

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  015144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/03/2024
NAME OF PROVIDER OR SUPPLIER  The Healthcare Center at Buck Creek		STREET ADDRESS, CITY, STATE, ZIP CODE  850 9th Street, Northwest Alabaster, AL 35007	

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)
<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 29671</p> <p>Based on interviews, record review and facility policies titled Room &amp; Roommate Change Policy, the facility failed to notify Resident Identifier (RI) #5 of a room change prior to the move.</p> <p>This affected Resident Identifier (RI) #5, one of one resident who expressed dissatisfaction with their room change.</p> <p>This deficiency was cited as a result of the investigation of complaint/report number AL00047738.</p> <p>Findings include:</p> <p>A review of an undated facility's policy titled Room and Roommate Change Policy documented:</p> <p>.PROCEDURE .The Resident has the right to refuse to transfer to another room in the Center if the purpose of the transfer is .</p> <p>c. Solely for the convenience of staff .</p> <p>RI #5 was admitted to the facility on [DATE], with diagnoses to include Unspecified Dementia.</p> <p>A review of a progress note for RI # 5 documented . 04/29/2024 . This resident was transferred from North wing (he/she) was alert and oriented to person and place with some confusion noted .</p> <p>On 05/01/2024 at 5:30 PM, an interview was conducted with RI #5. During the interview, RI #5 informed the surveyor that he/she was not supposed to be on that unit (secure/memory) and was only there because Licensed Practical Nurse (LPN) #12 did not like him/her. RI #5 said that LPN #12 had informed him/her that this unit (secure/memory) would be a better fit, and he/she told LPN #12 he/she did not want to move. RI #5 said that LPN #12 informed him/her that he/she had no choice in the matter.</p> <p>A second interview was conducted with RI #5 on 05/02/2024 at 12:46 PM. RI #5 said he/she did not belong on this unit (secure/memory), and LPN #12 had him/her moved because she did not like him/her. RI #5 said he/she did not want to change rooms. RI #5 further stated LPN #12 informed him/her of the move and no one else had spoken to him/her about the move. RI #5 said LPN #12 said he/she did not have a choice in the move. RI #5 said he/she missed his/her old room and his/her friends on the old unit (North wing).</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/02/2024 at 10:00 AM, an interview was conducted with the Social Worker (SW). The SW said that on 04/26/2024, LPN #12 informed her about RI #5's increased wandering in other residents' rooms. As a result, RI #5 was moved to the locked/secure unit. The SW said the process for RI #5's room change was she contacted RI #5's daughter, spoke with admissions, and confirmed the availability of a bed. The SW said the room change took place on 04/29/2024. The SW stated RI #5 had only one episode of wandering documented on 04/26/2024. The SW said that she did not have a conversation with RI #5 prior to the move. In addition, the SW said if the move was necessary, the resident would not be given a choice.</p> <p>On 05/02/2024 at 6:19 PM, an interview was conducted with the Administrator/abuse coordinator. The Administrator said on 04/29/2024 when RI #5 was moved to the secure/memory unit she was on vacation. The Administrator stated that the move occurred due to the resident wandering in and out of rooms, and increased confusion. The Administrator said that it was normal to communicate with the resident before the move, if possible. If the resident expressed a desire not to move, questions should be asked to understand the reason behind not wanting to move. The Administrator said she was not sure why someone had not spoken with RI #5 before the move. The Administrator said the consequences of not communicating with a resident prior to a move, would result in confusion, a lack of understanding regarding the move, and difficulties in adjusting to a new environment.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 29671</p> <p>Based on interviews, record review, review of a facility policy titled Abuse, Neglect, Misappropriation, Exploitation Policy, and review of information from the Alabama Department of Public Health (ADPH) Online Reporting System, the facility failed to protect the Resident Identifier (RI) #5's right to be free from verbal, mental, and physical abuse by a staff.