

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015199	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER Crowne Health Care of Eufaula		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Rivers Avenue Eufaula, AL 36027	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33738</p> <p>Based on interviews, residents record reviews, review of a facility policy titled Abuse Policy, review of Facility Reported Incidents (FRI), and review of the facility's investigative files, the facility failed to protect residents' right to be free from abuse perpetrated by other residents.</p> <p>1) On 04/12/2024 Resident Identifier (RI) #15 was physically abused when RI #14 hit him/her with a broom handle causing bruising to his/her wrist and legs.</p> <p>2) On 04/25/2024 RI #1 was physically abused when he/she was slapped in the face by RI #17.</p> <p>3) On 07/14/2024 RI #1 was physically abused when RI #4 hit him/her in the forehead.</p> <p>4) On 08/30/2024 RI #4 was physically abused when RI #9 slapped him/her in the face.</p> <p>This deficiency was cited as a result of the investigation of FRI/complaint/report numbers AL00047553, AL00047690, AL00048340, and AL00048715 and affected RI #1, RI #4, and RI #15, three of 12 residents sampled for abuse concerns.</p> <p>Findings include:</p> <p>A facility policy titled Abuse Policy dated October 2022, revealed the following:</p> <p>. IT IS THE POLICY .TO ENSURE THAT EACH RESIDENT IS FREE FROM VERBAL, SEXUAL, PHYSICAL AND MENTAL ABUSE, MISAPPROPRIATION OF RESIDENT PROPERTY AND EXPLOITATION.</p> <p>Definitions . Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish.</p> <p>Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>Physical abuse includes, but is not limited to, hitting, slapping, . or kicking .</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>1) RI #14 was originally admitted to the facility on [DATE] and had diagnoses to include Dementia with Agitation.</p> <p>RI #14's annual Minimum Data Set (MDS) assessment with an Assessment Reference Data (ARD) of 01/26/2024, documented a Brief Interview for Mental Status (BIMS) score of three of 15, indicating RI #14 had severely impaired cognition.</p> <p>RI #15 was readmitted to the facility on [DATE] and had diagnoses to include Acute and Chronic Respiratory Failure.</p> <p>RI #15's quarterly MDS assessment with an ARD of 03/20/2024, documented a BIMS score of 13 out of 15 indicating intact cognition.</p> <p>On 04/12/2024 the State Agency received an Online Incident Report (FRI) from the facility alleging physical abuse when RI #14 hit RI #15 across the legs with a broom.</p> <p>The facility's investigative file was reviewed and contained a document dated 04/17/2024, signed by the Administrator, summarizing the incident as follows:</p> <p>. On 04/12/2024, . (RI #14) walked across the hallway and into the room of (RI #15). (RI #14) pulled the covers off resident (RI #15), picked up a nearby plastic boom and hit (swatted) the legs of (RI #15). (RI #15) was lying in (his/her) bed at the time of the incident.</p> <p>(RI #15) turned on (his/her) call light, told (RI #14) to get out of (his/her) room and called for help. LPN (Licensed Practical Nurse #15) . responded to the call light and the commotion that was going on down mid ways of the hallway. As (LPN #15) arrived in the doorway of (RI #15's) room, she saw (RI #14) swat (hit) (RI #15's) toe area with the plastic broom. (LPN #15) took the broom from RI #14 and called for help, . (RI #14) was . monitored 1:1. (RI #15) was checked head to toe for any injuries and there (was) no immediate bruising or redness.</p> <p>(RI #15) says (RI #14) came in (RI #15's) room and told (RI #15) to get out of (his/her) bed then (RI #14) hit (RI #15) with the broom three times, once on (the) wrist, once on (the) leg and once on (the) toe.</p> <p>Conclusion:</p> <p>Our facility does substantiate this incident as physical abuse . (RI #15) had body audits for a couple of days to check for injuries that may have appeared after the incident. The nurse discovered a small 1 x 2 cm . (one times two centimeter) circular bruise the following day that may have appeared as a result of this incident.</p> <p>On 09/18/2024 at 3:37 PM RI #15 was asked about the incident with RI #14 and the broom. RI #15 said, RI #14 hit him/her on the legs and hand. RI #15 said, he/she had a small bruise to his/her legs and hand and he/she was scared at the time RI #14 was hitting him/her with the broom.