe vaping, use must be supervised by staff in the designated area, if permitted by facility policy.4. Fire Safety Measures- Battery Safety: Facility staff should inspect vaping devices for potential hazards, including malfunctioning batteries or charging cords. Charging of devices in resident rooms is strictly prohibited.- Fire Prevention: Vaping devices are considered fire hazards due to battery use. The facility will include vape-related risks in its safety training for staff and monitor adherence to safe vaping practices.5. Resident and Family Education- Health and Safety Information: Residents and families will be educated on the health and safety risks associated with vaping, including potential respiratory issues, fire hazards, and the risk of exposure to other residents.- Facility Policy: Staff will inform residents and families of this vaping policy upon admission, ensuring they understand the designated vaping areas and usage rules.6. Staff Vaping Regulations- Staff Compliance: Staff members are only permitted to use e-cigarettes during scheduled breaks and in designated areas, following the same restrictions as residents.- Professional Conduct: Staff must not (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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	vape in the presence of residents, visitors, or in areas where residents are receiving care to maintain a professional and therapeutic environment.7. Incident Reporting and Consequences- Incident Documentation: Any incident involving unauthorized use of vaping devices in non-designated areas or near oxygen equipment must be reported and documented immediately.- Policy Violations: Repeated violations of this policy by residents, visitors, or staff may lead to further action, including restriction of vaping privileges for residents or disciplinary action for staff. Additional action may result in discharge of the resident or termination of the staff. 8. Review and Compliance- Regular Review: This policy will be reviewed annually to ensure alignment with current health and safety regulations and best practices.- Compliance with State and Federal Laws: The facility will comply with all stated and federal regulations regarding e-cigarettes and vaping in healthcare settings. This policy ensures that skilled nursing facilities provide a safe, controlled environment that limits potential risks from vaping, while respecting residents' rights within regulated boundaries. An OSHA Fact Sheet - Lithium-ion Battery Safety, dated 01/2025, revealed, Chemical Hazards - Lithium-ion batteries contain various components that present different chemical hazards to workers, such as flammability, toxicity, corrosivity, and reactivity hazards. The Fact Sheet continued, Safety Hazards - In addition to electrical hazards, lithium-ion batteries can also present hazards resulting from thermal runaway. Because lithium-ion batteries combine a flammable electrolyte with a significant amount of stored energy, thermal runaway reactions are possible. Thermal runaway is a chain reaction where the heat released from the failure of one cell damages nearby cells. This can be initiated by internal short circuiting due to defects during manufacturing, mechanical damage to the battery, exposure to excessive heat or cold, and improper charging. Thermal runaway can be identified by several indicators including a rise in battery temperature, venting of gas, vapor, or smoke from the battery, or the presence of fire. Fires caused by thermal runaway can produce additional chemical hazards. The Training section indicated, In workplaces with lithium-ion batteries, it is important that employers ensure that an emergency action plan ([NAME]) includes lithium-related incident response procedures based on the manufacturer's instructions and NFPA (National Fire Protection Association) guidance for responding to battery failures, including fires and/or explosions caused by thermal runaway, and that workers are trained on these procedures. An admission Record revealed the facility initially admitted Resident #3 on 03/27/2019 and re-admitted the resident on 02/06/2024. According to the admission Record, the resident had a medical history that included diagnoses of epilepsy, hemiplegia and hemiparesis affecting the left dominant side, post-traumatic stress disorder (PTSD), anxiety, major depressive disorder, delusional disorders, visual hallucinations, mood disorder, dementia with other behavioral disturbance, suicidal ideations, and nicotine dependence. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/19/2025, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident currently used tobacco products. Resident #3's Smoking and Safety nursing assessment, effective 10/11/2024, indicated the resident used vape products and followed the facility's policy on the location and time of smoking. Resident #3's Smoking and Safety nursing assessment, effective 01/15/2025, indicated the resident used vape products and followed the facility's policy on the location and time of smoking. Resident #3's Care Plan Report included a focus area, initiated 08/02/2024, that indicated the resident currently used a vape in a designated area. Interventions directed staff to: assess lung sounds as needed (initiated 10/10/2024); instruct resident and representative about vaping risks and hazards and about vaping cessation aides that were available (initiated 10/10/2024); notify the charge nurse immediately if the resident was noted with any unsafe vaping practices (initiated 10/10/2024); ensure nurse observed the resident for signs and symptoms of respiratory illness or infections (initiated 10/10/2024), provide education to the resident and representative on the facility's policy and procedure related to vaping materials (initiated 10/10/2024); ensure a safe smoking assessment was completed quarterly and as needed (initiated 10/10/2024); and ensure the resident could vape in a designated location (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	plug or twist. Dry snuff may be loose finely cut or powdered dry tobacco and may be typically sniffed through the nostrils. Moist snuff and snus can be loose or pouched tobacco and placed in the mouth. The policy revealed, 3. All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process. 4. Residents who use smokeless tobacco will be further assessed, using the Resident Safe Smokeless Tobacco Assessment, to determine whether or not supervision is required during use, or if resident is safe to use smokeless tobacco at all. An admission Record revealed the facility admitted Resident #60 on 01/31/2025. According to the admission Record, Resident #60 had a medical history that included chronic respiratory failure with hypoxia, dysphagia, pleural effusion, and cognitive communication deficit. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/06/2025, revealed Resident #60 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS revealed Resident #60 required supervision or touching assistance with oral and personal hygiene. Resident #60's Care Plan included a focus area initiated on 06/23/2025 that indicated the resident required assistance with Activities of Daily Living (ADLs). Interventions directed staff to provide assistance with ADLs, mobility, and transfers as needed (initiated 06/23/2025). The resident's Care Plan did not address a focus area related to smokeless tobacco use. On 07/21/2025 at 9:56 AM, a smokeless tobacco container and a cup containing used smokeless tobacco packets were observed on Resident #60's bedside table. During an interview on 07/21/2025 at 9:56 AM, Resident #60 stated that they had used smokeless tobacco since their admission to the facility, and no one had said anything to the resident about using smokeless tobacco. On 07/21/2025 at 9:59 AM, a smokeless tobacco container was observed on Resident #60's bedside table. Resident #60 was not in the room at the time of the observation. Resident #60's medical record 07/21/2025 revealed no documented evidence of a Resident Safe Smokeless Tobacco Assessment. During an interview on 07/30/2025 at 3:40 PM, Certified Nurse Aide (CNA) #30 stated she believed that Resident #60's family brought smokeless tobacco into the facility for the resident. CNA #30 stated that the resident always had smokeless tobacco and a spit cup at the bedside and no one had said anything to CNA about the resident keeping the items. During an interview on 07/31/2025 at 8:34 AM, Unit Manager (UM) #5 stated that Resident #60 was initially admitted to the first floor of the facility and was recently moved to the second floor. UM #5 stated they were not aware that Resident #60 had tobacco in their possession. UM #5 stated the facility should have completed an assessment upon admission or when the resident notified the facility that they wanted to use a tobacco product. During an interview on 07/31/2025 at 9:34 AM, the Director of Nursing (DON) also stated that Resident #60 should have had a smoking assessment completed upon admission. The Administrator (ADM) was interviewed on 07/31/2025 at 10:26 AM. The ADM stated that it was their expectation for staff to follow all policies and procedures related to smoking.

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	015136	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Falkville Rehabilitation and Healthcare Center	10 West 3rd Street Falkville, AL 35622

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on interview, record review, and facility policy review, the facility failed to address repeated resident behaviors of violating the facility's vaping policy, to include developing and implementing interventions to address a resident's known behaviors of vaping in their room in the bed and hiding vape paraphernalia from staff, and failed to provide education to staff on the appropriate actions to take when they observed the resident vaping in the resident's room or saw vape paraphernalia in the resident's room for 1 (Resident #3) of 6 residents reviewed for smoking safety. The failure had the likelihood to cause serious injury, serious harm, serious impairment, or death due to the fire risk associated with the resident's non-compliant behaviors of vaping in bed and hiding vape paraphernalia from staff, as well as the lack of appropriate interventions and education of the staff to address those behaviors.It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, serious harm, serious impairment, or death to residents. The Immediate Jeopardy (IJ) was related to 42 CFR 483.40, Behavioral Health Services.The survey team notified the Administrator (ADM) of the IJ and provided the IJ template on 07/26/2025 at 9:38 AM. The IJ began on 10/16/2024 and was removed on 07/28/2025 after the survey team performed onsite verification on 07/28/2025 to confirm that the removal plan had been implemented. Noncompliance for F740 remained at a lower scope and severity of no actual harm with the potential for more than minimal harm.Findings included:A facility policy titled, Behavior Documentation and Reporting, revised 12/31/2024, revealed, Process: It is the goal of this facility to ensure timely, consistent, and objective documentation of resident behaviors to support care planning, quality of care, regulatory compliance, and early identification of concerns such as unmet needs, abuse, mental health issues, or medication side effects. The policy also indicated, Procedure: 1. When to Document Behaviors: Staff must document behavioral events that:- Indicate changes from baseline behavior.- Are aggressive, disruptive, harmful to self/others.The policy also indicated, 2. Documentation: Use objective, descriptive language if documenting in narrative form that when possible answers:- Who is involved?- What happened? (include direct quotes if verbal)- When and where did it occur?- What was the resident's affect or facial expression?- What interventions were attempted?- Outcome of the behavior and follow-up actions.The policy also indicated, 3. Location of documentation may be included in:- Progress notes in the medical record (daily or episodic).- 24-hour report (for handoff communication).- Behavior monitoring tool or flow sheet.The policy also specified, 4. Notification and Escalation:- Notify the physician for significant or escalating behaviors.- Notify responsible party for severe or repeated behaviors.- Notify DON, Social Services, or Behavioral health Provided as appropriate.The policy also indicated, 5. Care Planning and Interventions:- IDT [Interdisciplinary Team] reviews documented behaviors weekly or as triggered.- Care plan undated to reflect behavioral patterns, triggers, and specific interventions. A facility policy titled, Vaping Policy, revised 09/01/2024, revealed, Purpose: To ensure the safety, health, and well-being of all residents, staff, and visitors by regulating the use of electronic cigarettes (e-cigarettes) or vaping devices on the skilled nursing facility property. This policy aims to reduce fire hazards, prevent secondhand vapor exposure, and support a clean, smoke-free environment. Policy Statement - Vaping and the use of e-cigarettes are only permitted in designated areas on the skilled nursing facility property and must comply with all local, state, and federal regulations. Unauthorized vaping in non-designated areas is prohibited to maintain the health and safety of residents and staff. Policy Guidelines:1. Definitions- Electronic Cigarette (E-Cigarette): Any electronic device designed to deliver nicotine, THC [tetrahydrocannabinol, a cannabinoid], or other substances to the user through inhalation of vapor.- Vaping: The act of inhaling vapor produced by an e-cigarette or similar device.2. Designated Areas for Vaping- Designated Smoking/Vaping Area: E-cigarette use, or vaping may only be permitted in an area specifically designated for smoking and vaping, located outside and away from resident care areas, (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	entrances, and ventilation systems.- Indoor Restrictions: Vaping is strictly prohibited in all indoor areas, including resident rooms, communal spaces, hallways, and administrative areas.3. Resident Use of vaping Devices- Assessment and Consent: Residents who wish to use e-cigarettes must be assessed for safe use. This includes ensuring they are cognitively capable of operating the device safely and storing it securely.- Storage: All vaping devices and associated materials must be safely stored with nursing staff.- Supervised Use: For residents with cognitive or physical limitations that could impair safe vaping, use must be supervised by staff in the designated area, if permitted by facility policy.4. Fire Safety Measures- Battery Safety: Facility staff should inspect vaping devices for potential hazards, including malfunctioning batteries or charging cords. Charging of devices in resident rooms is strictly prohibited.- Fire Prevention: Vaping devices are considered fire hazards due to battery use. The facility will include vape-related risks in its safety training for staff and monitor adherence to safe vaping practices.5. Resident and Family Education- Health and Safety Information: Residents and families will be educated on the health and safety risks associated with vaping, including potential respiratory issues, fire hazards, and the risk of exposure to other residents.- Facility Policy: Staff will inform residents and families of this vaping policy upon admission, ensuring they understand the designated vaping areas and usage rules.6. Staff Vaping Regulations- Staff Compliance: Staff members are only permitted to use e-cigarettes during scheduled breaks and in designated areas, following the same restrictions as residents.- Professional Conduct: Staff must not vape in the presence of residents, visitors, or in areas where residents are receiving care to maintain a professional and therapeutic environment.7. Incident Reporting and Consequences- Incident Documentation: Any incident involving unauthorized use of vaping devices in non-designated areas or near oxygen equipment must be reported and documented immediately.- Policy Violations: Repeated violations of this policy by residents, visitors, or staff may lead to further action, including restriction of vaping privileges for residents or disciplinary action for staff. Additional action may result in discharge of the resident or termination of the staff. 8. Review and Compliance- Regular Review: This policy will be reviewed annually to ensure alignment with current health and safety regulations and best practices.- Compliance with State and Federal Laws: The facility will comply with all stated and federal regulations regarding e-cigarettes and vaping in healthcare settings. This policy ensures that skilled nursing facilities provide a safe, controlled environment that limits potential risks from vaping, while respecting residents' rights within regulated boundaries. An admission Record revealed the facility initially admitted Resident #3 on 03/27/2019 and re-admitted the resident on 02/06/2024. According to the admission Record, the resident had a medical history that included diagnoses of epilepsy, hemiplegia and hemiparesis affecting the left dominant side, post-traumatic stress disorder (PTSD), anxiety, major depressive disorder, delusional disorders, visual hallucinations, mood disorder, dementia with other behavioral disturbance, suicidal ideations, and nicotine dependence. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/19/2025, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident currently used tobacco products. Resident #3's Smoking and Safety nursing assessment, effective 10/11/2024, indicated the resident used vape products and followed the facility's policy on the location and time of smoking. Resident #3's Smoking and Safety nursing assessment, effective 01/15/2025, indicated the resident used vape products and followed the facility's policy on the location and time of smoking. Resident #3's Care Plan Report included a focus area, initiated 08/02/2024, that indicated the resident currently used a vape in a designated area. Interventions directed staff to: assess lung sounds as needed (initiated 10/10/2024); instruct resident and representative about vaping risks and hazards and about vaping cessation aides that were available (initiated 10/10/2024); notify the charge nurse immediately if the resident was noted with any unsafe vaping practices (initiated 10/10/2024); ensure nurse observed the resident for signs and symptoms of respiratory illness or infections (initiated 10/10/2024), provide education to the resident and representative on the facility's policy and procedure related to (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	vaping materials (initiated 10/10/2024); ensure a safe smoking assessment was completed quarterly and as needed (initiated 10/10/2024); and ensure the resident could vape in a designated location (initiated 10/10/2024). Resident #3's Care Plan Report revealed no revisions had been made related to the resident's non-compliance with the vaping policy or the family member's non-compliance with providing the resident with vaping supplies and not alerting nursing staff. Resident #3's Care Plan Report revealed no interventions were put in place for staff to observe vape paraphernalia in the room when providing care or instructions regarding what to do if staff witnessed non-compliance. Resident #3 had multiple behavior-focused care plans, none of which addressed non-compliance with the vaping policy. A nurse's Progress Note[s], dated 10/16/2024 at 1:13 PM, revealed Resident #3 enjoyed lying in bed and vaping. A nurse's Progress Note[s], dated 10/17/2024 at 1:59 AM, revealed Resident #3 liked to lay in bed and vape and listen to music. An IDT Meeting Progress Note[s], dated 05/28/2025 at 7:06 PM revealed, Resident vapes in the designated smoking areas of the facility. The Progress Note indicated Resident #3 had been educated on proper storage of the vape device, scheduled smoking times, and the need for staff supervision while vaping. The Progress Note indicated Resident #3's smoking assessment and care plan were reviewed and current. A late entry IDT Progress Note[s], dated 06/25/2025 at 7:01 AM revealed, Resident vapes in the designated smoking areas of the facility. The Progress Note indicated Resident #3 had been educated on proper storage of the vape device, scheduled smoking times, and the need for staff supervision while vaping. The Progress Note indicated Resident #3's smoking assessment and care plan were reviewed and current. A late entry IDT Meeting Progress Note[s], dated 07/09/2025 at 5:22 PM revealed, Resident vapes in the designated smoking areas of the facility. The Progress Note indicated Resident #3 had been educated on proper storage of the vape device, scheduled smoking times, and the need for staff supervision while vaping. The Progress Note indicated Resident #3's smoking assessment and care plan were reviewed and current. Nurse Practitioner (NP) #1's Progress Note[s], dated 07/10/2025 at 1:18 PM, revealed Resident #3 was in no apparent distress resting quietly in [resident's] bed watching TV and vaping. Resident #3's Behavior Monitoring & Interventions record, dated from 06/24/2025 through 07/23/2025, revealed no documentation of behaviors or non-compliance with the vaping policy. A facility document titled Incidents by Incident Type, dated from 07/22/2024 through 07/22/2025, revealed no incidents involving Resident #3's non-compliance with the vaping policy. On 07/23/2025 at 3:23 PM, NP #1 stated Resident #3 was actively vaping in bed when she visited on 07/10/2025. NP #1 stated Resident #3 hid the vapes from the staff, and a family member continuously brought new vapes to replace the ones removed by staff. NP #1 stated she had observed Resident #3 vaping in their room too many times to count. NP #1 stated there were designated times the residents went out to vape, and the nursing staff were to keep the vaping devices locked up between those times. During an interview on 07/23/2025 at 5:06 PM, NP #1 stated she had not alerted the nurses or nursing staff about Resident #3 vaping in their room anymore because it was a well-known fact by the staff. NP #1 stated Resident #3 had been caught vaping several times, and when staff confiscated the vape device from the resident's room, the resident called a family member, and the family member brought in a new vape device to hide. During an interview on 07/23/2025 at 5:20 PM, Resident #3 stated they tried to hide their vape devices all the time, and family brought new vape devices to their room when the resident needed one. Resident #3 stated yesterday staff took their vape device away and the time before that was about two weeks ago. Resident #3 stated they knew the staff did not like them vaping in their room, but they did not like to get out of bed and go outside to vape and felt like they should be able to vape in their room like they did at home. Resident #3 stated their family member was aware of the vaping rules. During an interview on 07/23/2025 at 5:34 PM, Certified Medication Aide/Certified Nurse Aide (CMA/CNA) #2 stated she saw Resident #3 vaping in their room, or a vape device on the resident's bedside table quite often. CMA/CNA #2 stated a family member brought Resident #3 another vape when staff took them from the resident's room. CMA/CNA #2 stated it was a widely known fact that Resident #3 would sneak and vapes in their room. CMA/CNA #2 (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated the last time a vape device was removed from the resident's room was just a few days prior. CMA/CNA #2 stated when staff saw a vape device in Resident #3's the room, it was reported to the Unit Manager (UM). During an interview on 07/23/2025 at 5:39 PM, CMA/CNA #3 stated Resident #3 got caught quite often vaping in their room, and she had seen the resident do so multiple times, once or twice a week after a family visit. CMA/CNA #3 stated it was a well-known fact that Resident was not compliant with the vaping rules, most everybody knows that. She stated that when she would see the resident vaping. CMA/CNA #3 stated she reported Resident #3 vaping in their room to the UM, so they could remove the device. CMA/CNA #3 stated the last time she saw Resident #3 vaping in their room was yesterday, 07/22/2025. During an interview on 07/23/2025 at 5:41 PM, CNA #4 stated she had seen Resident #3 vaping in their room before, and had notified the nurse about it. CNA #4 stated it was a well-known fact the Resident #3 hid vaping devices in their room. During an interview on 07/24/2025 at 8:24 AM, the Assistant Director of Nursing/Infection Preventionist (ADON/IP) stated she was familiar with Resident #3 and was aware the resident's family brought in vape materials for the resident pretty frequently, and the resident hid them in the room from staff. During an interview on 07/24/2025 at 8:27 AM, Unit Manager (UM) #5 stated she was aware that Resident #3's family member often brought vape materials to the resident's room. UM #5 stated she had not spoken to the family member about the policy or the need to bring vaping materials to the nurse's station. During an interview on 07/24/2025 at 8:46 AM, Registered Nurse (RN) #6 stated she was familiar with Resident #3 and was aware the resident's family member brought in vaping materials to the resident. RN #6 stated she had personally seen the resident vaping in the bed and had reported it to the Unit Manager. RN #6 stated that when Resident #3 was transferred up to the second floor, management warned them of the resident's behaviors and that the resident vaped in their room. RN #6 stated there was a behavioral note the nurses could put in the computer to record Resident #3's non-compliance, but she had not done that. During an interview on 07/24/2025 at 5:35 PM, Resident #3's family member (FM) #31 stated they had not talked to anyone at the facility regarding their family member's issues with vaping. FM #31 stated they were unaware they needed to bring the vape devices to the nurse's station instead of giving them to the resident when they visited. During an interview on 07/24/2025 at 2:45 PM, the Social Services Director (SSD) stated she was very familiar with Resident #3 and was fully aware the resident did not follow the rules for vaping. The SSD stated if she were made aware that a resident had a vape device, she would retrieve it from the resident and go over the vaping policy again with the resident, reminding them they had signed the vaping policy at admission. The SSD stated that in Resident #3's case every time staff would take a vape device from the resident's room the family member brought in another vape device. The SSD stated she had explained to the family member the need to bring the new vape devices to the nurse's station, but the family member did not hear or listen. The SSD stated when Resident #3 was non-compliant, she would tell the DON or ADM, but she did not document it anywhere. The SSD stated behavior management was part of the Interdisciplinary Team's (IDT) functions. The SSD stated during IDT meetings, she updated behavior care plans and smoking/vaping care plans; however, Resident #3's care plan was not up to date with their non-compliance and should have been. During an interview on 07/24/2025 at 11:47 AM, the Director of Nursing (DON) stated Resident #3 was resistant to the vaping policy. The DON stated Resident #3 did not like to get out of bed, and the only way Resident #3 could vape was to go outside. The DON stated she had not had a conversation with the family member about bringing vape supplies to the nurses instead of taking them to the resident's room but thought someone else had. The DON confirmed there were no care conference notes about talking to the family member, and Resident #3's care plan did not include the resident not following the policy. The DON stated the care plan should have been accurate as to what Resident #3 was doing and include correct interventions for the staff to follow. The DON stated the Resident #3's smoking assessments were not correct, as she had not answered the questions correctly, and Resident #3 had been non-compliant with vaping in their room for a long time. The DON confirmed there were no behaviors recorded on the Resident #3's behavior (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	log for the last 30 days, and she did not see any nurse's notes about the vaping in their room or hiding vaping supplies from staff. However, the DON provided a copy of phone screenshots of two text message exchanges with Resident #3's family member. The first message, dated 10/10/2024 at 10:23 AM, requested the family member to call the DON when they had a chance to discuss the facility vaping policy. The second message, dated 11/02/2024 at 11:53 AM, revealed the family member asked if they provided a vape device that did not have to be plugged in, could the resident have it. The DON's response was, They said no vapes indoors since they have a spark inside. During an interview on 07/25/2025 at 8:35 AM, the ADM stated this week she had learned there were issues regarding Resident #3 keeping vaping supplies in their room and vaping in their room. The ADM stated she had only been at the facility five weeks, and had learned that on several occasions staff had to confiscate vape devices from Resident #3's room, but she did not know when that occurred. During a concurrent interview with the ADM and DON on 07/25/2025 at 3:02 PM, the DON stated her expectation going forward was that staff alerted management when residents were non-compliant with things like smoking/vaping inside that could cause harm to other residents and that information was placed in the resident's medical record regarding what happened or what was done to prevent it from happening again. The ADM stated they recently became aware of details regarding Resident #3's vaping, had heard about things being found in the resident's room in the past, but was not aware the resident was actively still vaping in their room. The ADM stated that was a very serious issue and should have been addressed before now. The ADM stated she expected going forward that staff would treat an issue like smoking in bed to be one of sheer urgency, documenting what was seen and what was done about it in the medical record and in all areas it should go. The ADM stated the goal should always be to keep the residents safe, even from themselves sometimes.**********The facility submitted a removal plan that indicated the following:********** F740 Removal PlanDate of IJ Removal Plan: 07/24/2025 1. Immediate action(s) taken for the resident(s) found to have been affected: On 07/21/2025, a vape was removed from Resident #3 by the Assistant Administrator.On 07/24/2025, a vape was removed from Resident #3 by the Assistant Administrator.On 07/24/2025, the Administrator spoke to Resident #3's responsible party [family member] by phone and educated them on the safety issues and the violation of facility rules of vaping. It was explained that continued violation could possibly lead to an emergency discharge.On 07/26/2025, Resident #3 was reassessed for smoking safety via the smoking assessment, and the care plan was updated to reflect the behaviors of noncompliance.Resident #3 will be followed in the weekly behavior meeting for a minimum of 30 days and until consistent resident compliance is observed.Resident #3 will be followed by mental health care providers for management of behavioral challenges.2. How did you identify residents affected or likely to be affected: On 07/24/2025, the facility conducted a comprehensive house-wide audit led by the Administrator, Director of Nursing (DON), and Unit Managers to identify any resident in possession of vapes. The audit included physical inspection of resident rooms, common areas, personal belongings, and locked storage where permitted.During the audit, unsecured vapes were found in two resident rooms and were immediately confiscated. Documentation of each finding was submitted to the Administrator, and the residents were re-educated on smoking/vaping policies and safety expectations.Resident Council was conducted by [NAME] President (VP) of Operations and the Activity Director on 07/24/2025. The vaping policy and emergency discharge process were explained. This included the five residents who are currently vaping.Residents will be monitored for noncompliance and residents who refuse to follow the facility's vaping policy will be reviewed in our daily clinical meeting.All residents who vape but exhibit noncompliance with the facility's vaping policy will be followed in the weekly behavior meeting for a minimum of 30 days and until consistent resident compliance is observed. These residents will be referred to behavioral health services as appropriate.3. How the practice will be (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	monitored:On 07/26/2025, as of 4:00 PM, education was initiated by the Assistant Administrator, DON, and Staff Development Coordinator (SDC) for all staff on the vaping policy, including supervision protocols, what to do if staff find resident with a vape. A total of 120 staff members out of 138 were in-serviced on the vaping policy, behaviors, reporting and monitoring of residents who are not following the vaping policy (93 in person and 25 via phone). As of 4:00 PM on 07/26/2025, any staff member who has not been in-serviced will not be allowed to work until they are in-serviced by the SDC, DON, or Assistant Director of Nursing (ADON).A quality assurance-performance improvement (QAPI) meeting was held on 07/25/2025, which included the [NAME] President of Operations, Regional Director of Health Services, Administrator, DON, and the Medical Director (via phone). The following areas were reviewed: Vaping policy and behaviors of noncompliance with vaping policy.Audits will be completed daily by a member of the staff on Resident #3 to ensure that this resident does not have vape paraphernalia hidden in the resident's room. This will be completed by the Administrator/Designee.All residents who vape will be audited once a week times (x) 8 weeks to ensure that residents are not keeping vapes in their rooms. These audits will be completed by the Administrator/Designee.Clinical interdisciplinary team (IDT) will review resident records to ensure that behaviors are being monitored, are reported to administration and provider, are appropriately care-planned, and that the interventions remain effective in morning clinical meetings.IDT team to include, Administrator/designee, Director of Nursing/designee, Unit Managers, Restorative Nurse, Medical Record Nurse, Minimum Data Set (MDS) Coordinator, and Social Services were provided education on 07/27/2025, on the inclusion of residents who exhibit noncompliance with the facility's vaping policy to be followed in the weekly behavior meeting for a minimum of 30 days and until consistent resident compliance is observed.IDT will hold weekly behavior meetings and review resident records to ensure that behaviors are being monitored, reported to administration and providers, are appropriately care-planned, and that the interventions remain effective. Residents who exhibit noncompliance with the facility's The vaping policy to be followed in the weekly behavior meeting for a minimum of 30 days and until consistent resident compliance is observed.4. The facility alleges all corrective actions were completed by 07/26/2025. 5. The facility alleges the immediacy of the IJ was removed on 07/26/2025. **********The IJ was removed on 07/27/2025 at 4:45 PM, after the survey team verified the facility's implementation of the removal plan as follows:1. The survey team reviewed the following records: - a written statement dated 07/21/2025 and signed by the Assistant Administrator that indicated he had removed a vaping device from Resident #3's room on that date; - a written statement dated 07/24/2025 and signed by the Assistant Administrator that indicated he had removed a vaping device from Resident #3's room on that date; - a written statement dated 07/26/2025 and signed by the ADM regarding her conversation with Resident #3's family member on 07/24/2025; - a written statement dated 07/26/2025 and signed by the ADM regarding her conversation with Resident #3 regarding the vaping policy and of that conversation being a final notice. The ADM documented if another occurrence of vaping in the room occurred Resident #3 would be given an emergency discharge notice; - a Progress Note, dated 07/26/2025 at 2:11 PM, that revealed Resident #3's Smoking Safety Assessment had been updated to include non-compliance with the vaping policy; - Resident #3's Care Plan Report that had been revised to include Resident #3's history of non-compliance with the vaping policy; and - Resident #3's Order Summary Report that included orders for evaluation by the facility's psychiatric provider.Surveyors interviewed the ADM and Resident #3 who both confirmed conversations had occurred regarding the vaping policy and included that the non-compliance issues could lead to an emergency discharge. Surveyors confirmed the facility would be conducting behavior IDT meetings on Fridays going forward.2. The survey team reviewed the following:- a written statement, dated 07/24/2025, signed by the ADM, DON, UM #5, and UM #15 that revealed a comprehensive house-wide audit had been completed to identify residents in possession of vaping materials;- a list of all the (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Falkville Rehabilitation and Healthcare Center	10 West 3rd Street Falkville, AL 35622

