

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  015167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2025
NAME OF PROVIDER OR SUPPLIER  Marion Regional Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  184 Sasser Drive Hamilton, AL 35570	

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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055</b></p> <p>Based on observations, interviews, resident record review, and review of a facility policy titled Resident's Rights: Privacy and Confidentiality the facility failed to honor resident privacy rights when Certified Nursing Assistant (CNA) #10 failed to knock on doors and gain permission to enter, before entering resident rooms on 02/18/2025 during the evening dining observation.</p> <p>This affected Resident Identifier (RI) #28 and RI #32, two of 19 sampled residents.</p> <p>Findings include:</p> <p>Review of a facility policy titled Resident's Rights: Privacy and Confidentiality with a review date of 03/2020, revealed the following:</p> <p>. Policy: It is the policy of [NAME] Regional Nursing Home that residents' confidentiality and privacy should be protected.</p> <p>Procedure: 1. Residents . have the right to- .</p> <p>b) Privacy while in their rooms. Staff should respectfully knock on doors or verbally announce the request to enter the room prior to entry.</p> <p>RI #32 was admitted to the facility on [DATE].</p> <p>RI #28 was admitted to the facility on [DATE].</p> <p>On 02/18/2025 at 5:11 PM, CNA #10 was observed removing a meal tray from the meal cart, and without knocking on the door or gaining permission to enter the room, CNA #10 entered RI #28's and RI #32's room and set up RI #28's meal tray. CNA #10 exited the room, removed RI #32's meal tray from the meal cart and reentered the room again, without knocking on the door or gaining permission to enter. After setting up RI #32's meal tray, CNA #10 exited the residents' room.</p> <p>On 02/18/2025 at 5:13 PM, CNA #10 reentered RI #28's and RI #32's room, without knocking on the door, or gaining permission to enter the residents' room.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/18/2025 at 5:14 PM, the surveyor conducted an interview with CNA #10. When asked what she should do before entering a resident's room, CNA #10 said knock on the door before entering the room. When asked why this was not done before she entered RI #28's and RI #32's room when passing out the residents' meal trays, CNA #10 said, she did not realize she had not knocked on the residents' door.</p> <p>On 02/20/2025 at 11:52 AM, the surveyor conducted an interview with the Clinical Nurse Educator (CNE). The CNE said, staff were taught they were supposed to knock on the resident's door and introduce themselves before entering the resident's room. When asked what type of concern this would be when not done, the CNE said, this would be an invasion of the resident's privacy, it may startle the resident, and it could be a dignity concern.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for 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> 48195</p> <p>Based on resident record review, interviews, review of a facility policy titled Protecting Residents from Abuse, Neglect and Exploitation, review of the facility investigative file, and review of a Facility Reported Incident (FRI) to the State Agency, the facility failed to protect Resident Identifier (RI) #25's right to be free from abuse on 09/14/2024 when RI #313, a resident with unmanaged behaviors, hit RI #25 in the face. RI #25 described the incident as abusive.</p> <p>This deficient practice was cited as a result of the investigation of the complaint/report number AL00048923 and affected RI #25, one of two residents sampled for abuse.</p> <p>Cross Reference F740</p> <p>Findings include:</p> <p>A facility policy titled, Protecting Residents from Abuse, Neglect, and Exploitation documented:</p> <p>. Policy: It is the policy of [NAME] Regional Nursing Home to protect residents from abuse. This includes but is not limited to verbal, physical, mental/emotional, .</p> <p>Procedure: . When protecting residents from abuse, utilizes the following prevention/intervention strategies: .</p> <p>D) Ongoing assessment, care planning and monitoring of residents with needs or behaviors that may lead to inadequate care, including abuse/neglect.</p> <p>E) Assessing residents with signs and symptoms of behavioral issues with the development of targeted care plans that can assist in resolving behavioral issues.