</p> <p>On 04/25/2024 Certified Nursing Assistant (CNA) #9 observed Licensed Practical Nurse (LPN) #12 stand up and say she was going to go to RI #5's room and call his/her dead mother a bitch. On approximately 04/27/2024 or 04/28/2024 CNA #10 overheard LPN #12 on the phone during a break say she went in RI #5's room and called him/her an ugly bitch and called his/her dead mother an ugly bitch.</p> <p>On 04/26/2024 the Social Worker (SW) was informed by LPN #12 that RI #5 was wandering in other resident's room. The Social Worker started the process of having RI #5 moved to the secure/memory unit without informing RI #5 prior to the move. On 04/29/2024 RI #5 was moved to the secure/locked unit in the facility. The resident expressed he/she did not want to move and stated he/she felt LPN #12 had him/her moved because she did not like him/her.</p> <p>This failure affected RI #5, one of eight sampled residents reviewed for abuse prevention.</p> <p>This deficiency was cited as a result of the investigation of complaint/report number AL00047738.</p> <p>Findings Include:</p> <p>The ADPH Online Facility Report Incident dated 04/29/2024, identified . Incident Type .Abuse-Verbal . Incident Detail . CNA alleged the nurse (LPN #12) told the resident (RI #5) that his/her dead mother was a bitch .</p> <p>A review of the facility Abuse, Neglect, Misappropriation, Exploitation Policy, effective January 2019, revealed:</p> <p>Purpose: To prohibit and prevent abuse .</p> <p>Definitions: .</p> <p>Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . It includes verbal abuse .physical abuse, and mental abuse .</p> <p>Involuntary Seclusion: is defined as separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates) against the resident's will .</p> <p>Mental Abuse: is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Physical Abuse: Includes, but is not limited to hitting, slapping, punching, biting and kicking .</p> <p>Verbal abuse: May be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability .</p> <p>RI #5 was admitted to the facility on [DATE] with diagnoses that included Unspecified Dementia, without behavioral disturbance.</p> <p>A review of Resident #5's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/26/2024, revealed RI #5 had a Brief Interview for Mental Status (BIMS) score of 5 (five) of 15, which indicated the resident had severe cognitive impairment.</p> <p>A review of a progress note for RI #5 dated 04/26/2024 documented . alert and oriented . Resident has been redirected x3 attempts out of other residents' rooms. Resident's on the hallway has c/o (complained) to this writer (LPN #12) about being in their room while coughing. Resident has been wandering around the unit and is forgetful about where (his/her) room is as well as in the dining room asking where the dining room is . This was the only note in the RI #5's medical record that documented wandering behaviors.</p> <p>A review of a progress notes for RI #5 documented . 04/29/2024 . This resident was transferred from North Wing (he/she) is alert and oriented to person and place with some confusion noted .</p> <p>RI #5 was interviewed on 05/01/2024 at 5:30 PM. RI #5 said that LPN #12 had told him/her how ugly his/her mother was and had physically poked his/her shoulder with two fingers while saying this to him/her. RI #5 said this caused him/her to feel bad and he/she did not like what LPN #12 had said to him/her. RI #5 informed the surveyor that he/she was not supposed to be on the secured unit (Secure/Memory) and was only there because LPN #12 did not like him/her. RI #5 stated that LPN #12 had informed him/her that this unit would be a better fit, and he/she told LPN #12 they did not want to move. RI #5 said that LPN #12 had informed him/her that he/she had no choice in the matter.</p> <p>A second interview was conducted with RI #5 on 05/02/2024 at 12:46 PM. RI #5 said, LPN #12 had told him/her how ugly his/her mother was and had physically poked his/her shoulder with two fingers while saying this to him/her. RI #5 said this caused him/her to feel bad and he/she did not like what LPN #12 had said to him/her. RI #5 said this made him/her feel bad and she did not respond to the comment made by LPN #12. RI #5 said he/she was not doing good, because he/she did not belong on the secured unit. RI #5 stated LPN #12 had him/her moved because she (LPN #12) did not like him/her. RI #5 said he/she did not want to change rooms prior to being moved to the secure/locked unit. RI #5 further stated LPN #12 informed him/her of the move and said he/she had no choice. RI #5 said he/she missed his/her old room and his/her friends.