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	rooms audited during the house-wide audit; - a signed written statement, dated 07/24/2025, in which the Maintenance Director confirmed they found and immediately removed two vaping devices in resident rooms and reported the findings to the ADM;- a signed written statement, dated 07/24/2025, in which the Assistant Administrator confirmed they had educated the two residents who had been in possession of vaping materials removed by the Maintenance Director about the expectations of vaping while residing in the building; - ad hoc Resident Council meeting minutes, dated 07/24/2025 at 1:38 PM, that revealed the [NAME] President (VP) of Operations held a meeting with all the current residents who vaped and explained to them the vaping policy, the safety concerns with vaping in their rooms, and the possibility of an emergency discharge from the facility if they were found vaping in their rooms again; and- the Morning Meeting Template/Daily Clinical Meeting documents that included any compliance issues with residents who vaped.Surveyors interviewed the following: - Residents who vaped to confirm they had conversations with the VP of Operations regarding the vaping policy and non-compliance consequences; and - The Maintenance Director, who confirmed removing vaping devices from resident rooms. 3. The survey team reviewed the following records:- the facility's Vaping Policy;- multiple in-service and training sign-in sheets with staff signatures and specific agenda items discussed from the Vaping Policy, including the designated vaping area location, the designated times for residents to vape, and policy rationales. As of 07/26/2025 at 4:00 PM, 120 employees out of a total of 138 employees had been in-serviced, and the remaining staff were not to be allowed to work until they were in-serviced;- the audit sheets for the last three days were reviewed, and no issues were noted. The audits were being conducted daily, and no new issues of non-compliance had been reported through this process;- the Behavior Management tracking log to be reviewed in the IDT meetings; and- QAPI meeting minutes from the meeting held with the IDT on Behavior Management.The surveyors interviewed: - Staff to ensure they had received the education on the vaping policy and knew what to report. No issues were noted and staff were knowledgeable of the process;- Staff members listed on the attendee's sheet from the ad-hoc QAPI meeting were interviewed for content and attendance without any issues noted; and- Members of the IDT were interviewed to ensure the content of the education provided.4. Surveyors validated all items were completed by 07/27/2025.5. Surveyors validated the immediacy of F740 was removed on 07/27/2025.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, facility policy review, facility document review, and a review of Alabama State Committee of Public Health Administrative Code, the facility's administration failed to:1) address ongoing resident non-compliance with the facility's vaping policy. Administration had created a quality assurance performance improvement (QAPI) plan on [DATE] for vaping non-compliance without any further action being taken to address ongoing non-compliance with the vaping policy for 1 (Resident #3) of 6 residents reviewed for smoking safety. Resident #3 continued vaping in his/her room.The failure had the likelihood to place all residents in the facility at risk for serious harm/injury/impairment or death related to fire hazards and the risk of injury related to battery explosion.It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, serious harm, serious impairment, or death to residents. The IJ began on [DATE] when it was noted in Resident #3's medical record that staff were aware the resident was noncompliant with the facility's vaping policy. The survey team notified the Administrator of the IJ and provided the IJ template on [DATE] at 9:38 AM. After Quality Assurance review the survey team re-entered the facility on [DATE] to further investigate another incident of non-compliance related to Resident #104.2) The facility further failed identify and correct concerns related to ensuring residents' Advance Directives were honored. The facility's administration failed to ensure the facility educated facility staff who assisted residents and/or families when completing documentation related to their Advance Directive decisions. The residents' record had incomplete and/or invalid documentation regarding the residents' end-of-life decisions and did not include the required Power of Attorney (POA), Living Will, or Surrogate paperwork included in the residents' records as indicated. This affected 13 (Residents #104, #97, #79, #116, #66, #67, #117, #82, #115, #32, #55, #64, and #77) of 36 residents reviewed for code status.The administration identified concerns with staff response to an event that occurred on [DATE] involving Resident #104 and their code status but failed to identify that do not resuscitate (DNR) forms were not complete, accurate, and that required Power of Attorney (POA), Living Will, or Surrogate documents were not included in the residents' record.The failure created the likelihood that a resident's end-of-life decisions would not be honored and cardiopulmonary resuscitation (CPR) being provided or withheld against the residents' decision.It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, serious harm, serious impairment, or death to residents. The Immediate Jeopardy (IJ) was related to 42 CFR 483.70 Administration at F835-Administration.The survey team notified the Regional Nurse Consultant, the Administrator, and the Director of Nursing (DON) of the IJ and provided the updated IJ template for F835 on [DATE] at 11:20 AM.The IJ began on [DATE] and was removed on [DATE], after the survey team performed onsite verification that the removal plan had been implemented. Noncompliance for F835 remained at a lower scope and severity of no actual harm with the potential for more than minimal harm. Findings included:Cross-Reference F689, F578, F678, and F867.A facility policy titled, Quality Assurance and Performance Improvement (QAPI), revised [DATE], revealed, Policy: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. The Policy Explanation and Compliance Guidelines revealed, 1. The QAPI program includes the establishment of a Quality Assessment and Assurance (QAA) Committee and a written QAPI Plan. 2. The QAA Committee shall be interdisciplinary and shall: a. Consist at a minimum of: .iii. At least three other members of the facility's staff, at least one of which must be the Administrator, owner, a board member, or other individual in a leadership role; .c. Develop and implement appropriate plans of action to correct identified quality deficiencies. d. Regularly review and analyze data, including data collected under the QAPI program . and act on (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	available data to make improvements. The policy continued, 4. The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program. Documentation may include, but is not limited to: a. The written QAPI plan. b. Systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events. c. Data collection and analysis at regular intervals. d. Documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities. The Program Development Guidelines further revealed, 2. Governance and Leadership - a. The governing body and/or executive leadership is responsible and accountable for the QAPI program. b. Governing oversight responsibilities include but are not limited to the following: i. Approving the QAPI plan annually, and as needed. ii. Ensuring the program is ongoing, defined, implemented, maintained, and addresses identified priorities. iii. Ensuring the program is sustained during transitions in leadership and staffing.The policy continued, vi. Ensuring the corrective actions address gaps in systems and are evaluated for effectiveness. vii. Setting clear expectations around safety, quality, rights, choice, and respect. The policy also indicated, 3. Program Feedback, Data Systems and Monitoring - a. The facility maintains procedures for feedback, data collection systems, and monitoring, including adverse event monitoring.The policy also indicated, 4.Program Activities - a. All identified problems will be addressed and prioritized, whether by frequency of data collection/monitoring or by the establishment of sub-committees. Considerations include, but are not limited to: i. High-risk, high-volume, or problem-prone areas. ii. Incidence, prevalence, and severity of problems in those areas. iii. Measures affecting resident health, safety, autonomy, choice, health equity, and quality of care. The policy further specified, 5. Program Systematic Analysis and Systematic Action - a. The facility takes actions aimed at performance improvement as documented in QAA Committee meeting minutes and action plans. Performance/success of the actions will be monitored and documented in subsequent QAA Committee or sub-committee meetings. b. To ensure improvements are sustained, the effectiveness of performance improvement activities will be monitored in QAA Committee meetings in accordance with the QAPI plan, but no less than annually.A facility policy titled, Vaping Policy, revised [DATE], revealed, . Indoor Restrictions: Vaping is strictly prohibited in all indoor areas, including resident rooms, communal spaces, hallways, and administrative areas. 3. Resident Use of vaping DevicesAssessment and Consent: Residents who wish to use e-cigarettes must be assessed for safe use. Storage: All vaping devices and associated materials must be safely stored with nursing staff.7. Incident Reporting and ConsequencesIncident Documentation: Any incident involving unauthorized use of vaping devices in non-designated areas or near oxygen equipment must be reported and documented immediately. Policy Violations: Repeated violations of this policy by residents, visitors, or staff may lead to further action, including restriction of vaping privileges for residents or disciplinary action for staff. Additional action may result in discharge of the resident or termination of the staff.A facility QAPI plan, dated [DATE], indicated the Administrator (ADM) learned of residents vaping in their rooms and new admissions coming into the facility with vaping devices. Identified Issue(s) Administrator found out about residents vaping in their rooms, new admissions coming into the facility with vapes on [DATE] [[DATE]].Root Cause Analysis completed: the contributing factors found that resulted in residents vaping in their rooms was that staff were not educated on our vaping policy and an established system to be in compliance Safety Plan for Resident(s) identified.The Administrator completed a house wide [sweep/search] collecting all resident vapes and chargers who staff know have them in their rooms. No issues with this. This was completed on [DATE][2025].Plan for all other residents that may be affected.The Administrator conducted an emergency resident council meeting explaining the vaping policy on [DATE] [[DATE]].- Ombudsman came to facility on [DATE] [[DATE]] to talk to residents about vaping policy.System change identified & education plan.- Established outside vaping courtyard 1st floor- Establish set vaping times in designated outside area 10:30 [AM], 1:30 [PM], 6:00 [PM] Housekeeping and evening activity responsible for taking out vapers [Residents who used vaping devices]- In-serviced nursing (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	staff on vaping policy including established vaping times, designated vaping area, and that residents aren't allowed to have vapes or vape chargers in their room nursing is responsible for storage of vape and enforcing policy - Nursing must secure vapes in locked med room and charge them.Monitoring System- Vaping log to monitor adherence to established vaping times. - Staff are instructed to let management know of any residents that have vapes. This will be addressed and corrected.Along with the facility QAPI plan regarding vaping, the facility also provided the following:- A signed written statement by the DON regarding the phone conversations held with Resident #3's Family Member (FM) #31 on [DATE], [DATE], and [DATE] regarding vaping and the facility policy;- A Midnight Census report, dated [DATE], used by the previous ADM when collecting vaping devices from residents' rooms on [DATE]; - A copy of the emergency Resident Council meeting minutes, dated [DATE], with residents' signatures; - A list of the designated vaping times; - A copy of the vaping policy;- An Inservice Training Sign In Sheet, dated [DATE], with staff signatures;- A [Facility Name] Facility Non-Smoking & Vaping Policy Acknowledgement, with each residents' signature and Vapers Sign In Sheet[s] for each time the residents went outside to vape; however, there was no Facility Non-Smoking & Vaping Policy Acknowledgement or Vapers Sign In Sheet signed for Resident #3, either by the resident or their family member. On [DATE] at 3:23 PM, NP #1 stated Resident #3 was actively vaping in their bed when she visited on [DATE]. NP #1 stated Resident #3 hid the vapes from the staff, and a family member continuously brought new vapes to replace the ones removed by staff. NP #1 stated she had observed Resident #3 vaping in their room too many times to count. NP #1 stated there were designated times the residents went out to vape, and the nursing staff were to keep the vaping devices locked up between those times. During an interview on [DATE] at 5:06 PM, NP #1 stated she had not alerted the nurses or nursing staff about Resident #3 vaping in their room anymore because it was a well-known fact by the staff. NP #1 stated Resident #3 had been caught vaping several times, and when staff confiscated the vape device from the resident's room the resident called a family member, and the family member brought in a new vape device to hide.During an interview on [DATE] at 8:24 AM, the Assistant Director of Nursing/Infection Preventionist (ADON/IP) stated she was familiar with Resident #3 and was aware the resident's family brought in vaping materials for the resident pretty frequently, and the resident hid the vaping materials in the room from staff.During an interview on [DATE] at 8:27 AM, Unit Manager (UM) #5 stated she was aware that Resident #3's family member often brought vape materials to the resident's room. UM #5 stated she had not spoken to the family member about the policy or the need to bring vaping materials to the nurse's station.During an interview on [DATE] at 2:45 PM, the Social Services Director (SSD) stated she was very familiar with Resident #3 and was fully aware the resident did not follow the rules for vaping. The SSD stated if she were made aware that a resident had a vape device, she would retrieve it from the resident and go over the vaping policy again with the resident, reminding them they had signed the vaping policy at admission. The SSD stated that in Resident #3's case every time staff would take a vape device from the resident's room the family member brought in another vape device. The SSD stated she had explained to the family member the need to bring the new vape devices to the nurse's station, but the family member did not hear or listen. The SSD stated when Resident #3 was non-compliant, she would tell the DON or ADM, but she did not document it anywhere. The SSD stated behavior management was part of the Interdisciplinary Team's (IDT) function. The SSD stated during IDT meetings, she updated behavior care plans and smoking/vaping care plans; however, Resident #3's care plan was not up to date with their non-compliance and should have been.During an interview on [DATE] at 11:47 AM, the Director of Nursing (DON) stated Resident #3 was resistant to the vaping policy. The DON stated Resident #3 did not like to get out of bed, and the only way Resident #3 could vape was to go outside. The DON stated she had not had a conversation with the family member about bringing vape supplies to the nurses instead of taking them to the resident's room but thought someone else had. The DON confirmed there were no care conference notes about talking to the family member, and Resident #3's care plan did not address the (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident not following the policy. The DON stated the care plan should have been accurate to what the resident was doing with correct interventions for the staff to follow. The DON stated Resident #3's smoking assessments were not correct, as she had not answered the questions correctly. The DON stated Resident #3 had been non-compliant with vaping in their room for a long time. The DON confirmed there were no behaviors recorded on the Resident #3's Behavioral Log for the last 30 days, and she did not see any nurse's notes about the vaping in their room or hiding vaping supplies from staff. However, the DON provided a copy of phone screenshots of two text message exchanges with Resident #3's family member. The first message, dated [DATE] at 10:23 AM, requested the family member to call the DON when they had a chance to receive an update on the facility vaping policy. The second message, dated [DATE] at 11:53 AM, revealed the family member asked if they provided a vape device that did not have to be plugged in, could the resident have it. The DON's response was, They said no vapes indoors since they have a spark inside.During an interview on [DATE] at 8:35 AM, the ADM stated this week she had learned there were issues regarding Resident #3 keeping vaping supplies in their room and vaping in their room. The ADM stated she had only been at the facility five weeks and had learned that on several occasions, staff had to confiscate vape devices from Resident #3's room, but she did not know when that had occurred.A concurrent interview was held on [DATE] at 3:02 PM with the ADM and DON, as the ADM had only been in that role for five weeks and was unsure of some aspects of the QAPI program. The ADM stated the QAPI team met quarterly at a minimum and more often for ad hoc meetings for urgent matters. The ADM stated the team looked at metrics and numbers brought by designated staff, and the ADM was the one who organized the meeting and facilitated the review of any open QAPI plans. The ADM stated she had a formal meeting template that was used in the QAPI plan process which addressed the corrective action or safety plan that was needed for the issue or residents that may be affected; the plan for all other residents that may be affected; the system change that was identified; measures that were put into place and education needed; and the monitoring system that needed to be put into place so the issue did not reoccur. The ADM stated she recently became aware of the details regarding Resident #3's vaping but was not aware the resident was actively still vaping in their room. The ADM stated that it was a very serious issue and should have been addressed before now.**********The facility submitted a removal plan that was accepted by the state survey agency on [DATE] at 4:45 PM. The removal plan indicated the following:********** F835 Removal Plan[DATE]. Immediate action(s) taken for the resident(s) found to have been affected:On [DATE], the existing QAPI plan created on [DATE] addressing resident vaping noncompliance was immediately reviewed and revised by the Administrator, Director of Nursing, [NAME] President (VP) of Operations, Regional Director of Health Services, and the Medical Director (via phone). The QAPI plan was revised to include education to family and residents in addition to the staff regarding adherence to the facility vaping policy, including safety hazards due to noncompliance and consequences of violating the vaping policy. On [DATE], the [NAME] President (VP) of Operations completed education with the Administrator, and the Director of Nursing on the Quality Assurance Performance Improvement policy which includes monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.2. How did you identify residents affected or likely to be affected:A facility-wide search was conducted by the Administrator and Director of Nursing on [DATE] to identify and remove all vaping devices found in resident rooms or unsecured areas.All residents identified with a history of smoking or vaping were reassessed on [DATE] using the updated Smoking and Vaping Risk Assessment Tool.On [DATE], as of 4PM education was initiated by the Assistant Administrator/Director of Nursing (DON), SDC [Staff Development Coordinator] for all staff on vaping policy, including supervision protocols, what to do if staff find resident with a vape. 120 staff members out of 138 total were in-serviced on vaping policy (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(93 in person and 25 via phone). As of 4 PM [4:00 PM] on [DATE], any staff member who has not been in-serviced will not be allowed to work until they are in-serviced by the Staff Development Coordinator, DON, or Assistant Director of Nursing (ADON).3. How the practice will be monitored:The administrative team had a QAPI meeting on [DATE] to discuss the Administrator's responsibilities regarding policy enforcement, the facility's failure to ensure compliance with the vaping policy, and the systemic review of all vaping related issues. Attendees were the Administrator, DON, VP of Operations, Regional Director of Health Services (RDHS), and Medical Director via phone. The administrator/designee will be responsible for auditing and addressing any potential concerns or issues during the daily department head meeting conducted Monday through Friday. The daily department head meeting form was updated on [DATE] to capture discussions regarding vaping/smoking violations, associated behaviors, or issues. The Administrator will bring concerns or issues to the Quality Assurance Meeting monthly.The VP of Operations and the RDHS will review monthly QAPI Meeting minutes for three months or until substantial compliance is met to verify that the facility's QAPI addresses any noncompliance with the vaping policy and/or continued behaviors associated with noncompliance.The IDT team to include, Administrator/designee, DON/designee, Unit Managers, Restorative Nurse, Medical Record Nurse, MDS Coordinator, and Social Services were provided education on [DATE] [[DATE]], on the inclusion of residents who exhibit noncompliance behaviors with the facility's vaping policy to be followed in the weekly behavior meeting for a minimum of 30 days and until consistent resident compliance is observed.4. When were corrections completed?Corrections were all completed on [DATE].5. When is the immediacy of the IJ removal date?Effective Date of IJ Removal Plan Implementation: [DATE]. **********2) Cross-Reference F578.A facility policy titled, Advance Directives and Refusal of Treatment, dated [DATE], revealed, The resident has the right to refuse treatment, to refuse to participate in experimental research and to formulate an advance directive for the management of his/her care. The policy revealed, The resident shall have a copy of his or her advance directive(s), if any, made a part of his or her medical record. Forms of advance directives include a Living Will, a Durable Power of Attorney for Health Care Decisions, and the designation of a Health Care Proxy. The policy revealed, The DNAR [Do Not Attempt Resuscitation] and WD/WH [Withdrawing/Withholding] consent forms should be reviewed thoroughly with the resident, family, or significant other, and signatures and documentation from family members, physicians, and the properly witnessed signature of the resident must be obtained. Per the policy, The Facility's Social Service/Case Management designee shall assist the resident, family, or significant other in ensuring that the forms are properly completed. The policy revealed, Information regarding Advance Directives, policies, the Ethics Committee, and the relevant forms as discussed above should be presented to the following groups, which included Resident Council, Family Council, Individual Resident(s), Family, Significant other, Staff, Medical Director and Attending Physicians, Legal representatives, and Agency sponsors. The policy revealed, The policies should be presented in such a manner as to emphasize the Facility's desire to honor resident wishes and still provide the best care possible. The Facility will provide all possible assistance to the resident, family, or significant other in reaching an arrangement that serves the best interests of the resident.In accordance with Alabama State Committee of Public Health Administrative Code, Chapter 420-5-19-.01 Advance Directives revealed, Surrogate health care decision makers, as authorized by Act 97-187, shall complete the form attached hereto as Appendix I which, when properly completed and duly notarized, shall constitute the certification of the surrogate as required by the act and shall authorize the surrogate, including a representative of the ethics committee or another duly appointed committee at the facility where the patient is being treated, acting by unanimous consent as the surrogate, to make standard health care decisions for the patient as well as to make decisions regarding the providing, withholding, or withdrawal of life-sustaining treatment and artificially provided nutrition and hydration in instances involving terminal illness or injury and permanent (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	unconsciousness.During an interview on [DATE] at 10:44 AM, the Admissions Director (AD) she had not had any specific training on the DNRs.During an interview on [DATE] at 1:19 PM, the Social Services Director (SSD) she had never received any training at the facility on DNRs.During an interview on [DATE] at 1:40 PM, the Medical Records Director (MRD), who was a Licensed Practical Nurse (LPN), stated she had not been provided with any education on the DNR process and had never completed any DNR paperwork herself.During a telephone interview on [DATE] at 2:07 PM, previous Medical Records Staff (MR) #35 stated that she was not provided with any education of the DNR.During an interview on [DATE] at 2:45 PM, the Regional Nurse Consultant stated DNR forms should be reviewed by the AD during the admission process to determine if the resident had a DNR. She stated that the medical records nurse reviewed the code status with the family. She stated that if the family had any questions about the Advance Directives, the SSD was sending them to the MRD. She stated previous Medical Records Staff #35 was not reviewing the forms; they were going to the DON to review. She stated the MRD was responsible for ensuring the necessary paperwork was in the medical record. She stated she was not sure if those people had been trained or educated on the process.During an interview on [DATE] at 8:28 AM, the Medical Director stated he signed the DNR forms in pen when they were prepared, and the facility asked him to. He stated he had not signed a blank DNR and was not aware that there was a blank DNR with his signature on it. He stated he did not give the facility permission to do that.During an interview on [DATE] at 9:35 AM, the MRD stated she did keep some of the original DNR forms and other documents in a folder after they were uploaded to a resident's electronic medical record. A review of the folder revealed a blank DNR form with a photocopied physician signature. The file also included completed DNR forms for residents that contained photocopied physician signature and no dates. The MRD was not able to say where the form came from or why it was in the folder. She stated she was not aware it was in the folder.During an interview on [DATE] at 9:49 AM, the Regional Nurse Consultant, the Administrator, and DON #33 reviewed the DNR forms found in the folder kept by the MRD that had the photocopied physician signature. The Regional Nurse Consultant stated she thought it was a process that the DON who was replaced by DON #33 during the survey had done but they were not doing that currently. DON #33 stated that any DNRs she had signed and dated since she had been at the facility were signed by the physician himself.During an interview on [DATE] at 1:10 PM, the Medical Director stated he expected the DNR forms to be filled out correctly and the facility to have all the required documents.During an interview of [DATE] at 9:19 AM, the Regional Nurse Consultant stated that they discussed the incident involving Resident #104 during a Quality Assurance Performance Improvement (QAPI) meeting on [DATE] and stated mock code drills and audits were completed by the DON at the time.During an interview on [DATE] at 10:22 AM, the Regional Nurse Consultant stated that they identified an issue with the facility's DNR records once the POA, Living Will, and Surrogate paperwork were requested during the survey. She stated they had completed an audit to ensure DNRs were in place, but they had not identified that the DNR forms were not completed correctly or signed in the correct spot.During an interview on [DATE] at 3:18 PM, the Administrator stated admissions staff should get the DNR form and review it with the resident or family, then it should be checked by several other people through the process. She stated the admissions staff, the DON, and she as the Administrator were responsible for ensuring all the proper paperwork was in place. She stated they had staff training at the end of [DATE] on DNRs, to include the importance of documentation and who could revoke a DNR. The Administrator reviewed Resident #104's DNR form during the interview and stated it was not filled out correctly and it would not be valid.During an interview on [DATE] at 10:18 AM, DON #33 stated they had to contact residents' families and responsible parties to get the POA, Living Will, or Surrogate paperwork to support the DNR forms that were not in the residents' records. She stated they were able to get the paperwork for Residents #116, #117, #55, #32, #77, and #97 and upload them to the residents' records; they were still working on getting the paperwork for Residents #67, #82, #115, and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015136	A. Building B. Wing	09/02/2025