</p> <p>On 09/14/2024 at 8:11 PM the State Agency received an Online Incident Report (FRI) from the facility alleging physical abuse occurred at 6:29 PM that evening after RI #313 took a book from RI #25's side of the room, RI #25 took the book away from RI #313, and then RI #313 slapped RI #25 on the left side of the face.</p> <p>RI #313 was admitted to the facility on [DATE] and had diagnoses to include: Alzheimer's Disease and Mood Disorder.</p> <p>RI #313's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/07/2024 documented a Brief Interview of Mental Status (BIMS) score of four of 15 which indicated severe cognitive impairment. The MDS also documented RI #313 was able to walk independently without assistance of a wheelchair or walker.</p> <p>RI #25 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/20/2025 at 9:36 AM a telephone interview was conducted with LPN #13 who said around 6:30 PM on 09/14/2024 while charting at the desk, she heard RI #25 say, help, help. LPN #13 said, she responded and found RI #313 had hit RI #25 on the face and RI #25 had redness on his/her cheek. LPN #13 said, RI #313 was confused, had Dementia, and would pick up items. LPN #13 said, RI #25 had been physically abused.</p> <p>RI #313's Nursing Note dated 09/13/2024 at 3:15 PM, was signed by LPN #13 who documented: . Resident has been exhibiting some hostile behavior, resisting care, taking others belongings and becoming very agitated when request are made. Hospice physician ordered Depakote . TID which should begin this evening.</p> <p>On 02/20/2025 at 1:00 PM a follow up interview was conducted with LPN #13 regarding the incident on 09/13/2024 and RI #313's rummaging behavior. LPN #13 said, RI #25 had a lot of items around and RI #313 would go and pick up the personal items. LPN #13 said on 09/13/2024, RI #313 required staff redirection. When asked what level of supervision RI #313 required, LPN #13 said, RI #313 was monitored visually and redirected as needed and did not require one-on-one.</p> <p>On 02/20/2025 at 12:20 PM, an interview was conducted with the Director of Nursing (DON) who said, RI #313 was confused and had advanced Dementia. The DON was asked about RI #313's documented behaviors on 09/13/2024 of agitation and taking others personal belongings. The DON said, RI #313 would plunder through RI #25's personal items and required redirection. The DON said, the staff were visually monitoring RI #313 for behaviors but there was no documentation of monitoring. The DON said, the incident on 09/14/2024 when RI #313 hit RI #25 was considered abuse. The facility did not provide any evidence of RI #313 being monitored for behaviors.</p> <p>On 02/20/2025 at 10:06 AM an interview was conducted with the Administrator (ADM) who said, she was notified by the Social Worker and the DON of the incident around 7:00 pm on 09/14/2024. The ADM said, RI #313 and RI #25 shared a room, RI #313 was confused, walked to RI #25's side of the room pilfering, picked up a book of RI #25's, and when RI #25 tried to get the book back, RI #313 hit RI #25 in the left side of the cheek. The ADM said, redness was noted to RI #25's cheek, the roommates were separated, notifications were made, and an investigation was initiated. When asked what the investigation revealed, the ADM said, based on RI #25's testament and the redness on RI #25's cheek, the incident was substantiated. The ADM said, the incident was reported as resident on resident physical abuse.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39580</p> <p>Based on interviews, record review, and the Centers for Medicare &amp; Medicaid Services (CMS) Long-Term Care Resident Assessment Instrument 3.0 Manual, the facility failed to ensure:</p> <p>1) Resident Identified (RI) #23's annual Minimum Data Set (MDS) assessment dated [DATE] section A1500 was coded accurately to reflect RI #23's Preadmission Screening and Resident Review (PASRR) Level II.</p> <p>2) RI #25's annual MDS assessment dated [DATE] section A1500 was coded accurately to reflect RI #25's PASRR Level II.</p> <p>This deficient practice affected two of 19 sampled residents whose MDS was reviewed.</p> <p>Findings include:</p> <p>Review of the Centers for Medicare &amp; Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2024, revealed the following:</p> <p>. A1500: Preadmission Screening and Resident Review (PASRR)</p> <p>. Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition</p> <p>1) RI #23 was admitted to the facility on [DATE] with a diagnosis of Major Depressive Disorder, Anxiety Disorder, and Dementia with Behavioral Problem.</p> <p>RI #23's medical record contained a PASRR Level II Service Determination dated 10/12/2023.</p> <p>RI #23's annual MDS dated [DATE] documented: . A1500 Preadmission Screening and Resident Review (PASRR) . Is the resident currently considered by the state level II PASRR . was marked 0 indicating No.</p> <p>On 02/20/2025 at 11:02 AM an interview was conducted with the MDS Coordinator. When asked if RI #23 was marked on the MDS as a Level II, she said no. In referencing RI #23's Level II document, the MDS Coordinator noted where RI #23's document revealed he/she was a Level II. When asked what the importance of the MDS being marked correctly, she said to ensure accuracy of the MDS data.</p> <p>2) RI #25 was admitted to the facility on [DATE] with a diagnosis of Mood Disorder.</p> <p>RI #25's medical record contained a PASRR Level II Service Determination dated 03/04/2024.</p> <p>RI #25's annual MDS dated [DATE] documented: . A1500 Preadmission Screening and Resident Review (PASRR) . Is the resident currently considered by the state level II PASRR . was marked 0 indicating No.</p> <p>(continued on next page)</p>

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F 0641  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	On 02/20/2025 at 11:13 AM a follow up interview was conducted with the MDS Coordinator. When asked if RI #25 was marked on the MDS as a Level II, she said no. In referencing RI #25's Level II document, the MDS Coordinator noted that RI #25's document revealed he/she was a Level II. When asked why RI #25's MDS was not marked as being a Level II, she said this was miss coded and it would be corrected right away. When asked what the importance of the MDS being marked correctly, she said to ensure accuracy of the MDS data.		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33738</b></p> <p>Based on observations, interviews, record review, and review of a facility policy titled, Nebulizer Masks, Tubing and Bag Protocol, the facility failed to ensure Resident Identifier (RI) #13's oxygen tubing was labeled/dated; and further failed to ensure RI #34, RI #37, and RI #263's nebulizer masks were covered when not in use.</p> <p>This deficient practice affected four of five residents sampled for respiratory care.</p> <p>Findings Include:</p> <p>A review of a facility policy titled, Nebulizer Masks, Tubing and Bag Protocol, with a last modified date of 02/12/2025, documented: . Rationale: To provide infection control and protection for residents using nebulizer treatments. Policy: It is the policy . that nebulizer masks and tubing should be dried and stored when not in use. Procedure: . 2. The residents name . and the date should be written on the bag, tubing and mask .</p> <p>RI #13 was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease.</p> <p>RI #13's physicians orders dated 11/20/2024 documented: . Continuous; Oxygen Delivery Method: Nasal Cannula .</p> <p>On 02/18/2025 at 04:10 PM, the surveyor observed RI #13's oxygen concentrator with tubing by bedside. There was no date noted on the tubing.</p> <p>On 02/18/2025 at 4:25 PM an interview was conducted with Licensed Practical Nurse (LPN) #11. LPN #11 said there should be a date on the tubing.</p> <p>RI #34 was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease.</p> <p>RI #34's physicians orders dated 01/15/2025 documented: . ipratropium-albuterol (DUO-NEB) . 3 mL (milliliters) NEBULIZATION Every 4 hours PRN (as needed) .</p> <p>On 02/18/2025 at 4:03 PM, RI #34's nebulizer mask was observed laying face side down on bedside table. The mask was not in a bag and no date was observed on the mask or the tubing.</p> <p>On 02/19/2025 at 3:44 PM, RI #34's nebulizer mask was observed laying face side down on the dresser and was not in a bag or dated.</p> <p>RI #37 was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease.</p> <p>RI #37's physician's orders dated 01/23/2025 documented: . ipratropium-albuterol (DUO-NEB) . 3 mL NEBULIZATION Every 2 hours PRN .</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 02/19/2025 at 3:48 PM, RI #37's nebulizer mask was observed laying face side down on the dresser and not in a bag.</p> <p>RI #263 was admitted to the facility on [DATE] with diagnosis of Congestive Heart Failure.