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/02/2024 at 9:45 AM, an interview was conducted with CNA #9. According to CNA #9, on 04/25/2024, she observed RI #5 approach the nurse's desk where LPN #12 was sitting and inquired about the results of an x-ray. LPN #12 informed RI #5 that it was too early for the results as the x-ray technician had just left. CNA #9 stated that RI #5 then proceeded to call LPN #12 a bitch as he/she was walking away. After the resident walked away, CNA #9 said, LPN #12 stood up and said she would go to RI #5's room and call his/her dead mother a bitch. CNA #9 said, LPN #12 returned to her seat without going to RI #5's room or saying anything to RI #5. CNA #9 said she believed LPN #12 had RI #5 moved to the secure/memory unit related to the incident on 04/25/2024.</p> <p>On 05/02/2024 at 12:15 PM, an interview was conducted with CNA #10. According to CNA #10, on approximately 04/27/2024 or 04/28/2024, she overheard LPN #12 on the phone, during a break, saying she went to RI #5's room and called him/her an ugly bitch and his/her dead mother an ugly bitch. CNA #10 said, she felt RI #5 was moved to the secured unit because he/she made LPN #12 mad. When asked why she felt that way she explained it was based on what she heard LPN #12 say on the phone and it seemed likely to her that RI #5 had to move. CNA #10 stated she had never witnessed RI #5 wandering. CNA #10 said RI #5 questioned LPN #12 about the reason for the move and expressed she did not want to move. CNA #10 said, LPN #12 informed RI #5 he/she did not have a choice in the matter.</p> <p>On 05/03/2024 at 12:05 PM, a telephone interview was conducted with CNA #11. CNA #11 stated she had never observed RI #5 wandering, but rather observed RI #5 parking her wheelchair outside rooms and engaging in conversations with other residents who were friends. CNA #11 recalled that LPN #12 informed her that RI #5 would be moving, so she told RI #5 about the move. CNA #11 said RI #5 wanted to know the reason and initially refused to move. CNA #11 informed LPN #12 that RI #5 did not want to move but was told, by LPN #12, RI #5 did not have a choice in the matter. CNA #11 said LPN #12 walked RI #5 to the other (secured/memory) unit.</p> <p>On 05/02/2024 at 10:00 AM, an interview was conducted with the Social Worker (SW). The SW said that on 04/26/2024, LPN #12 informed her about RI #5's increased wandering in other residents' rooms. As a result, RI #5 was moved to the locked/secure unit. The SW said the process for RI #5's room change was she contacted RI #5's daughter, spoke with admissions, and confirmed the availability of a bed. The SW said the room change took place on 04/29/2024. The SW stated RI #5 had only one episode of wandering documented on 04/26/2024. The SW said that she did not have a conversation with RI #5 prior to the move. In addition, the SW said if the move was necessary, the resident would not be given a choice.</p> <p>On 05/02/2024 at 10:56 AM, an interview was conducted via telephone with LPN #12. LPN #12 said that during her shift on 04/29/2024, she received information from the Social Worker that RI #5 was approved to be moved to the locked unit. Upon informing RI #5 about the move, he/she became upset upon realizing it was to the locked unit and blamed LPN #12. LPN #12 explained to RI #5 that the administration believed the locked unit was a better fit, but RI #5 was dissatisfied with that response. According to LPN #12, RI #5 was transferred to the locked unit on 04/29/2024 and eventually calmed down. LPN #12 denied requesting the move of RI #5 to the locked unit. LPN #12 stated that on 04/26/2024, she informed the Social Worker about RI #5 wandering in the rooms of other residents. LPN #12 said RI #5 wandered into RI #6, RI #7, and RI #8's rooms.</p> <p>Upon review of RI #8's latest Quarterly MDS with ARD of 04/16/2024, RI #8's BIMS score was 11 out of 15, which indicated moderate impairment of cognition.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with RI #8 on 05/02/2024 at 5:15 PM. RI #8 confirmed he/she were friends with RI #5 and would see each other outside his/her room. RI #8 stated that RI #5 had never entered the room without permission to visit him/her. RI #8 also denied complaining about RI #5 wandering into his/her room.</p> <p>Upon review of RI #6's latest Significant Change MDS with ARD of 03/21/2024, it was found RI #6's BIMS score was 14 out of 15, which indicated that RI #6 was cognitively intact.