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#64.**********The facility submitted a removal plan that indicated the following:********** F835 Removal Plan [DATE]. Immediate action(s) taken for the resident(s) found to have been affected:All 12 identified residents (#97, #79, #116, #66, #67, #117, #82, #115, #32, #55, #64, and #77) had their Do Not Resuscitate (DNR) forms reviewed for completeness. Missing information (signatures, dates, physician verification) was corrected immediately. These were completed on [DATE] by Director of Nursing (DON) and Regional Director of Health Services (RDHS).On [DATE], an audit was completed by Medical Records, Director of Nursing and Regional Director of Health Services to verify the accuracy of residents Do Not Resuscitate forms (DNR). This included ensuring that DNR forms had the appropriate Power of Attorney (POA), Living Will, or Surrogate paperwork included in the resident record. This audit concluded that as of [DATE] there are 4 residents that do not have completed paperwork. These 4 resident's families/Responsible parties have been notified, if proper paperwork is not completed the residents' DNR status will be updated to Full code until proper paperwork is received.These 4 residents were updated to Full Code as of [DATE]. Families and the Medical Director were notified. When accurate documents are provided the facility will update the residents medical record. As of [DATE] at 4:00 PM there are 2 residents that do not have accurate paperwork. Both families have been notified, and they are waiting to get the surrogate form notarized. They have been called by the DON and RDHS on [DATE], [DATE], [DATE] and emailed several times and understand that the resident is a full code until complete and accurate paperwork is completed. Families understand and are aware that the resident is a full code. DON will follow up with 2 families daily to ensure forms are sent back to the facility.The DON was educated by the RDHS on [DATE] that the DON would continue to follow up daily with the 2 residents that did not have correct DNR paperwork. This will be monitored by the RDHS until DNR paperwork is completed accurately.On [DATE] RDHS educated Medical Records and DON on accurate and completed DNR paperwork to include all supporting documentation.On [DATE], the [NAME] President (VP) of Operations and Regional Director of Health Services completed education with the Administrator and Director of Nursing ensuring that DNR forms had the appropriate Power of Attorney (POA), Living Will, or Surrogate paperwork included in the resident record.On [DATE], the [NAME] President (VP) of Operations completed education with the Administrator, and the Director of Nursing on the Quality Assurance Performance Improvement policy which includes monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.On [DATE] the previous Director of Nursing's employment was terminated to prevent further issues with facilities nursing department.On [DATE], the existing QAPI plan created on [DATE] addressing resident vaping noncompliance was immediately reviewed and revised by the Administrator, Director of Nursing, [NAME] President (VP) of Operations, Regional Director of Health Services, and the Medical Director (via phone). The QAPI plan was revised to include education to family and residents in addition to the staff regarding adherence to the facility vaping policy, including safety hazards due to noncompliance and consequences of violating the vaping policy.2. How did you identify residents affected or likely to be affected:On [DATE] RDHS educated Medical Records and DON on accurate and completed DNR paperwork to include all supporting documentation.On [DATE], an audit was completed by Medical Records, Director of Nursing and Regional Director of Health Services to verify the accuracy of residents Do Not Resuscitate forms (DNR). This included ensuring that DNR forms had the appropriate Power of Attorney (POA), Living Will, or Surrogate paperwork included in the resident record.[TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015136	A. Building B. Wing	09/02/2025

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F 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, facility policy review, and a review of Alabama State Committee of Public Health Administrative Code, the Medical Director failed to provide oversight to ensure residents' end-of-life wishes were honored, including completion of the Alabama portable physician do not resuscitate (DNR) form and oversight of the development and implementation of a facility process for rescinding a DNR order in emergent situations. The failure created the likelihood of cardiopulmonary resuscitation (CPR) being incorrectly provided or withheld. It was determined the facility's non-compliance with one or more requirements of participation had caused or was likely to cause, serious injury, serious harm, serious impairment, or death to residents. The Immediate Jeopardy (IJ) was related to 42 CFR 483.70(g), F841, Medical Director. The IJ began on [DATE] when staff provided CPR for Resident #104, who had a DNR order. The DNR form was invalid, and the facility did not have the resident's Surrogate paperwork in the resident's medical record. Resident #104 expired on [DATE]. The survey team notified the Administrator of the IJ and provided the IJ template on [DATE] at 2:41 PM.The IJ was removed on [DATE], after the survey team performed onsite verification that the removal plan had been implemented. Noncompliance for F841 remained at a lower scope of no actual harm with potential for more than minimal harm.Findings included: Cross-Reference F578.A facility policy titled, Advance Directives and Refusal of Treatment, dated [DATE], revealed, The resident has the right to refuse treatment, to refuse to participate in experimental research and to formulate an advance directive for the management of his/her care. The policy revealed, IV. Revocation of DNAR Orders .A. Competent Resident. A Competent Resident may at any time request the revocation and removal of a DNAR Order from his or her medical record. The resident shall communicate his or her desire to his or her Attending Physician, who shall immediately remove and revoke the DNAR Order from the resident(s) medical record.B. Incompetent Resident. An Incompetent Resident(s) family may request the revocation and removal of a DNAR Order from the resident(s) medical record only when the DNAR Order was entered pursuant to the Family's request because of the absence of an Advance Directive. The Family shall communicate their desire to the Attending Physician who shall immediately remove and revoke the DNAR Order from the resident(s) medical record. An attorney-in-fact who has been designated in a Durable Power for Health Care Decisions, a Proxy, or a Surrogate can revoke a DNAR Order.The Code of Alabama S 22-8A-5 revealed: . (a) An advance directive for health care may be revoked at any time by the declarant by any of the following methods:(1) By being obliterated, burnt, torn, or otherwise destroyed or defaced in a manner indicating intention to cancel;(2) By a written revocation of the advance directive for health care signed and dated by the declarant or person acting at the direction of the declarant; or(3) By a verbal expression of the intent to revoke the advance directive for health care in the presence of a witness [AGE] years of age or older who signs and dates a writing confirming that such expression of intent was made. Any verbal revocation shall become effective upon receipt by the attending physician or health care provider of the above mentioned writing. The attending physician or health care provider shall record in the patient's medical record the time, date and place of when he or she received notification of the revocation.During an interview on [DATE] at 11:07 AM, Licensed Practical Nurse (LPN) #34 stated she became a full-time employee in February 2025. She stated that she was unsure of the process to rescind a DNR. She stated she thought she would have to explain the process and have the person sign a form to rescind the DNR with the witness of another nurse. During an interview on [DATE] at 1:19 PM, the Social Services Director (SSD) stated she stated she was not sure of the process to rescind a DNR because she did not do that, but she stated she thought that the physician and family would need to sign something. She stated if a resident with a DNR coded, and the spouse wanted CPR performed, she stated she thought the facility should follow what was on the DNR (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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F 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	form.During an interview on [DATE] at 1:40 PM, the Medical Records Director (MRD), who was an LPN, stated she started the position in [DATE]. She stated she had not had a situation where a DNR was rescinded but stated that there would basically be a lot of steps to get it changed. She stated she had never been put in a situation where a family member wanted to change the code status during a code, and that would be a very difficult situation, and she would be very confused if that happened. The MRD stated she did not know if the facility had a policy for rescinding a DNR in an emergent situation.During an interview on [DATE] at 10:44 AM, the AD stated she had not had any specific training on the DNRs. She stated she was not sure of the process to rescind a DNR.During an interview on [DATE] at 2:45 PM, the Regional Nurse Consultant stated DNR forms should be reviewed by the AD during the admission process to determine if the resident had a DNR. The Regional Nurse Consultant stated if a resident or family wanted to rescind a DNR, it could be a verbal revocation, and once the staff were aware of it, they should act on it. She stated they should involve the physician, obtain an order, and update the plan of care.During an interview on [DATE] at 1:10 PM, the Medical Director stated that in the situation of Resident #104, the nurse should do what the family said. He stated if FM #38 was alert and oriented and wanted CPR provided, then they should provide CPR, even if there was a DNR order. The Medical Director stated he expected the DNR forms to be filled out correctly and that the facility has all the required documents. He stated he was notified of the rescission of Resident #104's DNR but could not remember by whom, and he did not remember what he was told and did not recall if he had documented that the DNR was rescinded. There was no documentation in the medical record by the Medical Director regarding the incident or rescinding the DNR.During an interview on [DATE] at 8:28 AM, the Medical Director stated if a resident's spouse initiated the DNR but then changed their mind, then the staff should perform CPR. He stated it was his understanding that if the family member was alert and oriented, then they should be able to make that decision. He stated he signed the forms in pen when they were prepared, and the facility asked him to. He stated he had not signed a blank DNR and was not aware that there was a blank DNR with his signature on it. He stated he did not give the facility permission to do that.During an interview on [DATE] at 9:35 AM, the MRD stated she did keep some of the original DNR forms and other documents in a folder after they were uploaded to a resident's electronic medical record. A review of the folder revealed a blank DNR form with a photocopied physician signature. The file also included completed DNR forms for residents that contained photocopied physician signature and no dates. The MRD was not able to say where the form came from or why it was in the folder. She stated she was not aware it was in the folder. During an interview on [DATE] at 9:49 AM, the Regional Nurse Consultant, the Administrator, and DON #33 reviewed the DNR forms found in the folder kept by the MRD that had the photocopied physician signature. The Regional Nurse Consultant stated she thought it was a process that the DON who was replaced by DON #33 during the survey had done but they were not doing that currently. DON #33 stated that any DNRs she had signed and dated since she had been at the facility were signed by the physician himself. **********The facility submitted a removal plan that indicated the following: ********** F841 Removal Plan[DATE]. Immediate action(s) taken for the resident(s) found to have been affected:All current residents with Do Not Resuscitate (DNR) orders were immediately reviewed to verify the presence and accuracy of the Alabama Portable Physician DNR Order form. This was completed on [DATE] by the Director of Nursing (DON) and Regional Director of Health Services (RDHS). Any missing, incomplete, or unclear forms were corrected in collaboration with the Medical Director. A process for rescinding DNR orders in emergent situations was developed and implemented with immediate education provided to nursing and medical staff. Education and implementation was completed by the DON and RDHS on [DATE]. This was developed by [NAME] President of Operations, RDHS and Medical Director in coordination with Alabama law. The Medical Director was in agreement with the (continued on next page)