</p> <p>RI #263's physician orders dated 02/14/2025, documented: . ipratropium-albuterol (DUO-NEB) . 3 mL (milliliters) NEBULIZATION Every 6 hours .</p> <p>On 02/18/2025 at 3:55 PM, RI #263's nebulizer face mask was observed laying face down on the bedside table and not in a bag.</p> <p>On 02/19/2025 at 3:48 PM, RI #263's nebulizer mask was observed laying on the nebulizer machine and not in a bag. Neither the nebulizer mask nor the tubing were dated.</p> <p>On 02/19/2025 at 4:51 PM, LPN #12 accompanied the surveyor to RI #34, RI #37, and RI #263's room and observed that the residents' nebulizer masks were not covered or in a bag.</p> <p>On 02/19/2025 at 5:15 PM, an interview was conducted with LPN #12 who said nebulizer mask should be labeled with the resident's name and date and stored in a bag. LPN #12 the night shift nurse was responsible for changing the nebulizer mask and bag monthly. LPN #12 said germs could get on the mask when not covered. LPN #12 said uncovered nebulizer mask was an infection control issue.</p> <p>On 02/20/2025 at 9:33 AM, an interview was conducted with the Infection Preventionist (IP) who was a Registered Nurse (RN). The IP said resident's oxygen tubing was changed every 30 days or as needed, because bacteria could build up on the tubing. The IP said the oxygen tubing should be dated. The IP said when not in use, nebulizer mask should be stored in a Ziploc bag with the resident's name on it. She further stated that if there was no name on it, someone else could use it and that would be cross-contamination.</p> <p>During an interview on 02/20/2025 at 12:34 PM with the Director of Nursing (DON), who stated nebulized mask should be stored in a bag labeled with the date. The DON said uncovered nebulizer mask could get contaminated. The DON said oxygen tubing should be dated and the concern with it not being dated would be staff would not know when it was last changed.</p>

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48195</p> <p>Based on interviews, resident record review, and review of the facility's investigative file, the facility failed to develop and implement immediate interventions to prevent other residents from being affected by Resident Identifier (RI) #313's behaviors. The facility failed to develop targeted care plans to assist in resolving RI #313's behaviors, failed to monitor RI #313 for behaviors that led to abuse, and failed to assess RI #313's required level of supervision to protect other residents. On 09/13/2024, RI #313's Nurses' Notes documented that RI #313 was exhibiting hostile behavior, resisting care, taking others' belongings, and becoming very agitated when requests were made. On 09/14/2024, RI #313 continued to have behaviors including taking RI #25's, his/her roommate's, belongings which resulted in RI #313 hitting RI #25 in the face.</p> <p>This deficiency was cited as a result of the investigation of complaint/report number AL00048923 and affected RI #25 one of six residents sampled for behavior concerns.</p> <p>Cross Reference F600</p> <p>Findings include:</p> <p>RI #25 was admitted to the facility on [DATE].</p> <p>RI #313 was admitted to the facility on [DATE] and had diagnoses to include: Alzheimer's Disease and Mood Disorder.</p> <p>RI #313's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/07/2024 documented a Brief Interview of Mental Status (BIMS) score of four out of 15 which indicated severe cognitive impairment.</p> <p>RI #313 had a care plan dated 08/09/2024 that documented . Problem onset: I have a diagnosis of dementia, I am becoming increasingly more confused, and anxious. I have difficulty comprehending conversations . Approaches . Monitor resident for . behaviors, including wandering and aggressiveness.</p> <p>RI #313's Nursing Note dated 09/13/2024 at 1:48 PM documented: . New order per hospice start Depakote . TID (three times a day).</p> <p>RI #313's Nursing Note dated 09/13/2024 at 3:15 PM, signed by LPN #13 documented: . Resident has been exhibiting some hostile behavior, resisting care, taking others belongings and becoming very agitated when request are made. Hospice physician ordered Depakote . TID which should begin this evening.