</p> <p>An interview was conducted with RI #6 on 05/02/2024, at 5:20 PM. When asked if RI #6 knew RI #5, the response was yes, stating that they use to visit together. RI #6 was further questioned about RI #5 wandering into his/her room without permission, to which RI #6 replied that RI #5 would either come in to visit or sit outside the door to talk. RI #6 denied reporting to a nurse that RI #5 came in the room uninvited.</p> <p>Upon review of RI #7's latest Quarterly MDS with ARD of 02/29/2024, it was found RI #7's BIMS score was 11 out of 15, which indicated moderate impairment of cognition.</p> <p>An interview was conducted with RI #7 on 05/02/2024 at 5:25 PM. RI #7 confirmed remembering the RI #5 and said that RI #5 was a friend who had moved to a different hall. RI #7 stated that RI #5 had never wandered into his/her room without permission. Additionally, RI #7 denied reporting to a nurse about RI #5 entering the room without an invitation.</p> <p>On 05/02/2024 at 3:26PM, an interview was conducted with the Director of Nursing (DON). The DON said she became aware of an incident involving RI #5 and LPN #12 on 04/29/2024 when CNA #10 reported the incident. The DON explained that CNA #10 reported overhearing CNA #9 saying that LPN #12 had called RI #5's dead mother a bitch. The DON said after it was reported to her, she spoke with CNA #9, who shared that on 04/25/2024, she witnessed LPN #12 stand up and say she was going to RI #5's room and call his/her dead mother a bitch. The DON then interviewed RI #5, who she believed was interviewable. According to the DON, RI #5 said LPN #12 came in the room, saw a picture of his/her mother and told him/her she was ugly while poking his/her shoulder with two fingers. RI #5 also described LPN #12 as evil and sneaky, without providing further details.</p> <p>On 05/02/2024 at 6:19 PM, an interview was conducted with the Administrator/abuse coordinator. The Administrator said on 04/29/2024 when RI #5 was moved to the secure/memory unit she was on vacation. The Administrator stated that the move occurred due to the resident wandering in and out of rooms, and increased confusion. The Administrator said that it was normal to communicate with the resident before the move, if possible. If the resident expressed a desire not to move, questions should be asked to understand the reason behind for not wanting to move. The Administrator said she was not sure why someone had not spoken with RI #5 before the move. The Administrator also said, the consequences of not communicating with a resident prior to a move, would result in confusion, a lack of understanding regarding the move, and difficulties in adjusting to a new environment. The administrator said abuse should be reported immediately when it was received, heard, or witnessed. In addition, the administrator said the incident involving RI #5 and LPN #12, should have been first reported on 04/25/2024 when CNA #9 overheard LPN #12 saying she was going to go to RI #5's room and call his/her dead mother a bitch. The administrator said abuse should be reported immediately so an investigation could be started and for the protection of the residents from abuse.</p>		

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<p>F 0602</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 29671</p> <p>Based on interviews, record review, review of a facility policy titled, Abuse, Neglect and Misappropriation, Exploitation Policy, and review of information from the Alabama Department of Public Health's (ADPH) Online Reporting System, the facility failed to ensure Resident Identifier (RI) #1 was free from misappropriation of funds from his/her personal funds.</p> <p>On 04/13/2024 the facility administrator was informed by the Business Office Manager (BOM) that she had been arrested for elder abuse. According to information received from local law enforcement detective the BOM used RI# 1's personal bank account information to pay her personal credit card in the amount greater than \$16,000.</p> <p>The survey team applied the Reasonable Person Concept to determine the severity of psychosocial harm rose to the level of actual harm that was not immediate jeopardy.</p> <p>This deficient practice affected RI #1, one of eight sampled residents reviewed for abuse.</p> <p>This deficiency was cited as a result of the investigation of complaint/report number's and AL00047554.