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F 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facilities process.The Medical Director was educated by VP of Operations and RDHS on [DATE] on AL DNR form and law and educated on completion of the DNR form. Once in-service provided, the Medical Director reviewed the facility's process to ensure residents' end-of-life wishes are honored including emergent process for rescinding a DNR order.On [DATE], as of 3:00 PM education was initiated by the DON, Assistant Director of Nursing (ADON), RDHS and Staff Development Coordinator (SDC) for all licensed nursing staff on the facilities code procedures and the procedure required to rescind a DNR. 16 staff members of 25 total were educated (11 in person and 5 via phone). As of 3:00 PM on [DATE], staff members who have not been in-serviced will not be allowed to work until they are in-serviced by the SDC, DON, or ADON. The DON was educated by the RDHS that she is responsible for monitoring the schedule every day to identify scheduled staff who have not been in-serviced on the process and ensure the staff are trained before beginning their scheduled shift.Vice President (VP) of Operations educated the Medical Director on [DATE] on the process of rescinding DNR orders in an emergent situation.2. How did you identify residents affected or likely to be affected:An audit of all residents with Advance Directives or DNR orders was conducted on [DATE]. Residents without DNR orders were confirmed as full code. Families and/or POAs were contacted where necessary to verify documentation accuracy and confirm resident wishes. This was completed by Medical Records/DON/RDHS. The Medical Director was educated that he will be given all accurate DNR forms prior to signing and DNR to ensure the process is being done accurately. The Medical Director will be available for monthly QAPI meetings to ensure facilities DNR forms are updated accurately according to Alabama law.3. How the practice will be monitored:The Director of Nursing (DON) or designee will review all new admissions upon entry to verify completion of the appropriate DNR documentation and confirm end-of-life wishes are accurately reflected in the medical record. The Medical Director will review DNR compliance and the rescinding process quarterly in QAPI meetings. Results of audits and reviews will be presented to the facility Quality Assurance and Performance Improvement (QAPI) committee for ongoing oversight and corrective action as needed.4. When were corrections completed?Corrections were all completed on [DATE].5. When is the immediacy of the IJ removal date?Effective Date of IJ Removal Plan Implementation: [DATE].Plan Prepared By: [NAME] President of Operations and Director of Health Services **********The IJ was removed on [DATE] after the survey team verified the facility's implementation of the removal plan as follows: 1. Review of the facility's audit to verify the accuracy of the DNR forms and to ensure the DNR forms had the appropriate paperwork included in the resident's record indicated the facility had identified four residents that did not have the completed paperwork, Residents #31, #82, #68, and #24. It was verified that those residents' code statuses were changed to Full Code on [DATE] and that the residents' families were notified. The facility still had two residents for whom they were following up on the code status, and interviews with those families verified they had been in contact with the facility staff. The facility staff were also able to show text messages and emails to the families. An interview with the Medical Director verified that he was in agreement with the facility's policy to rescind a DNR. The nursing staff were educated on [DATE] that the process for rescinding DNR orders was that at any time, the person who had signed the Advance Directive paperwork could revoke a DNR and request life-saving measures contrary to a DNR order. This was verified by a review of sign-in sheets and interviews with staff, including one CMA; 13 LPNs, including the MRD, the MDS Coordinator, a respiratory LPN, a restorative LPN, a treatment LPN, and the SDC; four RNs, including the ADON/IP, a weekend supervisor, and one unit manager; and the social worker. Education that was provided to the Medical Director on DNR forms, and state law was reviewed, and verified with a sign-in sheet, email, and interview. Education to all licensed nursing staff on [DATE] on facility code procedures and the procedure to rescind a DNR was verified with sign-in sheet with 25 signatures.Interviews with staff including one CMA; 13 LPNs including the Medical Records LPN, MDS LPN, Respiratory LPN, Restorative LPN, Treatment LPN, and SDC; four RNs including the ADON/IP, (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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F 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	weekend supervisor, and one unit manager; and the social worker confirmed that they had received education on the CPR policy, medical emergency response, CPR components, and what to do to rescind a DNR. Eight CNAs were interviewed regarding emergency response.Education to the DON to monitor the schedule to ensure all staff were educated was verified with a sign-in sheet and interviews. Education provided to the Medical Director on the facility's policy to rescind a DNR was reviewed and verified by a review of a sign-in sheet, email, and by interview. 2. Review of the facility audit to verify the accuracy of the DNR forms and to ensure the DNR forms had the appropriate paperwork included in the resident's record indicated the facility had identified four residents that did not have the completed paperwork, Residents #31, #82, #68, and #24.A review of facility records revealed 36 residents with DNRs in the facility, and their records were checked to ensure the accuracy of the forms and the presence of the necessary paperwork. Resident #79 was identified as having two physician signatures on the DNR, with the Medical Director signing as the surrogate; however, the surrogate paperwork was not in the resident's records. The facility got the surrogate paperwork completed and uploaded to the record on [DATE]. Education provided to the Medical Director on accurate DNR forms and reviewing DNR forms during QAPI was verified by a review of a sign-in sheet, email, and by interview. The QAPI monitoring form to be used to ensure DNR forms were being reviewed to ensure they were updated accurately was reviewed. 3. The facility was using an audit form for new admissions to verify completion of the DNR and ensure end-of-life wishes were accurately reflected in the resident's record. The use of this form was verified and confirmed by an interview with the DON. The QAPI monitoring form to be used to ensure DNR forms were being reviewed to ensure they were updated accurately was reviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015136	A. Building B. Wing	09/02/2025

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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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, facility document review, facility policy review, and a review of Alabama State Committee of Public Health Administrative Code, the facility failed to ensure a Quality Assurance Performance Improvement (QAPI) plan that was developed, implemented, and monitored for effectiveness following adverse events.Specifically,1) The facility failed to ensure a QAPI plan created by the facility's administration on [DATE] was executed and audited for effectiveness related to a resident being non-compliant with the facility vaping policy by vaping in their room unsupervised, creating a potential risk of fire and battery explosion. The failure had the likelihood for serious harm/injury/impairment or death related to the fire risks and risk of explosion when the resident continued vaping in bed. The survey team notified the Administrator of the IJ and provided the IJ template on [DATE] at 9:38 AM. The facility provided a removal plan and after Quality Assurance review the team re-entered the facility on [DATE] and identified additional unaddressed concerns.2) On [DATE] facility staff attempted to provide life-saving measures to a resident who had made decision to have do-not-resuscitate code status after the resident's roommate and spouse asked staff to help the resident. The facility failed to check the resident's code status before initiating chest compressions and activating the Emergency Management System (EMS). Further facility staff failed to provide rescue breaths during the resuscitation efforts and failed to document the incident thoroughly. Upon review, the documentation in the resident's medical records regarding the resident's DNR code status was incomplete and invalid. The facility's QAPI committee failed to review the incident and identify:- That residents' do not resuscitate (DNR) forms were reviewed and audited to ensure accuracy and completeness, including ensuring Power of Attorney (POA), Living Will, or Surrogate paperwork to support the DNR forms were part of residents' medical records.- Facility staff were educated on the facility's code status procedures.- The facility had a process to ensure facility staff were aware of the procedure required to rescind a DNR. It was determined the facility's non-compliance with one or more requirements of participation had caused or was likely to cause serious injury, serious harm, serious impairment, or death to residents. The Immediate Jeopardy (IJ) was related to 42 CFR 483.75(c)(4), F867, QAPI/QAA Improvement Activities. Failure to implement the QAPI process after an adverse event to identify concerns with the DNR forms had the likelihood to result in cardiopulmonary resuscitation (CPR) being administered or withheld against the residents end-of-life decisions.The survey team notified the Regional Nurse Consultant, the Administrator, and the Director of Nursing (DON) of the IJ and provided the IJ template on [DATE] at 2:15 PM. The IJ began on [DATE] and was removed on [DATE] after the survey team performed onsite verification that the removal plan had been implemented. Noncompliance for F867 remained at a lower scope and severity of no actual harm.The failure affected 13 (Residents #104, #97, #79, #116, #66, #67, #117, #82, #115, #32, #55, #64, and #77) of 36 residents reviewed for code status but had the potential to affect all residents residing in the facility.Findings included:A facility policy titled, Quality Assurance and Performance Improvement (QAPI), revised [DATE], revealed, Policy: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. Policy Explanation and Compliance Guidelines revealed, 1. The QAPI program includes the establishment of a Quality Assessment and Assurance (QAA) Committee and a written QAPI Plan. 2. The QAA Committee shall be interdisciplinary and shall: a. Consist at a minimum of:i. The Director of Nursing Services; ii. The Medical Director or his/her designee; iii. At least three other members of the facility's staff, at least one of which must be the Administrator, owner, a board member, or other individual in a leadership role; and iv. The Infection Preventionist. b. Meet at least quarterly and as needed to coordinate and evaluate activities under the (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program, are necessary. c. Develop and implement appropriate plans of action to correct identified quality deficiencies. d. Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. The policy continued, 4. The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program. Documentation may include, but is not limited to: a. The written QAPI plan. b. Systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events. c. Data collection and analysis at regular intervals. d. Documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities. Program Development Guidelines revealed, 2. Governance and Leadership - a. The governing body and/or executive leadership is responsible and accountable for the QAPI program. b. Governing oversight responsibilities include but are not limited to the following: i. Approving the QAPI plan annually, and as needed. ii. Ensuring the program is ongoing, defined, implemented, maintained, and addresses identified priorities. iii. Ensuring the program is sustained during transitions in leadership and staffing, and the policy continued, vi. Ensuring the corrective actions address gaps in systems and are evaluated for effectiveness. vii. Setting clear expectations around safety, quality, rights, choice, and respect. The policy also indicated, 3. Program Feedback, Data Systems and Monitoring - a. The facility maintains procedures for feedback, data collection systems, and monitoring, including adverse event monitoring.The policy also indicated, 4. Program Activities - a. All identified problems will be addressed and prioritized, whether by frequency of data collection/monitoring or by the establishment of sub-committees. Considerations include, but are not limited to: i. High-risk, high-volume, or problem-prone areas. ii. Incidence, prevalence, and severity of problems in those areas. iii. Measures affecting resident health, safety, autonomy, choice, health equity, and quality of care. The policy also indicated, 5. Program Systematic Analysis and Systematic Action - a. The facility takes actions aimed at performance improvement as documented in QAA Committee meeting minutes and action plans. Performance/success of the actions will be monitored and documented in subsequent QAA Committee or sub-committee meetings. b. To ensure improvements are sustained, the effectiveness of performance improvement activities will be monitored in QAA Committee meetings in accordance with the QAPI plan, but no less than annually.The facility's Quality Assurance Performance Improvement Program and Plan, revised [DATE], revealed the Scope indicated QAPI will be integrated into all care and service areas of the organization, included, but not limited to the following, which included Tracking, investigating, and monitoring adverse events with action plans implemented to prevent reoccurrence. The plan revealed, The facility maintains procedures for feedback, data collection systems, and monitoring including adverse event monitoring. The plan revealed, Data is collected from all departments and is used to develop and monitor performance indicators, The plan continued, 4. Systems are in place to monitor core and services, including, which included Preventable Serious Adverse Events.1) A facility QAPI plan, dated [DATE], indicated the Administrator (ADM) learned of residents vaping in their rooms and new admissions coming into the facility with vaping devices. The plan indicated the following: Identified Issue(s) - Administrator found out about residents vaping in their rooms, new admissions coming into the facility with vapes on [DATE] [[DATE]]. Root Cause Analysis completed: the contributing factors found that resulted in residents vaping in their rooms was that staff were not educated on our vaping policy and an established system to be in compliance Safety Plan for Resident(s)- The Administrator completed a house wide [sweep/search] collecting all resident vapes and chargers who staff know have them in their rooms. No issues with this. This was completed on [DATE][2025].Plan for all other residents that may be affected.- The Administrator conducted an emergency resident council meeting explaining the vaping policy on [DATE] [[DATE]].- Ombudsman came to facility on [DATE] [[DATE]] to talk to residents about vaping policy.System change (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015136	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	identified & education plan.- Established outside vaping courtyard 1st floor.- Establish set vaping times in designated outside area 10:30 [AM], 1:30 [PM], 6:00 [PM]. Housekeeping and evening activity responsible for taking out vapers [Residents who used vaping devices].- In-serviced nursing staff on vaping policy including established vaping times, designated vaping area, and that residents aren't allowed to have vapes or vape chargers in their room nursing is responsible for storage of vape and enforcing policy.- Nursing must secure vapes in locked med room and charge them.Monitoring System- Vaping log to monitor adherence to established vaping times. - Staff are instructed to let management know of any residents that have vapes. This will be addressed and corrected.Along with the facility QAPI plan regarding vaping, the facility also provided:- A signed written statement by the DON regarding the phone conversations held with Resident #3's Family Member (FM) #31 on [DATE], [DATE], and [DATE] regarding vaping and the facility policy;- A Midnight Census report, dated [DATE], used by the previous ADM when collecting vaping devices from residents' rooms on [DATE]; - A copy of the emergency Resident Council meeting minutes, dated [DATE], with residents' signatures; - A list of the designated vaping times; - A copy of the vaping policy;- An Inservice Training Sign In Sheet, dated [DATE], with staff signatures;- A [Facility Name] Facility Non-Smoking & Vaping Policy Acknowledgement, with each residents' signature and Vapers Sign In Sheet[s] for each time the residents went outside to vape; however, there was no [Facility Name] Facility Non-Smoking & Vaping Policy Acknowledgement or Vapers Sign In Sheet[s] signed for Resident #3, either by the resident or their family member. During an interview on [DATE] at 8:35 AM, the ADM stated this week she had learned there were issues regarding Resident #3 keeping vaping supplies in their room and vaping in their room. The ADM stated she had only been at the facility five weeks and had learned that on several occasions, staff had to confiscate vape devices from Resident #3's room, but she did not know when that occurred. A concurrent interview was held on [DATE] at 3:02 PM with the ADM and DON, as the ADM had only been in the role for five weeks and was unsure of some aspects of the QAPI program. The ADM stated the QAPI team met quarterly at a minimum and more often for an ad hoc (for this situation) meetings for urgent matters. The ADM stated the team looked at metrics and numbers brought by designated staff, and the ADM was the one who organized the meeting and facilitated the review of any open QAPI plans. The ADM stated she had a formal meeting template that was used in the QAPI plan process which addressed the corrective action or safety plan that was needed for the issue or residents that may be affected; the plan for all other residents that may be affected; the system change that was identified; measures that were put into place and education needed; and the monitoring system that needed to be put into place so the issue did not reoccur. The ADM stated she recently became aware of the details regarding Resident #3's vaping but was not aware the resident was actively still vaping in their room. The ADM stated that it was a very serious issue and should have been addressed before now. The ADM stated her expectation going forward was for staff to treat an issue like smoking in bed to be one of sheer urgency and to document what was seen and what was done about it in the medical record and all areas the information should go. The ADM stated the facility's goal should always be to keep the residents safe, even from themselves sometimes.On [DATE] at 3:02 PM, the DON stated the decision to stop a QAPI plan was based on the specifics of the QAPI and when compliance could be maintained. The DON stated it was the responsibility of the Administrator and the DON to make sure a QAPI plan had all the essential components. The DON stated she took care of all the clinical plans and the Administrator took care of the other plans. The DON stated there had been a lot of turnover in the Administrator role recently, and there had not always been the best communication regarding what was still active and needed work. The DON stated there were items missing from the Vaping QAPI, and there had not been good updates on the facility's progress with that QAPI plan. The DON stated the former Administrator was the one who wrote the Vaping QAPI plan and was also the one who ran the meetings where those issues were discussed. The DON stated she could not speak to the room searches mentioned on the QAPI plan or why families were not notified of the vaping issues back in January [2025] when the (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	plan was started. The DON stated she and the new Administrator worked very closely together and would be going over the QAPI plans more thoroughly now. The DON stated her expectation going forward would be that staff alerted management when residents were noncompliant with things like smoking/vaping inside that could harm other residents, and that the information was placed in the resident's medical record regarding what happened and what was done to prevent it from happening again.**********The facility submitted a removal plan that indicated the following:********** F867 Removal Plan [DATE]. Immediate action(s) taken for the resident(s) found to have been affected: On [DATE] [[DATE]], the existing QAPI plan created on [DATE] addressing resident vaping noncompliance was immediately reviewed and revised by the Administrator, Director of Nursing (DON), [NAME] President (VP) of Operations, Regional Director of Health Services (RDHS), and the Medical Director (via phone). The QAPI plan was revised to include education to family and residents in addition to the staff regarding adherence to the facility vaping policy, including safety hazards due to noncompliance and consequences of violating the vaping policy. On [DATE] [[DATE]], the VP of Operations completed education with the Administrator, Director of Nursing on the Quality Assurance Performance Improvement policy which includes monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.2. How did you identify residents affected or likely to be affected:A facility-wide search was conducted by the Administrator and DON on [DATE] to identify and remove all vaping devices found in resident rooms or unsecured areas.All residents identified with a history of smoking or vaping were reassessed on [DATE] using the updated Smoking and Vaping Risk Assessment Tool.On [DATE], as of 4PM [4:00 PM] education was initiated by the Assistant Administrator/DON, and the Staff Development Coordinator (SDC) for all staff on the vaping policy, including supervision/monitoring protocols, and what to do if staff find a resident with a vape. 120 staff members out of 138 total were in-serviced on vaping policy (93 in person and 25 via phone). As of 4 PM [4:00 PM] on [DATE], staff members who have not been in-serviced will not be allowed to work until they are in-serviced by the (SDC), DON, or Assistant Director of Nursing (ADON).3. How the practice will be monitored: The administrative team had a QAPI meeting on [DATE] to discuss the Administrator's responsibilities regarding policy enforcement, the facility's failure to ensure compliance with the vaping policy, and the systemic review of all vaping related issues. Attendees were the Administrator, [NAME] President (VP), Regional Nurse Consultant, and Medical Director via phone. Going forward, the QAPI team will ensure the process is ongoing and the Administrator or designee will be responsible for the auditing for any potential alleged violations during daily department head meetings conducted Monday through Friday. The daily department head meeting form was updated on [DATE] to capture discussions regarding vaping/smoking violations, behaviors related to noncompliance, or other issues. The Administrator will bring all alleged violations monthly to the Quality Assurance Meeting.On [DATE], the VP of Operations completed education with the Administrator, Director of Nursing, Unit Managers, Infection Preventionist, Housekeeping Supervisor, Maintenance Director, and Dietary Manager on the Quality Assurance Performance Improvement policy which includes monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed .********** 2) Cross-reference F578, F678, F835, F842.An undated facility document titled, QAPI-Code Status, indicated that on [DATE] at 11:30 PM, the facility identified that licensed staff had initiated CPR on a resident when the resident had an active DNR order. The document indicated that emergency care protocol education of all licensed staff was initiated on [DATE] and was completed prior to nurses returning to work. The document indicated that on [DATE], all residents in the building with a DNR were reviewed and included a review of all Advance Directives or the lack thereof, to verify the accuracy of each resident's wishes reflected in the EMR [electronic medical record]. The document revealed the System change (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	identified & education plan indicated the DON or designee would verify each newly admitted resident's Advance Directive status/code status on admission to the facility to verify the relay of the correct code status in the EMR via signed physician's orders and scanned Advance Directive paperwork in EMR documents. Per the document, the Monitoring system included that the DON or designee would audit each newly admitted resident to verify the Advance Directive/code status was relayed in the EMR via signed physician's order and scanned Advance Directive paperwork in EMR documents, the DON or designee would complete a monthly audit to verify that all residents' Advance Directive were in place and accurate according to residents' wishes, and monitoring tools would be reviewed by the Administrator and reviewed in the monthly QAPI meeting with the QA committee, including the Medical Director. During an interview of [DATE] at 9:19 AM, the Regional Nurse Consultant stated that they discussed the incident involving Resident #104 during a Quality Assurance Performance Improvement (QAPI) meeting on [DATE] and stated mock code drills and audits were completed by the DON at the time.During an interview on [DATE] at 10:22 AM, the Regional Nurse Consultant stated that they identified an issue with the facility's DNR records once the POA, Living Will, and Surrogate paperwork were requested during the survey. She stated they had completed an audit to ensure DNRs were in place, but they had not identified that the DNR forms were not completed correctly or signed in the correct spot. **********The facility submitted a removal plan that indicated the following: ********** F867 Removal Plan[DATE]. Immediate action(s) taken for the resident(s) found to have been affected:On [DATE], RDHS and VP of Operations educated the Administrator and DON regarding policy enforcement, the facility's failure to ensure compliance with the Advance Directive policy, and the systemic review of all Advance Directive related issues.The administrative team had a QAPI meeting on [DATE] to discuss the facilities Advance directive policy to include: DNR forms are reviewed and audited to ensure accuracy and completeness, educating staff on the facilities code procedures and the facilities process to ensure staff are aware of the procedures required to rescind a DNR. Attendees were the Administrator, Director of Nursing (DON), [NAME] President (VP) of Operations, Regional Director of Health Services (RDHS), and Medical Director via phone.In this QAPI meeting the Administrator and RDHS educated the QAPI team on their responsibility to review the facility's performance of CPR/Code performance per the policy. It is the responsibility of the QAPI team to ensure that the advance directive policy along with resident rights is completed. On [DATE] the previous Director of Nursing's employment was terminated to prevent further issues with facilities nursing department.On [DATE], Regional Director of Health Services educated DON, ADON, and SDC on proper process for honoring and documenting DNR orders, including the steps to take if a family member requests CPR contrary to an existing DNR order.All licensed nursing staff received immediate education on the proper process for honoring and documenting DNR orders, including the steps to take if a family member requests CPR contrary to an existing DNR order. This was completed by Director of Nursing (DON)/Assistant Director of Nursing (ADON)/ Regional Director of Health Services (RDHS) on [DATE]. On [DATE], the existing QAPI plan created on [DATE] addressing resident vaping noncompliance was immediately reviewed and revised by the Administrator, Director of Nursing (DON), [NAME] President (VP) of Operations, Regional Director of Health Services (RDHS), and the Medical Director (via phone). The QAPI plan was revised to include education to family and residents in addition to the staff regarding adherence to the facility vaping policy, including safety hazards due to noncompliance and consequences of violating the vaping policy. On [DATE], the VP of Operations completed education with the Administrator, Director of Nursing on the Quality Assurance Performance Improvement policy which includes monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.2. How did you identify residents affected or likely to be affected:On [DATE] at 9:00 AM, an audit was completed by Medical Records, Director of Nursing and Regional Director of Health Services to verify the accuracy of (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	residents Do Not Resuscitate forms (DNR). This included ensuring that DNR forms had the appropriate Power of Attorney (POA), Living Will, or Surrogate paperwork included in the resident record. The DON was educated by the RDHS on [DATE] that the DON would continue to follow up daily with the 2 residents that did not have correct DNR paperwork. This will be monitored by the RDHS until DNR paperwork is completed accurately. This audit concluded that as of [DATE] there are 4 residents that do not have completed paperwork. These 4 resident's families/Responsible parties have been notified, if proper paperwork is not completed the residents' DNR status will be updated to Full code until proper paperwork is received. These 4 residents were updated to Full Code as of [DATE]. Families and the Medical Director were notified. When accurate documents are provided the facility will update the resident's medical record. As of [DATE] at 4pm there are 2 residents that do not have accurate paperwork. Both families have been notified, and they are waiting to get the surrogate form notarized. They have been called by the DON and RDHS on [DATE], [DATE], [DATE] and emailed several times and understand that the resident is a full code until complete and accurate paperwork is completed. Families understand and are aware that the resident is a full code. DON will follow up with 2 families daily to ensure forms are sent back to the facility.On [DATE] at 9:00 AM, education was completed by the Administrator/Director of Nursing (DON)/Regional Director of Health Services to admission Coordinator, Social Services, Medical Records and Assistant Director of Nursing on ensuring that DNR forms are reviewed and audited to ensure accuracy and completeness.On [DATE], as of 3:00 PM education was initiated by DON/ADON/RDHS and SDC for all licensed nursing staff on the facilities code procedures and the procedure required to rescind a DNR. 16 staff members of 25 total were educated (11 in person and 5 via phone). As of 3:00 PM on [DATE], staff members who have not been in-serviced will not be allowed to work until they are in-serviced by the (SDC), DON, or Assistant Director of Nursing (ADON). The DON was educated by the RDHS that she is responsible for monitoring the schedule every day to identify scheduled staff who have not been in-serviced on the process and ensure the staff are trained before beginning their scheduled shift.A facility-wide search was conducted by the Administrator and DON on [DATE] to identify and remove all vaping devices found in resident rooms or unsecured areas.All residents identified with a history of smoking or vaping were reassessed on [DATE] using the updated Smoking and Vaping Risk Assessment Tool.On [DATE], as of 4PM education was initiated by the Assistant Administrator/DON, and the Staff Development Coordinator (SDC) for all staff on the vaping policy, including supervision/monitoring protocols, and what to do if staff find a resident with a vape. 120 staff members out of 138 total were in-serviced on vaping policy (93 in person and 25 via phone). As of 4 PM on [DATE], staff members who have not been in-serviced will not be allowed to work until they are in-serviced by the (SDC), DON, or Assistant Director of Nursing (ADON).3. How the practice will be monitored:On [DATE], RDHS and VP of Operations educated the Administrator and DON regarding policy enforcement, the facility's failure to ensure compliance with the Advance Directive policy, and the systemic review of all Advance Directive related issues.The administrative team had a QAPI meeting on [DATE] to discuss the Administrator's responsibilities regarding policy enforcement, the facility's failure to ensure compliance with the Advance Directive policy, and the systemic review of all Advance Directive related issues. Attendees were the Administrator, DON, VP of Operations, Regional Director of Health Services (RDHS), and Medical Director via phone.In this QAPI meeting the Administrator and RDHS educated the QAPI team on their responsibility to review the facility's performance of CPR/Code performance per the policy. It is the responsibility of the QAPI team to ensure that the advance directive policy along with resident rights is completed.The administrative team had a QAPI meeting on [DATE] to discuss the Administrator's responsibilities regarding policy enforcement, the facility's failure to ensure compliance with the vaping policy, and the systemic review of all vaping related issues. Attendees were the Administrator, [NAME] President (VP), Regional Nurse Consultant, and Medical Director via phone.Going forward, the QAPI team will ensure the process is ongoing and the Administrator or designee will be responsible for the auditing for any potential alleged violations (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	during daily department head meetings conducted Monday through Friday. The daily department head meeting form was updated on [DATE] to capture discussions regarding vaping/smoking violations, behaviors related to noncompliance, or other issues. The Administrator will bring all alleged violations monthly to the Quality Assurance Meeting.On [DATE], the VP of Operations completed education with the Administrator, Director of Nursing, Unit Managers, Infection Preventionist, Housekeeping Supervisor, Maintenance Director, and Dietary Manager on the Quality Assurance Performance Improvement policy which includes monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.4. When were corrections completed?Corrections were all completed on [DATE].5. When is the immediacy of the IJ removal date?Effective Date of IJ Removal Plan Implementation: [DATE].Plan Prepared By: [NAME] President of Operations and Director of Health Services. **********The IJ was removed on [DATE] at 5:30 PM after the survey team verified the facility's implementation of the removal plan as follows: The survey team reviewed:- A written statement signed by the Administrator, DON, UM #5, and UM #13 concerning a house-wide audit on [DATE] to identify vaping devices and the log for the room-by-room search completed by those four staff members; - Smoking and Safety assessments newly completed for all the residents who currently used vaping devices were reviewed, and it was verified that Resident #3's new assessment included their non-compliance issues; and- Inservice & Training Sign In Sheets TOPIC: Vaping Policy along with the facility's Vaping Policy. Staff from both units and all shifts were interviewed regarding the content of the Vaping Policy In-service and were able to answer questions appropriately. All residents who used vaping devices were interviewed and stated they had been educated regarding the vaping policy and the consequences of being non-compliant, including possible emergency discharge from the facility for noncompliance. Education provided to the Administrator and DON regarding policy enforcement and compliance with the Advance Directive policy was verified with a sign-in sheet and interviews. The QAPI meeting on [DATE] was verified by reviewing the sign-in sheet that included signatures of the Administrator, the DON, the Medical Director via telephone, the Assistant Director of Nursing (ADON)/ Infection Preventionist (IP), SSD, the Regional Nurse Consultant, two unit managers, the MRD, a treatment nurse, and a restorative nurse.Interviews with the Administrator, the DON, the Medical Director, ADON/IP, SSD, one unit manager, the MRD, a treatment LPN, and a restorative LPN verified they were part of the QAPI discussion related to DNRs and their responsibility in the process. Termination of the previous DON was verified with an Employee Termination Form dated [DATE], a letter from the Administrator, and interviews with the Administrator. Education provided to the DON, ADON/IP, and the Staff Development Coordinator (SDC) related to the proper process for honoring and documenting DNR orders was verified through review of sign-in sheets and through interviews. Education on the proper process for honoring and documenting DNR orders, including steps to take if a family member requests CPR contrary to an existing DNR order, was verified by a review of in-service sign-in sheets with 25 staff signatures, and through interviews with staff, including one CMA; 13 LPNs, including the Medical Records Director, the MDS Coordinator, a respiratory LPN, a restorative LPN, a treatment LPN, and the SDC; four RNs, including the ADON/IP, a weekend supervisor, and one unit manager; and the social worker verified that they had received the education. The revised Vaping QAPI plan was reviewed and included education to family and residents, in addition to the staff, regarding adherence to the facility's vaping policy, the safety hazards of noncompliance, and the consequences of violating the vaping policy. A copy of an Inservice & Training Sign In Sheet, TOPIC: QAPI Policy Review signed by atten[TRUNCATED]