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>RI #313's Nursing Note dated 09/14/2024 at 7:00 PM, signed by LPN #13 documented: . At approximately 1820 (6:20 PM) resident's roommate began yelling help me, help me. When staff entered room resident was standing in her room holding a book that apparently belonged to (his/her) roommate. The roommate took the book away from the resident at which point resident slapped roommate in the face (left cheek). Slight erythema observed but roommate denies any pain at this time. Resident's were immediately separated. Resident is at nurses' station at this time, . DON . notified and orders received for Ativan (by mouth or intramuscular every six hours as needed) . for agitation.</p> <p>On 02/20/2025 at 9:36 AM a telephone interview was conducted with LPN #13, and she was asked about the incident on 09/14/2024 between RI #313 and RI #25. LPN #13 said, she was at the desk charting and she heard RI #25 say help, help. RI #313 had picked up a book belonging to RI #25, and when RI #25 tried to get the book back and RI #313 slapped RI #25 in the face. LPN #13 said, RI #313 had Advanced Dementia and was confused. LPN #13 said, at that time RI #313 was at the stage of Dementia where he/she picked things up.</p> <p>On 02/20/2025 at 1:00 PM in a follow up interview, LPN #13 was asked about RI #313 having hostile behavior as noted on 09/13/2025. LPN #13 stated, RI #25, RI #313's roommate had a lot of things around the room and RI #313 would go pick up the items and RI #313 required redirection. LPN #13 said, interventions that were used were staff would redirect RI #313 and one day there were medication changes. LPN #13 was asked what level of supervision RI #313 required. LPN #13 said, she did not think RI #313 required one on one supervision and RI #313 was just monitored visually and redirected as needed.</p> <p>On 02/20/2025 at 12:20 PM the Director of Nursing (DON) was asked about RI #313's Nursing Note dated 09/13/2024. The DON said, the note documented concerns of resisting care, taking others' belongings, and agitation. The DON said, RI #313 had Dementia that was pretty severe, RI #313 would be in the hallway and try to pick up something in the hallway and plundered through RI #25's side of the room. The DON said, RI #313 fiddled with stuff mostly in their room but also in the hallway. The DON gave an example of RI #313 picking up a bracelet and saying it was his/hers and then RI #313 would become resistive when redirection was attempted. The DON said, RI #313 would say it was his/hers and others could not have it. When asked how RI #313 was monitored, the DON said, they were watching RI #313. The DON said, they did not have monitoring sheets or documentation of the monitoring. When asked about what level of supervision RI #313 required after the incident of increased behaviors on 09/13/2024 the DON said, she did not think they did one-on-one, but they watched RI #313. The DON did not believe the incident could have been prevented because RI #313 was so Demented.</p> <p>On 02/20/2025 at 2:29 PM an interview was conducted with RI #25 who said, RI #313 would get into his/her personal items a bunch of times. When asked if this behavior was reported to staff, RI #25 said yes, he/she had notified staff of the behavior several times. When asked what staff did in response to the behavior, RI #25 said, staff would retrieve the item, tell RI #313 the item did not belong to him/her, and give the personal item back to RI #25.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  015167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2025
NAME OF PROVIDER OR SUPPLIER  Marion Regional Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  184 Sasser Drive Hamilton, AL 35570	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>29671</p> <p>Based on interviews, review of Resident Identifier (RI) #34's medical record, and a facility policy titled Psychotropic Medication Utilization the facility failed to ensure RI #34 was not ordered and administered a PRN (as needed) antipsychotic medication, Haldol, for greater than 14 days, without documented rationale in the resident's medical record for the continued use of the PRN antipsychotic medication.</p> <p>This deficient practice affected RI #34, one of six residents sampled for unnecessary medications.</p> <p>Findings include:</p> <p>A review of a policy titled Psychotropic Medication Utilization documented:</p> <p>Rationale: To provide guidelines for the utilization of psychotropic medications.</p> <p>10. Psychotropic medications used on a PRN (as needed) basis should have a specific condition and indication for the PRN use documented in the resident's medical record and is subject to limitations as noted:</p> <p>.