</p> <p>Findings Include:</p> <p>The ADPH Online Facility Report Incident dated 09/11/2023, identified . Incident Type .Misappropriation of Resident Property .The ADPH Incident Detail . Narrative summary of Incident: (RI #1's) daughter alleged the Business Office Manger stole \$30,000 from (RI #1) .</p> <p>The ADPH Online Facility Report Incident dated 04/13/2024, identified . Incident Type .Abuse-Exploitation . The ADPH Incident Detail . Narrative summary of Incident: The Business Office Manger informed the Administrator on 04/13/2024 that she was arrested for Elder Abuse on 04/12/2024 .</p> <p>A review of the facility Abuse, Neglect, Misappropriation, Exploitation Policy, effective January 2019, revealed:</p> <p>Purpose: To prohibit and prevent abuse .</p> <p>Definitions: .</p> <p>Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the residents consent .</p> <p>The facility's job description, titled Position Description for Business Office Manager documented:</p> <p>.Accountability Objective: To perform and/or oversee the successful and timely completion of all business office functions . within the parameters established by state and federal regulation . Support an environment that promotes optimal efficiencies . and superior quality of business office employees .</p> <p>(continued on next page)</p>		

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F 0602  Level of Harm - Actual harm  Residents Affected - Few	<p>A review of a document provided by the facility for the BOM titled WORKSITE EMPLOYEE WARNING NOTICE documented: .Breach of Company Policy . Business office Manager (BOM) will allow the resident's to sign their own checks. If a resident is unable to sign a check then the facility will contact the family to assist with making financial arrangements. Any additional violation will result in termination . 10/26/23 .(dated)</p> <p>RI # 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Major Depressive Disorder and Cognitive Communication Deficit.</p> <p>A review of Resident #1's Significant Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/29/2023, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13 of 15, indicating the resident had moderately cognitive intact.</p> <p>A review of RI #1's available Bank Statements for the month of June 2023 and August 2023 revealed mobile payments to Capital One in the amounts of \$1725.99 on 06/22/2023, \$640.81 on 08/02/2023, \$1669.83 on 08/11/2023 and \$1621.16 on 08/22/2023.</p> <p>A review of the Capital One statement's, obtained from the local detective, from June 2023 and August 2023 identified the BOM as an account holder. The statements identified payments made in the amounts of \$1725.99 on 06/21/2023, \$640.81 on 08/01/2023, \$1669.83 on 08/10/2023, and \$1621.16 on 08/21/2023 was applied to the BOM's Capital One credit card account.</p> <p>On 04/30/2024 at 3:00PM, an interview was conducted with RI # 1, who said that he/she did not have a Capital One credit card and had never set up payment through his/her bank account to pay a Capital One.</p> <p>On 04/30/2024 at 4:33PM, an interview was conducted with The Administrator (ADM). The ADM stated that the BOM had various responsibilities, including managing the finances for residents, handling insurance billing, collecting liability payments, and overseeing the resident trust account. The ADM said that RI #1 was a private pay resident who managed his/her own bank account. The ADM said that RI #1 had requested the former BOM's assistance in paying the monthly room and board, as well as the pharmacy bill. The ADM said, the former BOM kept RI #1's checkbook in the business office and would take it to RI #1's room, and help write out the check for payment. The ADM said, the BOM's job description would allow her to assist residents if the resident requested assistance. However, the ADM said it was not typical for the BOM to sign a check on behalf of residents. The ADM stated she investigated an allegation of misappropriation involving RI #1 and the former business office manager in September of 2023. The ADM said that in April of 2024, the BOM called her and reported she had been arrested for elder abuse.</p> <p>On 05/03/2024 at 3:15 PM, a second interview was conducted with the Administrator/Abuse Coordinator. During the interview, the Administrator said that she supervised the business office, which included the business office manager and receptionist. She explained that she provided daily supervision of the business office, and monthly audits were carried out by the corporate office. The Administrator said that she became aware in September 2023 during an investigation into the misappropriation of RI #1's funds that RI #1 's checkbook was kept in the business office by the BOM. The administrator stated the BOM could have contacted the family to assist with paying RI #1's monthly bills.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  015144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/03/2024