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to implement a water management program to minimize risk of water-borne illnesses. Specifically, the facility did not identify areas of its water system that would be vulnerable to legionella growth. The facility also failed to fit-test employees for N95 respirators per Centers for Disease Control (CDC) guidelines. These failures had the potential to affect all residents. Per the Midnight Census report, dated [DATE], the current census was 93. Findings included:1. The facility's undated policy titled Water Management Program indicated part of the scope of the program was, Identification of potentially hazardous areas or devices where Legionella could grow and spread.Review of the facility's Water Management Program revealed that on [DATE], legionella tests were taken from four locations around the facility. The room [ROOM NUMBER] sink was positive at a concentration of 0.40 colony forming units (CFUs) / milliliter (mL). The room [ROOM NUMBER] sink was positive at a concentration of 0.40 CFUs / mL. The room [ROOM NUMBER] sink was positive at a concentration of 2.0 CFUs / mL. The room [ROOM NUMBER] sink was positive at a concentration of 1 CFU / mL. According to the guidelines in the water plan, below 10 CFUs / mL was below detectable limits. No remedial action was required. The water management program also included flushing audits that were conducted after the tests.During an interview on [DATE] at 2:31 PM, the Maintenance Director stated they tested water semi-annually, and if the company that tested the water had recommendations, the facility followed those recommendations. In [DATE], several locations came back positive, and a management plan to flush the system three times weekly in different locations was implemented. After four weeks of flushing, they would resend samples to be tested again. After the retest, the company would give more instructions. They already did routine water flushes outside of the company's recommendation. During an interview on [DATE] at 3:26 PM, the Maintenance Director stated there was no flow chart in the facility for the water system. During an interview on [DATE] at 4:04 PM, the Maintenance Director stated there was no flow chart that identified areas where water might stagnate. They determined that the sinks were most vulnerable because most stagnation would be at the ends of the buildings and the ends of the lines. During an interview on [DATE] at 11:16 AM, the [NAME] President of Operations stated the facility did not test any other areas other than the taps / showers. They did not test the air conditioner units or the condensation in the ceiling of the facility over the summers. The company that performed the testing had never entered the building to conduct an assessment.During an interview on [DATE] at 1:01 PM, the Maintenance Director stated that over the years of testing the rooms and common areas for legionella, the ones that triggered for concerns were identified as vulnerable areas. There was no diagram detailing waterflow or possible areas of stagnant water in the building.2. During an interview on [DATE] at 3:36 PM, the Director of Nursing (DON) stated they followed the Centers for Disease Control (CDC) recommendations for fit testing as their policy.A Centers for Disease Control (CDC) and National Institute for Occupational Safety and Health (NIOSH) publication, dated [DATE], titled Fit Testing, indicated, A fit test is a test protocol conducted to verify that a respirator is both comfortable and provides the user with the expected protection. Before using a tight-fitting respirator in the workplace, The Occupational Safety and Health Administration (OSHA) requires users to pass a fit test to confirm proper fit and a tight seal against the user's face. Fit testing is important to ensure the expected level of protection is provided by minimizing the total amount of contaminants that leak into the facepiece through the face seal. Respirators are available in multiple size configurations and are not standardized across models. Fit testing is needed to determine if a particular size and model of respirator provides you with an acceptable fit. You must be fit tested for each respirator model you will wear for your designated work tasks.During an interview on [DATE] at 9:07 AM, the Infection Preventionist (IP) stated fit testing for N95 respirators was intended to be done yearly, but there was a gap in the testing at the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility. She had reached out to a university in the state to conduct fit testing on [DATE]. Approximately 45 staff members were fit tested. The facility last had its COVID-19 (coronavirus disease) outbreak on [DATE] The last fit test before the outbreak was in June of 2023. She also stated staff were not being fit tested on hire. She was able to submit a list of staff who had been fit tested, which included approximately 44 names. According to a staffing list provided by the facility, 135 staff were employed.During an interview on [DATE] at 3:54 PM, Licensed Practical Nurse #14 stated she started in [DATE], but she had not yet been fit tested for an N95 respirator.During an interview on [DATE] at 4:04 PM, the Maintenance Director revealed he had not been fit tested for an N95 respirator.During an interview on [DATE] at 8:52 AM, the Director of Nursing (DON) stated there was a turnover of the infection preventionist position in 2024, causing the gap in fit testing. She stated there was no formal fit testing for staff who provided care during the COVID-19 outbreak in 12/2024. The DON taught staff how to seal the respirators. She stated no residents died or were hospitalized during the outbreak.During an interview on [DATE] at 10:02 AM, the Administrator deferred to the IP on fit testing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015136	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interview, record review, facility document review, and facility policy review, the facility failed to report abuse allegations within the required timeframes for 2 (Resident #34 and Resident #107) of 5 residents reviewed for abuse. Specifically, the facility failed to report an incident to the state involving Resident #34 and Resident #85. The facility also failed to report an allegation of abuse involving Resident #107 to the state within the mandated two-hour timeframe.Findings included:An undated facility policy titled, Abuse, Neglect, Misappropriation of Resident Property, Suspicious Injuries of Unknown Sources, Exploitation, indicated, The facility will report all instances of alleged or suspected abuse, including verbal and mental abuse, neglect, suspicious injuries of unknown origin, exploitation, and misappropriation of resident property in the following manner: Notify the Administrator of any unusual situation in the facility, whether reportable or not immediately. The Administrator/designee in administrator's absence will report to the State Agency and all other required agencies, according to regulations. All allegations of abuse and instances that result in serious bodily injury must be reported within 2 hours.1. An admission Record indicated the facility admitted Resident #34 on 11/17/2023. According to the admission Record, the resident was admitted with diagnoses including cognitive communication deficit, schizophrenia, unspecified dementia, and depression.Resident #34's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/05/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) of 5, which indicated the resident was severely cognitively impaired.Resident #34's Care Plan Report included a problem statement, dated 11/28/2023, that indicated the resident had impaired cognitive function related to dementia. The Care Plan Report also included a problem statement, dated 06/05/2024, that indicated the resident had potential to be verbally aggressive and had periods of agitation.An admission Record indicated the facility admitted Resident #85 on 10/12/2023. According to the admission Record, the resident was admitted with diagnoses including vascular dementia and unspecified psychosis.Resident #85's quarterly MDS, with an ARD of 06/11/2025, revealed the resident had a BIMS of 00, which indicated the resident was severely cognitively impaired.Resident #85's Care Plan Report included a problem statement, dated 11/06/2023, that indicated the resident had impaired cognitive function related to vascular dementia.A nursing Progress Note, dated 02/23/2025 at 1:44 PM, revealed, [Resident #34] became aggressive with another resident, who was sitting in close proximity to [their] door. [Resident #34] was yelling and aggressively pushing a [Resident #85] while [they] were sitting in [their] chair. The note was authored by Licensed Practical Nurse (LPN) #16.An undated statement of investigation from the Director of Nursing (DON) revealed that during review of progress notes, she identified a nursing Progress Note, dated 02/23/2025, that indicated Resident #35 exhibited aggressive behaviors. The DON interviewed the staff. According to the statement, No staff felt that abuse occurred, made an allegation of abuse or knew anything about this. Staff reported that [Resident #85] was sitting in [their] wheelchair and that [Resident #34] disliked [Resident #85] sitting near [Resident #34's] doorway. [Resident #34] pushed [Resident #85] in [Resident #85's] wheelchair away from [Resident #34's] room.Three attempts were made to interview Licensed Practical Nurse #16 on 07/23/2025 at 2:57 PM, 07/23/2025 at 3:54 PM, and 07/23/2025 at 5:13 PM. All attempts were unsuccessful. Review of the Daily Schedule Report, dated 02/23/2025, revealed the following direct-care staff worked on Resident #34's unit during the time of the incident: Certified Nursing Aides (CNAs) #11, #7, #17, #18, #19, and #20, and Certified Medication Aide (CMA) #21.During an interview on 07/24/2025 at 2:48 PM, CNA #11 stated she had worked with Resident #34 but did not recall any altercations.Three attempts were made to interview CNA #7 on 07/24/2025 at 2:50 PM, 07/24/2025 at 4:13 PM, and 07/25/2025 at 9:08 AM. All attempts were unsuccessful.During an interview on 07/24/2025 at 4:16 PM, CNA #17 stated (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she did not remember Resident #34.Three attempts were made to interview CNA #18 on 07/24/2025 at 3:04 PM, 07/24/2025 at 4:15 PM, and 07/25/2025 at 9:11 AM. All attempts were unsuccessful.CNA #19 was contacted once on 07/24/2025 at 3:05 PM, but the CNA hung up immediately as the call started.Three attempts were made to interview CNA #20 on 07/24/2025 at 3:05 PM, 07/24/2025 at 4:17 PM, and 07/25/2025 at 9:11 AM.During an interview on 07/24/2025 at 2:56 PM, CMA #21 stated she saw no altercations involving Resident #34.During an interview on 07/25/2025 at 10:14 AM, the DON stated that the Administrator on 02/23/2025 was the current Assistant Administrator.During an interview on 07/25/2025 at 10:44 AM, the Assistant Administrator stated that it was the facility expectation to call the abuse coordinator if they saw a resident-resident altercation. An incident like a resident aggressively pushing another resident who was seated would be reported to him. That incident never made it to him, or he would have investigated it. Based on the note, he stated it should have been reported to the state and investigated.During an interview on 07/25/2025 at 10:44 AM, the Administrator stated that the facility expectation for the nursing staff, if they saw a resident-resident altercation, was to report it to the abuse coordinator, who would report it to the state and begin their investigation. She stated it also depended on the witness's statement whether it would be reported. During an interview on 07/25/2025 at 2:58 PM, the DON stated she found the progress note of the 02/23/2025 incident when doing a 24-hour progress note review. She stated the unnamed resident in Resident #34's progress note was Resident #85. After discovering the note, the DON interviewed the staff working that day, and none of the staff felt the incident constituted abuse. She stated she did not have the statements of the staff she spoke to regarding the incident. During an interview on 07/31/2025 at 8:52 PM, the DON stated anything that was potentially abuse should be reported to the abuse coordinator. She stated abuse was about the perception of the patient. She stated that allegations of abuse should be reported to the state, but she stated she would not report it if she investigated the allegation within the two-hour time frame and there was nothing negative to report to the state. She stated that for abuse to occur, harm had to happen.During an interview on 07/31/2025 at 10:02 AM, the Administrator stated that staff should report incidents that made them uncomfortable. The incident with Resident #34 and Resident #85 should have been reported to the abuse coordinator and then the state.2. An admission Record revealed the facility admitted Resident #107 on 12/20/2024. According to the admission Record, Resident #107 had a medical history that included chronic respiratory failure, polyneuropathy, and type 2 diabetes mellitus. The admission Record revealed Resident #107 was discharged on 01/07/2025 at 1:40 PM. A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/24/2024, revealed Resident #107 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. Resident #107's Care Plan included a focus area initiated on 12/31/2024 that indicated the resident could be very aggressive to staff and caregivers related to anxiety. The resident made inappropriate and derogatory comments about female staff members. Interventions directed staff to Administer medications as ordered, monitor/document for side effects and effectiveness (initiated 12/31/2024), assess the resident's coping skills and support system (initiated 12/31/2024), and psychiatric/psychogeriatric [NAME] as indicated (initiated 12/31/2024).A document review of an Alabama Department of Public Health Online Incident Reporting System form, dated 12/30/2024 at 5:42 PM, revealed that at approximately 8:00 PM on 12/28/2024, Resident #107 informed Unit Manager (UM) #13 that Licensed Practical Nurse (LPN) #29 was abusive/rude, intentionally shutting the resident's bedroom door when they preferred it open, and did not use an alcohol prep when administering their insulin. During an interview on 07/29/2025 at 2:40 PM, UM #13 confirmed Resident #107 made an abuse allegation towards LPN #29. UM #13 stated that Resident #107 was upset with LPN #29 because they were rude and slammed the resident's bedroom door. UM #13 stated that they immediately informed the Director of Nursing (DON) and removed LPN #29 from the unit. During an interview on 07/31/2025 at 9:34 AM, the DON stated that all allegations of abuse should be reported to the State of Alabama within two hours. The Administrator (ADM) was (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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Falkville Rehabilitation and Healthcare Center	10 West 3rd Street Falkville, AL 35622

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interviewed on 07/31/2025 at 10:26 AM. The ADM stated the incident should have been immediately reported to the state. The ADM stated allegations of abuse should be reported within two hours.