</p> <p>a. PRN orders for psychotropic medications, excluding antipsychotics should be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration.</p> <p>b. PRN orders for antipsychotic medications only, should be limited to 14 days. If the attending Physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic, they should evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate .</p> <p>RI #34 was admitted to the facility 01/15/2025 with diagnoses to include anxiety and agitation.</p> <p>A review of RI #34's medication orders revealed an order dated 01/24/2025 for two (2) milligrams of haloperidol (Haldol), an antipsychotic medication, every 4 hours by mouth as needed for agitation. The order did not include a duration or end date.</p> <p>RI #34's Medication Administration Report from 01/26/2025 through 02/14/2025 documented that Haldol 2 milligrams was administered 20 times during that time period.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Marion Regional Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  184 Sasser Drive Hamilton, AL 35570	
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/20/2025 at 12:52 PM an interview was conducted with the Director of Nursing (DON). The DON said that the order for PRN Haldol for RI #34 started on 01/24/2025 and ended on 02/18/2025 (24 days). The DON said it was the Registered Nurses' responsibility to track the start and end dates of psychotropic medications. According to the DON, facility policy permitted a PRN psychotropic medication to remain on the physician's order for fourteen days. The DON said that RI #34 had not been reevaluated for the continued appropriateness of the medication. The DON said that the PRN psychotropic order for RI #34 should have been discontinued by day fourteen.</p>		

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NAME OF PROVIDER OR SUPPLIER  Marion Regional Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  184 Sasser Drive Hamilton, AL 35570	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21055</p> <p>Based on observations, interviews, record review, and review of the facility's Procedure for Passing Meal Trays, the facility failed to ensure Certified Nursing Assistant (CNA) #10 distributed residents' meal trays in a manner to prevent the spread of infection between himself and residents. CNA #10 failed to perform hand hygiene before handling and delivering dinner meal trays for Resident Identifier (RI) #28 and RI #32 from the meal cart on 02/18/2025 during the evening dining observation.</p> <p>This deficient practice affected RI #28 and RI #32, two of 19 sampled residents.</p> <p>Findings Include:</p> <p>Review of an undated procedure form titled, Procedure for Passing Meal Trays, revealed the following:</p> <p>. 5. Staff should perform hand hygiene between each resident .</p> <p>RI #32 was admitted to the facility on [DATE].</p> <p>RI #28 was admitted to the facility on [DATE].</p> <p>On 02/18/2025 at 5:11 PM the surveyor observed CNA #10 removed RI #32's dinner meal tray from the meal cart without performing hand hygiene. CNA #10 entered RI #32's room, set up the meal tray for RI #32, exited the room, removed RI #28's meal tray from the dinner meal cart without performing hand hygiene, and re-entered the room with RI #28's meal tray.</p> <p>On 02/18/2025 at 5:14 PM, the surveyor conducted an interview with CNA #10 who said, she should sanitize her hands before she entered a resident's room. CNA #10 said staff not sanitizing their hands before they took a resident's food tray into the room could cause food borne illness. CNA #10 said she should have sanitized her hands before touching the residents' meal trays.</p> <p>On 02/20/2025 at 9:33 AM, the surveyor conducted an interview the Registered Nurse (RN)/Infection Preventionist (IP). The IP said, before removing a resident's meal tray from the meal cart staff should perform hand hygiene. The IP said, there was a potential for cross-contamination if hand hygiene was not performed. The IP said, staff should perform hand hygiene after providing any service for the resident.</p> <p>On 02/20/2025 at 11:52 AM, the surveyor conducted an interview with the Clinical Nurse Educator (CNE). The CNE said, in orientation staff were taught to perform hand hygiene before removing a residents meal tray from the food cart. The CNE said, when hand hygiene was not performed there was a potential for cross-contamination.</p>		