NAME OF PROVIDER OR SUPPLIER  The Healthcare Center at Buck Creek		STREET ADDRESS, CITY, STATE, ZIP CODE  850 9th Street, Northwest Alabaster, AL 35007	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0602</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Regional Business Office Consultant (RBOC) on 05/01/2024 at 12:00PM. The RBOC said that she conducted an audit which involved reviewing all private pay transactions, payment postings, and examining the accounts of all residents who had funds with the facility. The audit results showed no misappropriation of funds. The RBOC said it was not acceptable for the BOM to sign checks for residents. She said that during the investigation in September, it was discovered that the former BOM had signed at least one check payable to the facility for room and board. The RBOC stated that the former BOM was reprimanded and received training when this issue came to light during the September 2023 investigation. The RBOC stated that she provided monthly supervision to the business office to ensure proper cash balancing and to address any concerns that may have occurred. She also stated that she had no knowledge of the former BOM using RI #1's personal funds to pay her personal credit cards.</p> <p>An interview was conducted with the facility's [NAME] President of Revenue Cycle (VPRC) on 05/01/2024 at 12:23 PM. The VPRC said that she conducted an audit of all private pay residents, checks that had been scanned, the resident trust fund, and RI #1's account. The VPRC confirmed that no missing funds were discovered during the audit. It was revealed in the audit that the former BOM had signed and written out checks for RI #1 for room and board payments in June, July, August, and September of 2023. The VPRC said following the investigation, the former BOM received in-service training and was issued a write up before returning to work. The VPRC stated she had no knowledge of the BOM using RI #1's personal funds to pay her personal credit card.</p> <p>On 05/08/2024 at 10:30AM, a local detective was interviewed regarding the misappropriation of funds linked to RI #1. The detective revealed that the Former BOM at the facility utilized RI #1's banking details to pay her personal credit card bill from June 2023 through September 2023. The cumulative amount of these payments equaled \$16,705.00. He said, a payment of \$1725.99 was made on 06/22/2023, payment of \$640.81 was made on 08/02/2023, \$1669.83 was made on 08/11/2023, and a payment of \$1621.16 was made on 08/22/2023 to settle credit card payments for the BOM. The detective stated the BOM was arrested on 04/12/2024 for elder abuse (Misappropriation of resident's Property).</p> <p>On 05/17/2024 at 2:00 PM the Director of Nursing was interviewed via phone. The DON said it would be upsetting to a reasonable person, in a similar situation as RI #1 who had over 15 thousand of dollars misappropriated from her checking account by a staff member he/she entrusted with her checkbook and who aided writing checks.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 29671</p> <p>Based on record reviews, interviews, and a facility policy titled Abuse, Neglect, Misappropriation, Exploitation Policy, and review of information from the Alabama Department of Public Health's (ADPH) Online Reporting System, the facility failed to ensure staff implemented the facility's abuse policies and procedures when: staff failed to identify an allegation of abuse, protect residents from further potential abuse, and immediately report an allegation of verbal abuse on [DATE] involving Resident Identifier (RI) #5 and Licensed Practical Nurse (LPN) #12. Certified Nursing Assistant (CNA) #9, and CNA #10 became aware of the allegation, but did not report the incident for three days following the incident.