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	015136	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure residents' records were complete, accurately documented, and readily accessible for 6 (Residents #91, #29, #11, #8, #36, and #4) of 19 residents reviewed.Findings included:A facility policy titled, Documentation in Medical Record, dated 12/31/2024, revealed, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. The policy revealed, 4. Principles of documentation include, but are not limited to, b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care, and c. Documentation shall be timely and in chronological order. 1. An admission Record revealed the facility admitted Resident #91 on 06/28/2025. According to the admission Record, the resident had a medical history that included diagnoses of cognitive communication deficit, other specified persistent mood disorders, delirium due to known physiological condition, and psychotic disorder with hallucinations due to known physiological condition. A 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/30/2025, revealed Resident #91 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident had no behavioral symptoms during the lookback period. Resident #91's Baseline Care Plan included a problem area initiated 06/28/2025, that indicated the resident was at risk for elopement/wandering. Interventions directed staff to supervise the resident (initiated 06/28/2025). Resident #91's Care Plan Report included a focus area initiated 06/29/2025, that indicated the resident had impaired cognitive function/dementia or impaired thought processes related to vascular dementia. Interventions directed staff to cue, reorient, and supervise as needed (initiated 06/29/2025). Resident #91's BIMS Evaluation progress note, dated 06/27/2025 (the resident's admission was on 06/28/2025), indicated that it was a late entry. The Created Date was 07/01/2025. The progress note indicated the resident's BIMS summary score was 15. The note revealed that it was completed by the Social Services Director (SSD). During an interview on 07/24/2025 at 3:39 PM, the SSD stated she did not write down the date she completed Resident #91's assessment when she documented it as a late entry and just remembered it as 06/27/2025. She stated Resident #91 was admitted on [DATE], and she could have clicked the wrong date for the effective date of 06/27/2025. She stated she documented assessments on paper and then threw them away once she had documented them on the computer. She stated sometimes she documented the date of the assessment on the paper but not always. During an interview on 07/25/2025 at 3:43 PM, the Director of Nursing (DON) stated Resident #91's BIMS progress note was created on 07/01/2025. She stated it was a late entry by the SSD. She stated the effective date was wrong, and they did not know the date the SSD conducted the assessment without the paper documentation that the SSD would have written on at the time of the assessment. The DON stated they no longer had the paper documentation for Resident #91's BIMS evaluation. She stated the record did not accurately reflect the date the assessment occurred. The DON stated she expected medical records to be accurate. During an interview on 07/29/2025 at 2:15 PM, the Administrator stated she expected medical records to be complete and accurate so that the best decisions could be made for the residents. 2. An admission Record revealed the facility admitted Resident #29 on 04/23/2025 and readmitted the resident on 05/26/2025. According to the admission Record, the resident had a medical history that included diagnosis of Alzheimer's disease with early onset. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/25/2025, revealed Resident #29 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident had severe cognitive impairment. Resident #29's Care Plan Report included a focus area revised (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/29/2025, that indicated the resident had a terminal prognosis of Alzheimer's disease and received hospice services. Interventions directed staff to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met (initiated 04/24/2025). Resident #29's electronic health record revealed no notes or documentation of a physician visit that was required within 30 days of the resident's readmission on [DATE]. During an interview on 07/27/2025 at 4:05 PM, the [NAME] President (VP) of Operations stated documentation of physician visits for Resident #29 was being sent over from the physician's office. During an interview on 07/28/2025 at 4:47 PM, the Regional MDS Coordinator stated physician visits from the Medical Director were not onsite and not available to the facility to electronically access. During an interview on 07/28/2025 at 9:56 AM, the Director of Nursing (DON) stated the physician progress notes were in an electronic system that the facility staff could not access, and the notes were not in the facility's electronic health record program. The DON provided the requested physician visit records dated 06/04/2025 for Resident #29. During an interview on 07/29/2025 at 2:15 PM, the Administrator stated she expected medical records to be complete and accurate so that the best decisions could be made for the residents. 3. An admission Record revealed the facility admitted Resident #11 on 04/06/2021 and readmitted the resident on 01/07/2025. According to the admission Record, the resident had a medical history that included a diagnosis of bilateral primary osteoarthritis of knee. A quarterly MDS, with an ARD of 04/16/2025, revealed Resident #11 had a BIMS score of 4, which indicated the resident had severe cognitive impairment. Resident #11's Care Plan Report included a focus area revised 09/05/2024, that indicated the resident had a wish to remain in the facility. Interventions directed staff to make arrangements with required community resources to support independence post-discharge and send referrals to appropriate resources prior to discharge if discharge became an option (initiated 09/05/2024). Resident #11's electronic health record revealed no notes or documentation of a physician visit that was required between 60 to 90 days after the resident's readmission on [DATE]. During an interview on 07/27/2025 at 4:05 PM, the [NAME] President (VP) of Operations stated documentation of physician visits for Resident #11 was being sent over from the physician's office. During an interview on 07/28/2025 at 4:47 PM, the Regional MDS Coordinator stated physician visits from the Medical Director were not onsite and not available to the facility to electronically access. During an interview on 07/28/2025 at 9:56 AM, the Director of Nursing (DON) stated the physician progress notes were in an electronic system that the facility staff could not access, and the notes were not in the facility's electronic health record program. The DON provided the requested physician visit records dated 04/07/2025 for Resident #11. During an interview on 07/29/2025 at 2:15 PM, the Administrator stated she expected medical records to be complete and accurate so that the best decisions could be made for the residents. 4. An admission Record revealed the facility admitted Resident #8 on 08/28/2024 and readmitted the resident on 01/09/2025. According to the admission Record, the resident had a medical history that included diagnoses of encephalopathy and Alzheimer's disease with late onset. A quarterly MDS, with an ARD of 04/17/2025, revealed Resident #8 had a BIMS score of 7, which indicated the resident had severe cognitive impairment. Resident #8's Care Plan Report included a focus area revised 05/29/2025, that indicated the resident had a terminal prognosis of Alzheimer's disease and received hospice services. Interventions directed staff to consult with a physician and social services to have hospice care for the resident in the facility (initiated 01/10/2025). Resident #8's electronic health record revealed no notes or documentation of a physician visit that was required within 30 days of the resident's readmission on [DATE]. During an interview on 07/27/2025 at 4:05 PM, the [NAME] President (VP) of Operations stated documentation of physician visits for Resident #8 was being sent over from the physician's office. During an interview on 07/28/2025 at 4:47 PM, the Regional MDS Coordinator stated physician visits from the Medical Director were not onsite and not available to the facility to electronically access. During an interview on 07/28/2025 at 9:56 AM, the Director of Nursing (DON) stated the physician progress notes were in an electronic system that the facility staff could not (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	access, and the notes were not in the facility's electronic health record program. The DON provided the requested physician visit records dated 02/03/2025 for Resident #8. During an interview on 07/29/2025 at 2:15 PM, the Administrator stated she expected medical records to be complete and accurate so that the best decisions could be made for the residents. 5. An admission Record indicated the facility admitted Resident #36 on 02/20/2025. According to the admission Record, the resident had a medical history that included diagnoses of vascular dementia, cerebral infarction, atrial fibrillation, hypothyroidism, hyperlipidemia, and mood disorder. Resident #36's significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/07/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Resident #36's Care Plan Report included the following: - A focus area dated 02/24/2025 indicated the resident had impaired cognitive function related to dementia. Interventions directed staff to administer medications as ordered (initiated 02/24/2025).- A focus area indicated the resident used psychotropic medications related to behavior management. Interventions directed staff to administer psychotropic medications as ordered by the physician (initiated 02/26/2025).- A focus area dated 02/24/2025 indicated Resident #36 received antidepressant medications related to a mood disorder. Interventions directed staff to administer antidepressant medications as ordered by a physician (initiated 02/24/2025).- A focus area dated 02/24/2025 indicated the resident received anticoagulation therapy related to atrial fibrillation. Interventions directed staff to administer anticoagulant medications as ordered by the physician (initiated 02/24/2025).- A focus area dated 07/16/2025 indicated the resident used antianxiety medications related to agitation. Interventions directed staff to administer antianxiety medications as ordered by the physician (initiated 07/16/2025). Resident #36's June 2025 Medication Administration Record [MAR] included the following transcription of orders:- Citalopram (a selective serotonin reuptake inhibitor) 20 milligrams (mg), one tablet one time a day for depression, with a start date of 06/17/2025 and discontinued date of 06/20/2025 at 9:27 AM.- Divalproex sodium (a fatty acid derivative anticonvulsant) 125 mg delayed release sprinkle, six capsules one time a day for dementia with behaviors, with a start date of 06/17/2025 and a discontinued date of 06/20/2025 at 9:27 AM.- Levothyroxine sodium (a thyroid drug) 25 micrograms (mcg), one tablet in the morning for hypothyroid, with a start date of 06/17/2025 and discontinued date of 06/20/2025 at 9:27 AM.- Olanzapine (an antipsychotic) 5 mg, two tables at bedtime for severe vascular dementia with behaviors, with a start date of 06/18/2025 and a discontinued date of 06/20/2025 at 9:27 AM.- Risperidone (an antipsychotic) 1 mg, one tablet at bedtime for severe vascular dementia with behaviors, with a start date of 06/18/2025 and a discontinued date of 06/20/2025 at 9:27 AM.- Thiamine hydrochloride (a vitamin) 100 mg, one tablet one time a day for supplement, with a start date of 06/17/2025 and discontinued date of 06/20/2025 at 9:27 AM.- Apixaban (an anticoagulant) 5 mg, one tablet my mouth two times a day for a previous cerebrovascular accident (CVA, a stroke), with a start date of 06/16/2025 and a discontinued date of 06/20/2025 at 9:27 AM.- Hydrocortisone (a topical steroid) external cream 2.5%, apply two times a day for itching, with a start date of 06/19/2025 and a discontinued date of 06/20/2025 at 9:27 AM.- Ketoconazole (an antifungal) external cream 2%, apply to the face, scalp, and groin two times a day for itching/yeast; with a start date of 06/19/2025 and a discontinued date of 06/20/2025 at 9:27 AM.- Nystatin (a topical antifungal) powder100,000 units per gram, apply topically three times a day for yeast, with a start date of 06/16/2025 and a discontinued date of 06/20/2025 at 9:27 AM.- Acetaminophen (an analgesic) 325 mg, one tablet three times a day for pain, with a start date of 06/16/2025 and a discontinued date of 06/20/2025 at 9:27 AM.- Triamcinolone acetonide (a corticosteroid) external cream 0.1%, apply to skin two times a day for allergy, with a start date of 06/16/2025 and a discontinued date of 06/19/2025 at 2:27 PM.- Complete a pain scale every shift for pain, with a start date of 06/16/2025 and a discontinued date of 06/20/2025 at 9:27 AM. Resident #36's June 2025 MAR revealed staff did not document the completion of scheduled tasks or medication administration or a reason as to why scheduled tasks or (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication administration were not completed on the following dates:- On 06/17/2025: pain scale (morning shift).- On 06/19/2025: apixaban (9:00 PM), hydrocortisone cream (9:00 PM), ketoconazole cream (9:00 PM), triamcinolone acetonide (9:00 PM), nystatin (antifungal) powder (10:00 PM), acetaminophen (10:00 PM), and pain scale (evening shift).- On 06/20/2025: citalopram, divalproex sodium, levothyroxine, olanzapine, risperidone, thiamine, apixaban (9:00 AM), hydrocortisone cream (9:00 AM), ketoconazole cream (9:00 AM), triamcinolone acetonide (9:00 AM), nystatin (antifungal) powder (6:00 AM), acetaminophen (6:00 AM), and pain scale (morning shift). During an interview with Licensed Practical Nurse (LPN) #14 and Unit Manager (UM) #13, they stated that the blanks on Resident #36's MAR were due to the resident's hospitalization, but there was a way to notate hospitalization on the MAR. This was not done. 6. An admission Record revealed the facility admitted Resident #4 on 06/16/2025. According to the admission Record, the resident had a medical history that included diagnoses of cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy (CADASIL), type 2 diabetes mellitus, reflex neuropathic bladder, peripheral vascular disease, vascular dementia, and dyspnea (shortness of breath). Resident #4's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/25/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Resident #4's Care Plan Report included the following:- A focus area dated 06/17/2025 indicated the resident had diabetes mellitus. Interventions directed staff to administer diabetes medication as ordered by the doctor (initiated 06/17/2025).- A focus area dated 06/17/2025 indicated Resident #4 had an indwelling catheter in place.- A focus area dated 06/17/2025 indicated Resident #4 received oxygen therapy. Interventions directed staff to administer medications as ordered by the physician (initiated 06/17/2025). Resident #4's Order Recap [Recapitulation] Report, for the timeframe from 06/01/2025 through 07/31/2025, revealed the following:- An order dated 06/16/2025 directed that the resident's oxygen tubing and humidifier be changed weekly and as needed every Friday on night shift.- An order dated 06/19/2025 directed that the resident's indwelling urinary catheter output be measured every shift.- An order dated 06/16/2025 specified the resident was to receive insulin glargine subcutaneous solution, with 25 units to be injected subcutaneously twice daily. Resident #4's June 2025 Medication Administration Record [MAR] revealed staff did not document the completion of scheduled tasks or a reason why the tasks were not completed on the following dates:- 06/20/2025 and 06/27/2025: No documentation to indicate the oxygen tubing was changed.- 06/22/2025: No documentation of indwelling urinary catheter output. Resident #4's July 2025 Medication Administration Record revealed staff did not document the completion of scheduled tasks or medication administration or a reason why the tasks/medication administration were not completed on the following dates:- 07/04/2025, 07/11/2025, and 07/18/2025: No documentation of oxygen tubing changes.- 07/05/2025 (evening shift), 07/09/2025 (evening shift), 07/13/2025 (morning shift), 07/17/2025 (morning shift), and 07/24/2025 (morning shift): No documentation of indwelling urinary catheter output.- 07/21/2025: No documentation to indicate the insulin glargine injections were administered. During an interview on 07/29/2025 at 1:41 PM, Licensed Practical Nurse (LPN) #15 stated there should not be blanks on the MARs. She stated the blanks on the MARs showed up in the electronic medical record as if the staff did not click it off. She stated that it did not mean the task was not completed, just that it was not documented. She stated the blanks on the MAR that corresponded to Resident #4's insulin administration happened on her shift, and she believed the resident refused it that day. She stated the refusals should have been documented on the MAR. During an interview on 07/29/2025 at 2:08 PM, Unit Manager (UM) #5 stated she did not know the policy for documenting oxygen tubing changes if the oxygen was not used by the resident. She stated that she did not know the policy for documenting catheter output either but stated a certified nurse aide (CNA) reported output to the nurses so they could document it on the MAR. She stated that she did not know if a CNA failed to report the output or if the nurse failed to document. She also stated that she expected refusals of medication to be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015136	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented in the electronic medical record as a progress note. During an interview on 07/31/2025 at 8:42 AM, the Director of Nursing (DON) stated there should be no blanks on the MARs. She stated that there was an option to document that a resident was in the hospital as well as any refusals on the MAR. The DON stated that there was also an option to document that the administration/completion was not applicable if the order was not necessary at the time. She stated that CNAs obtained the catheter outputs, and the nurse documented them. She believed the blanks on the MARs were documentation oversights. During an interview on 07/31/2025 at 10:02 AM, the Administrator stated there should never be blanks on the MARs, even if the medication was not given for reasons outside of the nurse's control.

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	015136	A. Building B. Wing	09/02/2025

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. Based on interview, record review, facility document review, and facility policy review, the facility failed to provide notification of the rights and rules of the facility for 1 (Resident #34) of 3 residents. Specifically, neither Resident #34 nor the resident's representative signed the facility's notification of the rights and rules at the facility on the resident's admission.Findings included:During an interview on 07/29/2025 at 3:01 PM, the Administrator stated there was no policy for informing residents of their rights at the facility other than what was in the facility admission agreement.A facility policy titled, admission of a Resident, dated 12/31/2024, indicated, A Resident Handbook and/or Facility orientation material should be provided to the resident/family prior to or upon admission, so they understand what to bring to the facility.The facility's admission Agreement included a undated document titled, Resident Rights that indicated, The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The document further described resident rights and included a signature page.An admission Record indicated the facility admitted Resident #34 on 11/17/2023. According to the admission Record, the resident was admitted with diagnoses including cognitive communication deficit, schizophrenia, unspecified dementia, and depression.Resident #34's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/05/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) of 5, which indicated the resident was severely cognitively impaired.Resident #34's Care Plan Report included a problem statement, dated 11/28/2023, that indicated the resident had impaired cognitive function related to dementia. During an interview on 07/23/2025 at 5:34 PM, the [NAME] President of Operations stated the facility did not have the admission packet for Resident #34.During an interview on 07/23/2025 at 5:40 PM, the Admissions Director confirmed that Resident #34 did not have an admission agreement. The facility performed an audit a few months prior and discovered the resident had no admission agreement. The facility tried to reach out to Resident #34's family, but they had not been successful.During an interview on 07/29/2025 at 1:18 PM, the Admissions Director stated that the admission packet was where residents were informed of their rights at the facility as well as the facility rules. Resident #34 did not have a signed copy scanned into the record.During an interview on 07/31/2025 at 8:52 AM, the Director of Nursing (DON) stated that residents were given a copy of their resident rights at the facility during the admission process. They were also posted in the facility. She did not know why Resident #34 had no admission packet, but she speculated that was partly because the resident's sibling refused to come to the facility to sign the admission paperwork.During an interview on 07/31/2025 at 10:02 AM, the Administrator confirmed that the admission process was how residents were informed of the rights and rules at the facility. She did not know why Resident #34 did not have an admission agreement.

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	015136	A. Building B. Wing	09/02/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interviews, record review, facility document review, and a review of the facility's policy, the facility failed to protect a resident's right to be free from physical abuse by another resident. This failure affected 1 (Resident #91) of 5 residents reviewed for abuse. Specifically, Resident #106 hit Resident #91 in the back on 06/29/2025.Findings included:The facility's undated policy titled, Abuse, Neglect, Misappropriation of Resident Property, Suspicious Injuries of Unknown Source, Exploitation indicated, All of our residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. According to the policy, Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, and mental anguish. The policy indicated Willful means the individual must have acted deliberately (not inadvertently or accidentally), not that the individual must have intended to inflict injury or harm. An admission Record indicated the facility admitted Resident #106 on 05/09/2024. According to the admission Record, the resident had a medical history that included diagnoses of anxiety disorder, mood disorder due to known physiological condition, adjustment disorder with mixed anxiety and depressed mood, unspecified dementia with other behavioral disturbance, and Alzheimer's disease with late onset.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/06/2025, revealed Resident#106 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had no behavioral symptoms during the seven-day lookback period.Resident #106's Care Plan Report included a focus area initiated 06/12/2025 that indicated the resident had impaired social interaction. Interventions directed staff to monitor interactions with others (initiated 06/12/2025.)An admission Record revealed the facility admitted Resident #91 on 06/28/2025. According to the admission Record, the resident had a medical history that included diagnoses of cognitive communication deficit, other specified persistent mood disorders, delirium due to known physiological condition, and psychotic disorder with hallucinations due to known physiological condition. A 5-day scheduled assessment MDS, with an ARD of 06/30/2025, revealed Resident #91 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had no behavioral symptoms during the seven-day lookback period.Resident #91's Baseline Care Plan included a problem area initiated 06/28/2025 that indicated the resident was at risk for elopement/wandering. Interventions directed staff to supervise the resident (initiated 06/28/2025.)Resident #91's Care Plan Report included a focus area initiated 06/29/2025 that indicated the resident had impaired cognitive function/dementia or impaired thought processes related to vascular dementia (initiated 06/29/2025.) Interventions directed staff to cue, reorient, and supervise as needed (initiated 06/29/2025).Review of a Nurse Practitioner (NP) Progress Note, dated 06/29/2025, revealed Resident #91 continues to be confused and disoriented and stated their jaw hurts from being ?sucker punched'. The note indicated there was an altercation between the resident and their roommate that afternoon. No significant injuries were noted.A review of a facility Verification of Investigation report revealed that on 06/29/2025, Resident #91 and Resident #106 were roommates. Resident #91 was allegedly rummaging through Resident #106's closet, and Resident #106 became angry and began yelling. Staff were present in the adjoining bathroom and immediately intervened. Resident #106 became combative with staff and was making attempts to hit Resident #91. Staff removed Resident #91 from the room and placed Resident #106 on one-to-one (1:1) supervision until the resident was transferred to the hospital for an evaluation. The Clinical Assessment of Resident/ Description of Injury (if any) revealed Resident #91 had a full body assessment with no injuries or redness noted. No physiological differences in the resident were noted. Resident #91 was moved to a different unit after the altercation. According to the report, neither resident had a history of prior altercations with other residents. The report indicated the facility would offer all residents a choice to have name cards placed on their closet doors so that the (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	closets could be easily identified.Certified Nurse Aide (CNA) #7's written statement, dated 06/29/2025, revealed she was in Resident #106 and Resident #91's bathroom and heard yelling coming from the room. She immediately entered the room and observed Resident #106 yelling at Resident #91 to leave Resident #106's things alone. She stepped between the two residents, and Resident #106 pushed her and then moved toward Resident #91. She then observed Resident #106 hit Resident #91 in the back with a closed fist three times. She described the hit as a jab and indicated Resident #106's arm was not at a full extension.During a telephone interview on 07/23/2025 at 12:32 PM, CNA #7 stated she was in the residents' bathroom when the incident took place. She heard yelling and a loud noise. Resident #106 was coming up off the floor from the resident's knees and said tell Resident #91 to stay out of Resident #106's closet. Resident #106 then went toward Resident #91. Resident #91 was walking toward a bed when Resident #106 followed Resident #91. Resident #91's back was now facing Resident #106, and Resident #106 started hitting Resident #91 at least four times before the nurse came in. She was standing between the two residents but then she got scared and ran to the door to get the nurse. The nurse was right in the hallway when CNA #4 got to the residents' door, and the nurse came to help. CNA #7 described the hitting was with closed fist. During a telephone interview on 07/23/2025 at 5:24 PM, Licensed Practical Nurse (LPN) #9 stated she was the nurse on the unit when the incident occurred. The CNA called for her to come in the room. Each resident was sitting on their own bed. Resident #106 was mad and yelling that they wanted Resident #91 to stay out of their closet. Resident #91 was confused.During a follow-up telephone interview on 07/24/2025 at 11:37 AM, LPN #9 stated Resident #91 had told her the resident had been hit by Resident #106.During a telephone interview on 07/24/2025 at 4:19 PM, Nurse Practitioner (NP) #1 stated Resident #106 admitted to hitting Resident #91. During an interview on 07/25/2025 at 10:53 AM, the Administrator reviewed the facility abuse policy and stated the incident between Resident #106 and Resident #91 was abuse. During an interview on 07/30/2025 at 3:49 PM, the Director of Nursing (DON) stated her expectation was for the facility to prevent abuse from occurring. A resident should be free from abuse. During an interview on 07/31/2025 at 10:19 AM, the Administrator stated she expected to prevent resident-to-resident abuse by addressing the behaviors in a care plan and with the interdisciplinary team (IDT).

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	015136	A. Building B. Wing	09/02/2025

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview, record review, facility document review, and facility policy review, the facility failed to implement the facility abuse policies and procedures related to identifying, reporting, and investigating abuse for 2 (Resident #91 and Resident #85) of 5 residents reviewed for abuse. Specifically, the facility failed to identify a resident-to-resident altercation as abuse when Resident #91 was physically abused by Resident #106 and failed to follow up on a comment Resident #91 made to the nurse practitioner (NP) about having jaw pain due to having allegedly been sucker punched. Additionally, the facility failed to ensure staff identified and reported abuse when Resident #85 was aggressively pushed in their wheelchair by Resident #34. Findings included:The facility's undated policy titled, Abuse, Neglect, Misappropriation of Resident Property, Suspicious Injuries of Unknown Source, Exploitation, indicated, The facility will report all instances of alleged or suspected abuse, including verbal and mental abuse, neglect, suspicious injuries of unknown origin, exploitation, and misappropriation of resident property in the following manner: Notify the Administrator of any unusual situation in the facility, whether reportable or not immediately. The Administrator/designee in administrator's absence will report to the State Agency and all other required agencies, according to regulations. All allegations of abuse and instances that result in serious bodily injury must be reported within 2 hours. The policy further indicated, Each employee has an obligation to immediately report any incident or allegation that could constitute an instance of abuse or neglect, an injury or unknown origin, exploitation, or misappropriation of resident property to the Administrator or designee. The policy specified, The outcomes of the investigation must also determine whether the incident was abusive or neglectful in nature. The policy also indicated Willful means the individual must have acted deliberately (not inadvertently or accidentally), not that the individual must have intended to inflict injury or harm.1. An admission Record indicated the facility admitted Resident #106 on 05/09/2024. According to the admission Record, the resident had a medical history that included diagnoses of anxiety disorder, mood disorder due to known physiological condition, adjustment disorder with mixed anxiety and depressed mood, unspecified dementia with other behavioral disturbance, and Alzheimer's disease with late onset.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/06/2025, revealed Resident#106 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had no behavioral symptoms during the seven-day lookback period.Resident #106's Care Plan Report included a focus area initiated 06/12/2025 that indicated the resident had impaired social interaction. Interventions directed staff to monitor interactions with others (initiated 06/12/2025.)An admission Record revealed the facility admitted Resident #91 on 06/28/2025. According to the admission Record, the resident had a medical history that included diagnoses of cognitive communication deficit, other specified persistent mood disorders, delirium due to known physiological condition, and psychotic disorder with hallucinations due to known physiological condition. A 5-day scheduled assessment MDS, with an ARD of 06/30/2025, revealed Resident #91 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had no behavioral symptoms during the seven-day lookback period.Resident #91's Baseline Care Plan included a problem area initiated 06/28/2025 that indicated the resident was at risk for elopement/wandering. Interventions directed staff to supervise the resident (initiated 06/28/2025.)Resident #91's Care Plan Report included a focus area initiated 06/29/2025 that indicated the resident had impaired cognitive function/dementia or impaired thought processes related to vascular dementia (initiated 06/29/2025.) Interventions directed staff to cue, reorient, and supervise as needed (initiated 06/29/2025).a. A review of a facility Verification of Investigation report revealed that on 06/29/2025, Resident #91 and Resident #106 were roommates. Resident #91 was allegedly rummaging through Resident #106's closet, and Resident #106 became angry and began yelling. Staff were present in the adjoining bathroom and immediately intervened. Resident #106 became combative with staff and was making (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attempts to hit Resident #91. The section of the report titled, Investigation Summary indicated the staff witness (Certified Nurse Aide [CNA] #7) reported that Resident #106 struck Resident #91 in the back with a closed fist three times, like a jabbing to stop. The report indicated this was in a way to tell Resident #91 to stop, not in an abuseful manner. Staff removed Resident #91 from the room and placed Resident #106 on one-to-one (1:1) supervision until the resident was transferred to the hospital for an evaluation. The Clinical Assessment of Resident/ Description of Injury (if any) revealed Resident #91 had a full body assessment with no injuries or redness noted. There was no indication that Resident #91 was hit in the jaw during this encounter.A review of CNA #7's statement, dated 06/29/2025, revealed she was in Resident #106 and Resident #91's bathroom and heard yelling coming from the room. She immediately entered the room and observed Resident #106 yelling at Resident #91 to leave Resident #106's things alone. She stepped between the two residents, and Resident #106 pushed her and then moved toward Resident #91. She then observed Resident #106 hit Resident #91 in the back with a closed fist three times. She described the hit as a jab and stated Resident #106's arm was not fully extended. She stated she did not think Resident #106 intended to harm or abuse Resident #91.During a telephone interview on 07/23/2025 at 12:32 PM, CNA #7 stated she was in the residents' bathroom when the incident took place. She heard yelling and a loud noise. Resident #106 was coming up off the floor from the resident's knees and said tell Resident #91 to stay out of Resident #106's closet. Resident #106 then went toward Resident #91. Resident #91 was walking toward the bed when Resident #106 followed Resident #91. Resident #91's back was facing Resident #106, and Resident #106 started hitting Resident #91 at least four times before the nurse came in. CNA #7 said she was standing between the two residents but then she got scared and ran to the door to get the nurse. The nurse was in the hallway and came to help. CNA #7 described the hitting was with closed fist. During a telephone interview on 07/24/2025 at 11:37 AM, Licensed Practical Nurse (LPN) #9 stated Resident #91 had told her the resident had been hit by Resident #106. During a telephone interview on 07/24/2025 at 4:19 PM, Nurse Practitioner (NP) #1 stated Resident #106 admitted to hitting Resident #91. During an interview on 07/25/2025 at 8:40 AM, the Director of Nursing (DON) stated Resident #106 hit Resident #91 in the back to get Resident #91 out of Resident #106's personal space. During an interview on 07/25/2025 at 9:10 AM, the Administrator stated she was the Abuse Coordinator and was involved in the decision to determine the incident between Resident #106 and Resident #91 was not abuse. She stated it was determined not to be abuse because CNA #7 stated it was not abuse. She stated the witness statement of CNA #7 was important in the determination that the incident was not abuse. She stated punching with a closed fist was a definition of abuse, and Resident #106 did punch Resident #91; however, there was consideration that this was an issue between roommates and nobody was injured. She stated Resident #106 punched Resident #91, but the intention was not to hurt the other resident.During an interview on 07/25/2025 at 10:52 AM, the [NAME] President (VP) of Operations stated they verified Resident #106 hit Resident #91, but that the incident was not abuse.During an interview on 07/25/2025 at 10:53 AM, the Administrator reviewed the facility abuse policy, including the definition of willful and stated the incident between Resident #106 and Resident #91 was abuse and that the facility's initial conclusion that the incident did not constitute abuse was incorrect. b. An NP Progress Note dated 06/29/2025 and electronically signed (e-signed) by NP #1 on 07/01/2025 at 12:10 AM, revealed Resident #91 stated to the NP that the resident's jaw hurts from being ?sucker punched' and that there had apparently been an altercation between Resident #91 and their roommate that afternoon. There was no documentation to indicate the NP reported the resident's jaw pain or allegation of having been sucker punched to facility staff.During an interview on 07/24/2025 at 11:14 AM, NP #1 stated she worked at the facility seven days on and then seven days off. She stated that when she interviewed Resident #91, the resident stated their jaw was sore from being sucker punched. She stated she documented this in a progress note but did not report it to anyone. She indicated the interview was conducted in the resident's room in the Memory Care Unit (MCU) and that no one else was present in (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the room. She stated she did not know the reporting requirements and had not been told she was required to report allegations of abuse. She did not recall having abuse training and stated she did not receive in-services on abuse.During a follow-up telephone interview on 07/24/2025 at 4:19 PM, NP #1 stated Resident #91 stated the resident was punched in the jaw by their roommate. She explained that this incident occurred when a CNA heard a noise and CNAs came to the residents' room. Resident #106 admitted to hitting Resident #91 and was transferred out to another local facility.Review of NP #1's Inservice and Training Sign-In Sheet, dated 12/02/2024, revealed NP #1 signed to acknowledge that she received training on the facility's abuse policy, what to report, to whom to report, and when to report abuse.During an interview on 07/25/2025 at 9:10 AM, the Administrator stated NP #1 did not report Resident #91's allegation of being punched in the jaw, and this allegation was not investigated. During an interview on 07/30/2025 at 3:45 PM, the Director of Nursing (DON) stated NP #1 did not report Resident #91's allegation of being punched in the jaw.During a follow-up interview on 07/30/3025 at 3:45 PM, the DON stated her expectation for reporting abuse was if staff saw or heard anything, they were to report it immediately. During a follow-up interview on 07/13/2025 at 10:17 AM, the Administrator stated her expectation regarding allegations of abuse were that they should be reported to her immediately or to the DON. She would make sure the residents were safe and then begin interviewing witnesses. 2. An admission Record indicated the facility admitted Resident #34 on 11/17/2023. According to the admission Record, the resident was admitted with diagnoses including cognitive communication deficit, schizophrenia, unspecified dementia, and depression.Resident #34's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/05/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment.Resident #34's Care Plan Report included a problem statement, dated 11/28/2023, that indicated the resident had impaired cognitive function related to dementia. The Care Plan Report also included a problem statement, dated 06/05/2024, that indicated the resident had the potential to be verbally aggressive and had periods of agitation.An admission Record indicated the facility admitted Resident #85 on 10/12/2023. According to the admission Record, the resident was admitted with diagnoses including vascular dementia and unspecified psychosis.A nursing Progress Note, dated 02/23/2025 at 1:44 PM, revealed Resident #34 became aggressive with another resident who was sitting in close proximity to Resident #34's door. According to the Progress Note, Resident #34 was yelling and aggressively pushing a resident who was sitting in their own chair. The note was authored by Licensed Practical Nurse (LPN) #16.Resident #85's quarterly MDS, with an ARD of 06/11/2025, revealed the resident had a BIMS of 00, which indicated the resident had severe cognitive impairment.Resident #85's Care Plan Report included a problem statement, dated 11/06/2023, that indicated the resident had impaired cognitive function related to vascular dementia.An undated statement of investigation from the Director of Nursing (DON) revealed that during review of Progress Notes, she identified a nursing Progress Note dated 02/23/2025 that indicated Resident #35 exhibited aggressive behaviors. The DON interviewed the staff. According to the statement, No staff felt that abuse occurred, made an allegation of abuse or knew anything about this. Staff reported that [Resident #85] was sitting in [their] wheelchair and that [Resident #34] disliked [Resident #85] sitting near [Resident #34's] doorway. [Resident #34] pushed [Resident #85] in [Resident #85's] wheelchair away from [Resident #34's] room.Three attempts were made to interview Licensed Practical Nurse #15 on 07/23/2025 at 2:57 PM, 07/23/2025 at 3:54 PM, and 07/23/2025 at 5:13 PM. All attempts were unsuccessful. Review of the Daily Schedule Report, dated 02/23/2025, revealed the following direct-care staff worked on Resident #34's unit during the time of the incident: Certified Nurse Aides (CNAs) #11, #7, #17, #18, #19, and #20, and Certified Medication Aide (CMA) #21.During an interview on 07/24/2025 at 2:48 PM, CNA #11 stated she had worked with Resident #34 but did not recall any altercations.Three attempts were made to interview CNA #7 on 07/24/2025 at 2:50 PM, 07/24/2025 at 4:13 PM, and 07/25/2025 at 9:08 AM. All attempts were unsuccessful.During an interview on 07/24/2025 at 4:16 PM, CNA #17 stated she did not remember (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015136	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #34.Three attempts were made to interview CNA #18 on 07/24/2025 at 3:04 PM, 07/24/2025 at 4:15 PM, and 07/25/2025 at 9:11 AM. All attempts were unsuccessful.CNA #19 was contacted on 07/24/2025 at 3:05 PM, but the CNA hung up immediately as the call started.Three attempts were made to interview CNA #20 on 07/24/2025 at 3:05 PM, 07/24/2025 at 4:17 PM, and 07/25/2025 at 9:11 AM. All attempts were unsuccessful.During an interview on 07/24/2025 at 2:56 PM, CMA #21 stated she saw no altercations involving Resident #34.During an interview on 07/25/2025 at 10:14 AM, the DON stated that the Administrator as of 02/23/2025 when the incident involving Resident #34 and Resident #85 occurred was the current Assistant Administrator.During an interview on 07/25/2025 at 10:44 AM, the Assistant Administrator stated that it was a facility expectation to call the Abuse Coordinator if they saw a resident-resident altercation. An incident like a resident aggressively pushing another resident who was seated would be reported to him. That incident never made it to him, or he would have investigated it. Based on the note, he stated the incident should have been reported to the state and investigated.During an interview on 07/25/2025 at 10:44 AM, the Administrator stated the facility expectation for the nursing staff, if they saw a resident-resident altercation, was to report it to the Abuse Coordinator, who would report it to the state and begin their investigation. She stated the determination to report the allegation also depended on the witness's statement. During an interview on 07/25/2025 at 2:58 PM, the DON stated she found the Progress Note dated 02/23/2025 while completing a 24-hour Progress Note review. She stated the unnamed resident in Resident #34's Progress Note was Resident #85. After discovering the note, the DON interviewed the staff working that day, and none of the staff felt the incident constituted abuse. She stated she did not have written statements from the staff she spoke to regarding the incident. During an interview on 07/31/2025 at 8:52 PM, the DON stated anything that was potentially abuse should be reported to the Abuse Coordinator. She stated abuse was about the perception of the patient. She stated that allegations of abuse should be reported to the state but indicated she would not report the allegation if she investigated it within the two-hour time frame and there was nothing negative to report to the state. She stated that for abuse to occur, harm had to happen.During an interview on 07/31/2025 at 10:02 AM, the Administrator stated that staff should report incidents that made them uncomfortable. The incident with Resident #34 and Resident #85 should have been reported to the Abuse Coordinator and then the state.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide bed-hold notification to 2 (Resident #101 and Resident #36) of 4 residents reviewed for hospitalization; and failed to notify the ombudsman of a resident's discharge to the hospital for 1 (Resident #101) of 4 residents reviewed for hospitalization.Findings included:1. An admission Record indicated the facility admitted Resident #36 on 02/20/2025. According to the admission Record, the resident was admitted with diagnoses including vascular dementia and mood disorder.Resident #36's significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/07/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident was severely cognitively impaired.Resident #36's Care Plan Report included a problem statement, dated 02/24/2025, that indicated the resident had impaired cognitive function related to dementia. A nursing Progress Note, dated 03/12/2025 at 11:05 PM, revealed Resident #36 had left the facility via ambulance.A nursing Progress Note, dated 05/12/2025 at 2:10 PM, revealed Resident #36 had left the facility via ambulance.A nursing Progress Note, dated 06/18/2025 at 9:28 PM, revealed Resident #36 had left the facility for evaluation.During an interview on 07/24/2025 at 8:56 AM, Licensed Practical Nurse (LPN) #13 stated that her understanding of the bed-hold system was that administration notified the family of the bed hold policy.During an interview on 07/24/2025 at 3:28 PM, the Business Office Manager (BOM) stated that Medicaid residents automatically got a four-day bed hold. On the fifth day, they called the family and asked if they wanted the bed hold. For Medicare residents, the bed-hold policy was sent to the family on transfer. The family returned the signed form indicating whether they wanted to keep or decline the bed hold. Resident #36 was Medicaid. The resident had been out of the facility for longer than four days, and she was unsure if the appropriate bed-hold notifications went out.During an interview on 07/31/2025 at 8:52 AM, the Director of Nursing (DON) stated that bed-hold notifications were provided at time of transfer, and the BOM followed up the next business day. The DON stated Resident #36 did not get the bed-hold notifications; there were omissions in that process. It was an oversight from the BOM, who was transitioning into that position.During an interview on 07/31/2025 at 10:02 AM, the Administrator stated that residents and representatives were notified of the bed-hold policies during the transfer. The charge nurse and the BOM were able to do that. She did not know about ombudsman notifications of resident transfers.2. An admission Record indicated the facility admitted Resident #101 on 05/20/2025. According to the admission Record, the resident was admitted with diagnoses including chronic obstructive pulmonary disease, Alzheimer's disease, polydipsia, hypo-osmolality and hyponatremia, and alcohol dependence.Resident #101's discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/23/2025, revealed the resident discharged to the short-term general hospital.A nursing Progress Note, dated 05/23/2025 at 2:27 PM, revealed Resident #101 had a critical sodium level and was transported out of the facility.During an interview on 07/24/2025 at 8:56 AM, Licensed Practical Nurse (LPN) #13 stated that her understanding of the bed-hold system was that the administration notified the family of the bed hold policy.During an interview on 07/24/2025 at 3:27 PM, the Director of Nursing (DON) stated that the facility did not have the ombudsman notification for Resident #101.During an interview on 07/24/2025 at 3:28 PM, the Business Office Manager (BOM) stated that Medicaid residents automatically got a four-day bed hold. On the fifth day, they called the family and asked if they wanted the bed hold. For Medicare residents, the bed-hold policy was sent to the family on transfer. The family returned the signed form indicating whether they wanted to keep or decline the bed hold. Resident #101 was Medicaid pending. She stated a bed-hold was offered, and they would have to see if they could find the form that would have been signed.During an interview on 07/31/2025 at 8:52 AM, the DON stated that bed-hold notifications were provided at time of transfer, and the BOM followed up the next business day. The DON stated Resident #101 did not get the bed-hold (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notifications; there were omissions in that process. It was an oversight from the BOM, who was transitioning into that position. She continued that the report of transfers was sent to the ombudsman monthly, but there was a technical glitch within their electronic medical record that stopped them from sending out Resident #101's transfer notification.During an interview on 07/31/2025 at 10:02 AM, the Administrator stated that residents and representatives were notified of the bed-hold policies during the transfer. The charge nurse and the BOM were able to do that. She did not know about ombudsman notifications of resident transfers.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to resubmit a Level 1 Pre-admission Screening and Resident Review (PASARR) following the addition of new qualifying psychiatric diagnoses. Specifically, Resident #34 and Resident #59 were diagnosed with new significant mental illnesses (SMIs) after their admission, but no new PASARR was completed.Findings included:A facility policy titled, Resident Assessment - Coordination with PASARR Program, copyrighted in 2024, revealed, Policy: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related condition in accordance with the State's Medicaid rule for screening. a. PASARR Level I - initial prescreening that is completed prior to admission. i. Negative Level I Screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii. Positive Level I Screening - necessitates a PASARR Level II evaluation prior to admission. b. PASARR Level II - a comprehensive evaluation by the appropriate state - designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs. 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review.1. An admission Record revealed the facility admitted Resident #59 on 01/06/2025. According to the admission Record, the resident had a medical history that included, on admission, attention deficit hyperactivity disorder, major depressive disorder, and generalized anxiety disorder. Additional psychiatric diagnoses were added as follows: delirium (03/31/2025), major depressive disorder with severe psychotic features (05/15/2025), psychotic disorder with delusions (06/20/2025), and major depressive disorder with severe psychotic symptoms (06/30/2025).A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/24/2025, revealed Resident #59 had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. Further review of the MDS revealed the resident was exhibiting Other behavioral symptoms daily (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds), and was receiving antipsychotic, antianxiety, and antidepressant medications daily.Resident #59's Care Plan included a focus area initiated 02/05/2025 that indicated the resident was verbally aggressive and would yell out and curse at others at times. Revisions were made to the focus area on 02/06/2025 to include the resident having angry outbursts, on 05/28/2025 to include the resident yells out frequently and yells staff names instead of using the call light, and on 06/25/20250 to include the resident yells out related to attention and medication seeking.An additional focus area initiated on 01/07/2025 indicated Resident #59 had an anxiety problem related to a diagnosis of anxiety disorder.An additional focus area initiated on 02/14/2025 indicated Resident #59 used psychotropic medications related to dementia with behaviors.A review of Resident #59's PASRR Level I Screening & Results report was dated as completed on 12/13/2023, more than two years prior to the resident's initial admission to the facility.A review of Resident #59's PASRR Level I Screening & Results report dated 07/29/2025 at 2:26 PM revealed the assessment did not have all the resident's current psychiatric diagnoses checked for question 2a., such as Major Depression, Depressive Disorder, and (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Psychotic Disorder.During an interview on 07/29/2025 at 3:02 PM, the Admissions Director stated Resident #59 was admitted to the facility on [DATE], and the PASARR was completed in December of 2023. The Admissions Director stated the PASARR should not have been accepted as the resident's admission PASARR, and another one should have been completed. She also stated she had completed another PASARR Level I that day [07/29/2025 at 2:26 PM] and sent it to OBRA for review of the need for a Level II; however, it was also missing several diagnoses.During an interview on 07/31/2025 at 8:52 AM, the Director of Nursing (DON) stated PASARRs were updated if new SMIs were added. The facility's OBRA representative, however, had told the facility to update the PASARR only if it would change the level of services. During an interview on 07/31/2025 at 10:02 AM, the Administrator stated the PASARR should be updated for new SMIs that were diagnosed after the resident's admission.2. An admission Record indicated the facility admitted Resident #34 on 11/17/2023. According to the admission Record, the resident was admitted with diagnoses including cognitive communication deficit, with an onset date of 09/03/2024; schizophrenia, with an onset date of 11/17/2023; unspecified dementia, with an onset date of 11/17/2023; anxiety, with an onset date of 10/28/2023; and depression, with an onset date of 03/27/2025.Resident #34's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/05/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) of 5, which indicated the resident was severely cognitively impaired.Resident #34's Care Plan Report included a problem statement, dated 11/17/2023, that indicated the resident was at risk for depression. Another problem statement, dated 11/17/2023, indicated the resident had impaired coping due to schizophrenia.Resident #34's State of Alabama Department of Public Health PASRR Level 1 Screening & Results, dated 09/28/2024, indicated the resident had an SMI of schizophrenia, with no mood or anxiety disorders indicated on the Level 1 PASRR.During an interview on 07/28/2025 at 3:09 PM, the Medical Records Director stated she was learning the PASARR process. She did state that if a resident was diagnosed with new SMIs after admission, she would have to submit for another screening level due to the level of care changes.During an interview on 07/28/2025 at 9:37 AM, the Admissions Director stated that if a resident had new diagnoses of SMIs, nursing would let her know and they would get a new PASARR.During an interview on 07/29/2025 at 1:18 PM, the Admissions Director stated that she had reached out to the Omnibus Budget Reconciliation Act (OBRA) Office to see if they needed to submit another screening for Resident #34. During an interview on 07/29/2025 at 2:57 PM, the Medical Records Director stated that as far as she knew, there was no new PASARR unless a resident discharged completely and then returned.During an interview on 07/29/2025 at 3:02 PM, the Admissions Director stated if they added a new SMI, the resident would need a new PASARR.During an interview on 07/31/2025 at 8:52 AM, the Director of Nursing (DON) stated PASARRs were updated if new SMIs were added. The facility's OBRA representative, however, had told the facility only to update the PASARR if it would change the level of services. Resident #34's dementia diagnosis was the primary diagnosis, so anxiety and depression would not have changed the outcome.During an interview on 07/31/2025 at 10:02 AM, the Administrator stated the PASARR should be updated for new SMIs that were diagnosed after the resident's admission.