</p> <p>On [DATE] Certified Nursing Assistant (CNA) #9 observed LPN #12 stand up and say she was going to go to RI #5's room and call his/her dead mother a bitch and she did not report the incident as LPN did not take any action only making a verbal threat. On either [DATE] or [DATE] CNA #10 overheard LPN #12 on the phone during a break say she went in RI #5's room and called him/her an ugly bitch and called his/her dead mother an ugly bitch. CNA #9 and CNA #10 did not identify the incident as abuse or suspected abuse, did not protect RI #5 from potential verbal abuse, and did not immediately report the incident. Due to the staff's failure LPN #12 continued to work on the hallway with RI #5 posing the likelihood of further harm.</p> <p>This failure affected RI #5; one of eight sampled residents reviewed for abuse prevention.</p> <p>This deficiency was cited as a result of the investigation of complaint/report number AL00047738.</p> <p>Findings Include:</p> <p>A review of the facility Abuse, Neglect, Misappropriation, Exploitation Policy, effective [DATE], revealed Purpose: To prohibit and prevent abuse . and to ensure reporting and investigation of alleged violations . Definitions: . Alleged Violation: A situation or occurrence that is observed or reported by team member . but has not yet been investigated . The following protocol has been established in the event of an allegation of abuse:</p> <p>1. Protection</p> <p>First and foremost the resident/patient will be immediately assessed and removed from any potential harm.</p> <p>Examine the resident . for any sign of injury, including a physical assessment or psychosocial assessment .</p> <p>4. Prevention.</p> <p>Establish a safe environment: Team members are required to report incidents of suspected abuse, neglect, or misappropriation of property without fear of reprisal .</p> <p>5. Identification</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>If actual violation or alleged violation occurs the resident will be immediately assessed and removed from any potential harm .</p> <p>7. Reporting/Response Alleged violations/violations will be reported to the Administrator, designee immediately .</p> <p>RI #5 was admitted to the facility on [DATE] with diagnoses that included Unspecified Dementia, without Behavioral Disturbance and Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation.</p> <p>A review of Resident #5's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 5 (five) of 15, which indicated the resident had severe cognitive impairment.</p> <p>On [DATE] at 9:45AM, an interview was conducted with CNA #9. According to CNA #9, on [DATE], she observed RI #5 approach the nurses' desk where LPN #12 was sitting and inquired about the results of an x-ray. CNA #9 said, LPN #12 informed RI #5 that it was too early for the results as the x-ray technician had just left. CNA #9 said as RI #5 was walking away he/she called LPN #12 a bitch. CNA #9 said she witnessed LPN #12 stand up and say she would go to RI #5's room and call his/her dead mother a bitch. CNA #9 said she did not report what she heard because she believed that LPN #12 only made a threat and she did not witness anything being done.</p> <p>On [DATE] at 12:15 PM, an interview was conducted with CNA #10. According to CNA #10, on approximately [DATE] or [DATE], she overheard LPN #12 on the phone, during a break, say she went to RI #5's room and called him/her an ugly bitch and his/her dead mother an ugly bitch. CNA #10 said she did not do anything because she thought it was not true and she did not see LPN #12 do anything to RI #5. CNA #10 said that when she returned to work on [DATE] she overheard CNA #9 talking about the incident and she then reported the incident to the Director of Nursing.</p> <p>On [DATE] at 3:26 PM, an interview was conducted with the Director of Nursing (DON). The DON said she became aware of an incident involving RI #5 and LPN #12 on [DATE] when CNA #10 reported the concern. After receiving the information an investigation was started. The DON said LPN #12, who had already left for day, was informed she would be on suspension. The DON said that CNA #9 should have reported the incident when she first heard the threat on [DATE].</p> <p>On [DATE] at 6:19 PM, an interview was conducted with the Administrator/abuse coordinator. The Administrator said abuse should be reported immediately when it was received, heard, or witnessed. The Administrator said the abuse witnessed by CNA #9 should have been reported on [DATE] when CNA #9 overheard LPN #12 say she was going to go to RI #5's room and call her deceased mother a bitch. The Administrator said abuse should be reported immediately so an investigation could be started and for the protection of the residents.</p>		