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	015136	A. Building B. Wing	09/02/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure a PASARR (Pre-admission Screening and Resident Review) assessment was completed prior to admission to the facility for 1 (Resident #59) of 3 residents screened for PASARR. Findings included:A facility policy titled, Resident Assessment - Coordination with PASARR Program, copyrighted in 2024, revealed, Policy: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related condition in accordance with the State's Medicaid rule for screening. a. PASARR Level I - initial prescreening that is completed prior to admission. i. Negative Level I Screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii. Positive Level I Screening - necessitates a PASARR Level II evaluation prior to admission. b. PASARR Level II - a comprehensive evaluation by the appropriate state - designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs. An admission Record revealed the facility admitted Resident #59 on 01/06/2025. According to the admission Record, the resident had a medical history that included, on admission, attention deficit hyperactivity disorder, major depressive disorder, and generalized anxiety disorder. Additional psychiatric diagnoses were added as follows: delirium (03/31/2025), major depressive disorder with severe psychotic features (05/15/2025), psychotic disorder with delusions (06/20/2025), and major depressive disorder with severe psychotic symptoms (06/30/2025). A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/24/2025, revealed Resident #59 had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. Further review of the MDS revealed the resident was exhibiting Other behavioral symptoms daily (e.g. physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds), and was receiving antipsychotic, antianxiety, and antidepressant medications daily. Resident #59's Care Plan included a focus area initiated 02/05/2025 that indicated the resident was verbally aggressive and would yell out and curse at others at times. Revisions were made to the focus area on 02/06/2025 to include the resident having angry outbursts, on 05/28/2025 to include the resident yells out frequently and yells staff names instead of using the call light, and on 06/25/2025 to include the resident yells out related to attention and medication seeking. An additional focus area initiated on 01/07/2025 indicated Resident #59 had an anxiety problem related to a diagnosis of anxiety disorder. An additional focus area initiated on 02/14/2025 indicated Resident #59 used psychotropic medications related to dementia with behaviors. A review of Resident #59's PASRR Level I Screening & Results report revealed it was dated as completed on 12/13/2023, more than two years prior to the resident's initial admission to the facility. During an interview on 07/29/2025 at 3:02 PM, the Admissions Director stated that if an admission was coming from the hospital or a hospice facility, both entities completed the PASARR Level I prior to the resident's admission to the facility. She stated Resident #59 was admitted to the facility on [DATE], and the PASARR was completed in December of 2023. The Admissions Director stated the PASARR should not have been accepted as the resident's admission PASARR; another one should have been completed, and she did not catch it when the resident came in.

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	015136	A. Building B. Wing	09/02/2025

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review, interview, facility document review, and facility policy review, the facility failed to revise and update a baseline care plan following an incident of abuse, which affected 1 (Resident #91) of 5 residents reviewed for abuse. Specifically, Resident #91 rummaged through their roommate's closet, and their roommate hit them in response. The facility did not revise the care plan to include the rummaging behavior or include interventions to prevent future abuse of the resident.Findings included:An undated facility policy titled, Abuse, Neglect, Misappropriation of Resident Property, Suspicious Injuries of Unknown Source, Exploitation indicated, All our residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. The policy revealed, The facility will make all reasonable efforts to prevent instances of abuse, but in cases where such an instance occurs, the facility will use the event as an opportunity to develop new interventions to prevent a re-occurrence.An admission Record revealed the facility admitted Resident #91 on 06/28/2025. According to the admission Record, the resident had a medical history that included diagnoses of cognitive communication deficit, other specified persistent mood disorders, delirium due to known physiological condition, and psychotic disorder with hallucinations due to known physiological condition.A 5-day scheduled Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/30/2025, revealed Resident #91 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident had no behavioral symptoms during the lookback period.Resident #91's Baseline Care Plan included a problem area initiated 06/28/2025, that indicated the resident was at risk for elopement/wandering. Interventions directed staff to supervise the resident (initiated 06/28/2025).Resident #91's Care Plan Report included a focus area initiated 06/29/2025, that indicated the resident had impaired cognitive function/dementia or impaired thought processes related to vascular dementia. Interventions directed staff to cue, reorient, and supervise as needed (initiated 06/29/2025).A facility Verification of Investigation revealed that on 06/29/2025, Resident #91 was allegedly rummaging through their roommate's closet then the roommate became angry and began yelling at Resident #91. The Summary of Testimony revealed that a staff witnessed the incident and stated the roommate struck Resident #91 on the back with a closed fist three times. The document indicated Resident #91 was transferred to another unit within the facility.Resident #91's Baseline Care Plan or Care Plan Report revealed no evidence of being revised to include the resident's rummaging behavior or interventions to prevent future abuse.During an interview on 07/25/2025 at 8:04 AM, the Director of Nursing (DON) stated Resident #91 was transferred to the memory care unit because a quick decision had to be made to separate the resident from their roommate, and that was where there was a bed available. The DON stated the resident exhibited behaviors of rummaging and wandering. She stated the resident had been at the facility for less than 24 hours prior to the incident. She stated Resident #91's comprehensive care plan was not due at the time of the incident or transfer to the memory care unit. She stated a resident's behaviors should be documented on the baseline care plan for a resident moved to the memory care unit within the first 48 hours of admission, to ensure the staff were monitoring the resident. During a follow-up interview on 07/25/2025 at 10:15 AM, the DON stated Resident #91's care plans did not reflect rummaging as a behavior.During an interview on 07/30/2025 at 2:09 PM, Unit Manager (UM) #13 stated she was the UM for the memory care unit. She stated that after reviewing the resident's record, she was not aware of any behavior that made the resident vulnerable to abuse. During an interview on 07/30/2025 at 3:16 PM, the Social Services Director (SSD) stated she was responsible for the initiation of behavior care plans. She stated she was not part of the team when an abuse incident occurred, nor was she part of the investigation process. She stated she was part of the interdisciplinary team (IDT), and when they reviewed an incident, if a behavior caused abuse, then she added that behavior into the care plan. She stated (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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Falkville Rehabilitation and Healthcare Center	10 West 3rd Street Falkville, AL 35622

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #91's behaviors that occurred that resulted in the incident between Resident #91 and their roommate should have been care planned. She stated Resident #91 did not have a care plan that addressed prevention of future abuse and confirmed rummaging behaviors were not on the resident's care plans.During an interview on 07/30/2025 at 3:44 PM, the DON stated her expectation of a baseline care plan was for it to be completed within 24 hours of admission. She stated the baseline care plans were updated as needed, prior to the comprehensive care plan being due.During an interview on 07/31/2025 at 10:15 AM, the Administrator stated she expected the behaviors that led to the abuse to be identified, and care planned to prevent future abuse. She stated if a comprehensive care plan was not due, then she expected Resident #91's baseline care plan to be updated to address their rummaging behavior.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, record review, and facility policy review, the facility failed to provide necessary services to maintain grooming and personal hygiene for 1 (Resident #3) of 3 residents reviewed for showers, who was unable to carry out activities of daily living (ADLs) for themselves.Findings included:An undated facility policy titled Resident Showers revealed, Policy: It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice.An admission Record revealed the facility admitted Resident #3 on 03/27/2019. According to the admission Record, the resident had a medical history that included diagnoses of epilepsy, hemiplegia and hemiparesis affecting the left dominant side, dementia with other behavioral disturbance, muscle weakness, and chronic pain syndrome.An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/19/2025, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 6, indicating the resident had moderate cognitive impairment. Further review of the MDS revealed the resident was dependent on staff for a shower or bath. Resident #3's Care Plan included a focus area initiated on 06/22/2025 that indicated the resident required assistance with ADLs related to diagnoses of dementia and decreased mobility. The focus area was revised during the survey on 07/21/2025 to include Resident #3 refused baths/showers at times and refused to allow staff to shave them. Interventions directed staff to keep the call light within easy reach of the resident and to answer it in a timely manner, to observe for any decline in ADL performance, to observe the resident for pain that may interfere with ADL participation, to provide assistance with ADLs, and to provide privacy and converse with the resident while giving care (all initiated on 06/22/2025). There were no new interventions added with the revision on 07/21/2025. During an interview on 07/21/2025 at 10:05 AM, Resident #3 stated they wished to be shaved. The resident stated a friend had come in and shaved them, but the staff had not shaved the resident for a couple of weeks. Resident #3 stated they might get one shower a week. During the interview, an observation was made of the resident's hair being unkept and greasy. During an interview on 07/23/2025 at 10:08 AM, Resident #3 was observed in bed with a shirt and adult brief on and no pants. Food debris from breakfast remained all over the resident's shirt and on the bed linens around them. The resident continued with facial hair that had not been shaved. During an interview on 07/24/2025 at 11:40 AM, Resident #3 stated they had not gotten a shower in a while. Observation during the interview revealed that the resident's hair remained greasy with white flakes throughout, and their facial hair remained unshaved. During an observation on 07/23/2025 at 9:44 AM, a request was made to Unit Manager (UM) #5 to see the shower book for the hall Resident #3 resided on. The book was not available at the nurses' station, so UM #5 got on the elevator and went to the other floor to find it. After 16 minutes, UM #5 returned to the nurses' station at 10:00 AM, with the Director of Nursing (DON). The DON stated the shower book was just a communication tool for the Unit Manager, and that all showers and baths were recorded in the computer system by the UM. She stated that at times the certified nurse aides (CNAs) would document the showers themselves in the computer system; however, the UM was the checks and balances. The DON stated the shower book was just a list of the showers to be completed for the day. The CNAs would initial [next to the resident name] when they had completed the shower; then the showers got put into the computer. She stated the facility did not keep a paper copy of the shower sheets for review. The DON stated that if the shower was not recorded in the computer, there was no way to prove that it was done. A review of Resident #3's Task: ADL - Bathing log for 06/24/2025 through 07/23/2025, for the last 30 days, revealed Question 1, the resident's self-performance for bathing, revealed no data. A review of Resident #3's Task: ADL - Bathing log for 06/24/2025 through 07/23/2025, for the last 30 days, revealed Question 2, the bathing support provided, revealed no data.A review of Resident #3's Task: ADL - Bathing log for 06/24/2025 through 07/23/2025, for the last 30 days, revealed Question 3, the type of bath offered and provided, revealed no data.A review of (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3's Behavior Monitoring & Interventions log for 06/24/2025 through 07/23/2025, for the last 30 days revealed no behaviors observed. A review of Resident #3's Progress Notes revealed the last documented refusal of a shower/bed bath was dated 02/18/2025. During an interview on 07/23/2025 at 5:34 PM, Certified Medication Aide/Certified Nurse Aide (CMA/CNA) #2 stated there was a sheet in the shower book with every resident's shower schedule on it, and the staff was supposed to initial when the shower/bath had been given. She stated the staff should also document there if a resident refused the shower/bath. She stated Resident #3 had refused a shower before, but did not refuse one all the time. CMA/CNA #2 stated there were times when she had forgotten to do the documentation of showers/baths. During an interview on 07/23/2025 at 5:39 PM, CMA/CNA #3 stated there was a shower book at the nurses' station where staff were to initial after they had completed a resident's shower/bath. She stated the sheets would then go to the UM, and the UM would put the information into the resident's charts. CMA/CNA #3 stated she had forgotten to fill out the book because she had gotten busy. During an interview on 07/29/2025 at 12:08 PM, the DON stated there was no evidence in their EMR (electronic medical record) to show showers were being offered or being refused [by Resident #3], and their behavior of refusing showers was not being recorded in the computer. She stated she did not have documentation to show they were giving showers because they did not keep the paper shower sheets, which would also show any refusals, and no one had been putting the results of the shower sheets into the computer like they should be. The DON stated her expectation would be for staff to give showers to the resident according to their scheduled time and as needed. If the resident refused the shower, staff should document that in the resident's medical record and alert their supervisor of the refusal so that it could be care planned and behavioral issues addressed. During an interview on 07/29/2025 at 12:13 PM, the Administrator stated she was not aware of the lack of documentation regarding resident's showers; however, at that juncture, she could not say honestly that she was surprised. The Administrator stated her expectation was for staff to give the residents the care they required, which involved bathing and showering them. She stated that if a resident refused, it needed to be documented, and a supervisor alerted to address the issues.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on interview, observation, record review, and facility policy review, the facility failed to ensure they honored residents' food preferences, which affected 1 (Resident #9) of 7 residents reviewed for the dining task.Findings included:A facility policy titled, Standardized Menus, dated 09/01/2024, indicated, The facility shall provide nourishing, palatable meals to meet the nutritional needs of the residents based on the Recommended Daily Allowances (RDA) of the Food and Nutrition Board of the National Research Council, of the National Academy of Sciences, standardized cycle menus are planned in advance and utilized. The policy revealed the Compliance Guidelines included 13. The facility will support the resident's right to make personal dietary choices.An admission Record revealed the facility admitted Resident #9 on 06/27/2025. According to the admission Record, the resident had a medical history that included diagnoses of muscle weakness and iron deficiency anemia.An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/30/2025, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #9's Care Plan Report included a focus area initiated 06/28/2025, that indicated the resident had a nutritional problem or a potential nutritional problem. Interventions directed staff to provide and serve the resident's diet as ordered (initiated 06/28/2025).Resident #9's Order Summary Report, with active orders as of 07/30/2025, contained an order, with a start date of 06/27/2025, for a no added salt, regular texture, and thin consistency diet.During an interview on 07/21/2025 at 11:24 AM, Resident #9 stated there was no variety of food for breakfast. The resident stated that it was the same thing every day: scrambled eggs, sausage, and a biscuit. The resident stated they would like dry cereal and milk occasionally. The resident stated they did not want oatmeal. The resident stated the certified nurse aides (CNAs) asked the resident what they wanted for lunch and dinner but did not give them a choice for breakfast. During an interview on 07/22/2025 at 9:49 AM, the Culinary Director stated that she had three to seven days to meet with a newly admitted resident to discuss their food preferences. She stated that she documented their preferences on a preference sheet. She stated she had not met with newly admitted residents regarding food preferences in three months (Resident #9 was admitted within this timeframe). An observation on 07/23/2025 at 7:35 AM revealed Resident #9's breakfast tray included scrambled eggs, a biscuit, and one sausage patty. There was no hot or cold cereal present. During a concurrent interview, the resident stated they preferred dry cereal and milk, in addition to the eggs and sausage. During a follow-up interview on 07/29/2025 at 3:34 PM, Resident #9 stated they were still getting the same breakfast every day: sausage, eggs, and a biscuit. The resident stated if the staff asked them, then they would let the staff know they would like dry cereal. During a follow-up interview on 07/29/2025 at 4:12 PM, the Culinary Director stated she had still not met with newly admitted residents to discuss their food preferences.During a follow-up interview on 07/30/2025 at 10:09 AM, Resident #9 stated their breakfast that day was oatmeal, gravy, grits, eggs, and sausage. The resident stated the staff had not asked what their food preferences were. The resident stated they had not been offered dry cereal and did not eat the oatmeal that was served.During an interview on 07/30/2025 at 8:54 AM, CNA #22 stated there was a set menu for breakfast: biscuit, grits, sausage, and some residents got gravy and eggs. She stated she only asked residents about their meal preferences for lunch and dinner, not breakfast. During an interview on 07/30/2025 at 9:01 AM, CNA #23 stated she talked to residents about the menu with alternates for the following day and wrote what they wanted on the meal ticket, then turned it into the kitchen staff. She stated that she did it for lunch and dinner but did not do that for breakfast. She stated residents received the same breakfast every day: eggs, grits, a biscuit, and sausage. During an interview on 07/30/2025 at 9:10 AM, CNA #24 stated the facility had a main menu and an alternate choice menu. She stated that she obtained a resident's meal preference by asking the resident what they wanted for lunch and dinner (continued on next page)

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	015136	A. Building B. Wing	09/02/2025

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following day. She stated that she focused on lunch and dinner but could write breakfast preference on the meal ticket too. She stated the facility had new residents that came in and out on rehabilitation, so she did not know their preferences. She stated she would know their preferences if they asked for something different for breakfast. She stated she was familiar with Resident #9 but had not asked Resident #9 about their breakfast preference. She stated she knew Resident #9 did not like oatmeal, but she had not told the kitchen staff. During an interview on 07/30/2025 at 9:51 AM, the Director of Nursing (DON) stated her expectations were for residents' food preferences to be honored. She stated she expected their preferences to be reviewed upon admission and as needed by the Culinary Director. During an interview on 07/30/2025 at 9:56 AM, the Administrator stated that it was her expectation that residents be asked their likes and dislikes for food preferences. She stated that the Culinary Director should have been doing that, and she should have been making sure the Culinary Director was doing it. The Administrator stated residents have the right to voice their food likes and dislikes.

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	015136	A. Building B. Wing	09/02/2025

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and facility document review, the facility failed to ensure the survey results were posted in a location accessible to all residents and representatives. Specifically, the survey results were posted behind the first floor nurses' station, and the signage indicated that people were to request access. This had the potential to affect all residents. Per the Midnight Census report, dated 07/21/2025, the current census was 93.Findings included:During an interview on 07/24/2025 at 8:45 AM, the Regional Nurse Consultant stated that there was no policy on the survey results location. During an observation on 07/23/2025 at 10:11 AM, survey results facility signage was noted next to the first floor nursing station at the front of the building. The facility signage indicated, State surveys performed by Alabama Department of Public Health are available for review at the first floor nursing station. Please ask the nurse if you would like to review these surveys.During an observation on 07/23/2025 at 10:15 AM, after touring the facility, the only location of the survey results was noted to be behind the nursing station on the first floor.During an interview on 07/23/2025 at 12:32 PM, Licensed Practical Nurse (LPN) #8 stated the survey results binder was behind every nurses' station.During an interview on 07/23/2025 at 1:06 PM, the Administrator stated the survey results were behind the first floor nursing station.During an interview on 07/24/2025 at 8:45 AM, the Regional Nurse Consultant stated the survey results were originally next to the visitor sign-in, but they moved the results to the nursing station. She confirmed the signage indicated one needed to ask the nurse for access to the survey results.During an interview on 07/31/2025 at 8:52 AM, the Director of Nursing stated that the survey results binder should be accessible to the public without having to ask. She confirmed that the survey results binder being behind the first floor nurses' station was an inherent obstacle to accessing the binder.During an interview on 07/31/2025 at 10:02 AM, the Administrator stated that the survey results should be accessible without having to ask. The survey results were originally in a good location, but she moved them because the building was being refurbished, and she did not realize that having to request access to the survey results violated the regulation.