</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 09/19/2024 at 10:56 AM LPN #15 was asked about the incident between RI #14 and RI #15 on 04/12/2024. LPN #15 stated, she heard someone hollering help, some commotion down the hall, and found the commotion going on in RI #15's room. LPN #15 stated, she observed RI #14 hitting RI #15 with a small broom with the wooden handle. LPN #15 said, she only saw RI #14 hit RI #15 one time and she was not sure how many times RI #15 was hit before she got to the room, but RI #15 was yelling out, she thought it was a hard hit. LPN #15 did not see any injury that day but the next day there was a bruise on RI #15's wrist and legs. LPN #15 said, RI #14 hitting RI #15 with the broom was physical abuse and RI #15 was scared and upset at the time it occurred.</p> <p>2) RI #1 was readmitted to the facility on [DATE] and had diagnoses to include Dementia and Psychosis.</p> <p>RI #1's significant change MDS assessment with an ARD of 04/02/2024 documented a Brief Interview for Mental Status (BIMS) score of three out of 15 indicating severely impaired cognition.</p> <p>RI #17 was readmitted to the facility on [DATE] and had diagnoses to include Adjustment Disorder with Depressed Mood and Dementia with Agitation.</p> <p>RI #17's quarterly MDS assessment with an ARD date of 02/19/2024 documented a BIMS score of eight out of 15 indicating severely impaired cognition.</p> <p>On 04/25/2024 the State Agency received an Online Incident Report (FRI) from the facility alleging physical abuse when RI #17 slapped RI #1 in the face and RI #1 had a red area on his/her face where he/she was slapped.</p> <p>The facility's investigative file was reviewed and contained a document dated 04/30/2024 summarizing the incident as follows:</p> <p>. On 04/25/2024, . the nurse reported to the DON (Director of Nursing) that two . residents who reside in the dementia unit had a physical altercation. (RI #1) was reaching for a plastic cup that was on the table and the other resident, (RI #17) . slapped (RI #1) in the face.</p> <p>(Certified Nursing Assistant/CNA #10) witnessed the incident and intervened immediately. separated the two residents and called for help. (RI #1) had some initial redness to (his/her) face immediately . but this faded away within the hour.</p> <p>Conclusion:</p> <p>Our facility does substantiate this incident as physical abuse as it was witnessed by a staff member.</p> <p>On 09/18/2024 at 09:03 AM CNA #10 was asked about the incident between RI #1 and RI #17 on 04/25/2024. CNA #10 stated, she was sitting in the dayroom with residents when RI #1 went to take a cup that was on the table in front of RI #17. CNA #10 said, RI #17 slapped RI #1 in the face. CNA #10 stated, she immediately separated them both and yelled for help. CNA #10 said, the incident was resident to resident abuse physical abuse and she thought it made RI #1 feel scared and frightened.</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 09/18/2024 at 09:25 AM the Director of Nursing (DON) was asked about the incident between RI #1 and RI #17 on 04/25/2024. The DON stated, she first asked CNA #10 if there were any injuries and if the residents were separated. The DON stated, RI #1 had initial redness to his/her face, but it resolved within 30 minutes. The DON said, the incident was substantiated by the facility, and it was physical abuse.</p> <p>3) RI #4 was admitted to the facility on [DATE] and had diagnoses to include Schizophrenia and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>RI #4's annual MDS assessment with an ARD of 04/26/2024 documented a BIMS score of three out of 15 indicating severe cognitive impairment.</p> <p>RI #1 was readmitted to the facility on [DATE] and had diagnoses to include Dementia and Psychosis.</p> <p>RI #1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/19/2024 documented a BIMS score of three out 15 indicating severe cognitive deficits.</p> <p>On 07/14/2024 the State Agency received an Online Incident Report (FRI) from the facility alleging physical abuse when RI #4 struck RI #1 in the forehead.</p> <p>The facility's investigative file was reviewed and contained a document dated 07/19/2024, signed by the Administrator, summarizing the incident as follows:</p> <p>. On 07/14/2024, . residents . were sitting in the day room of the Secure . unit preparing for supper . Resident (RI #1) got up to exit the dayroom and as (he/she) walked passed . (RI #4) . near (RI #4's) personal space . (RI #4) unexpectedly hit (RI #1) in the forehead. (CNA #7) witnessed the incident and immediately intervened .</p> <p>Conclusion:</p> <p>Our facility does not substantiate this incident as physical abuse . It is believed that (RI #1) may have invaded (RI #4's) personal space and reacted by striking out at (RI #1).</p> <p>On 09/18/2024 at 4:45 PM an interview was conducted with CNA #7 who witnessed the incident on 07/14/2024 between RI #1 and RI #4. CNA #7 said, she was sitting in the day room with the other residents around dinner time when she saw RI #1 walking around and got in RI #4's personal space. CNA #7 said, RI #4 hit RI #1 in the middle of the forehead with a fist. CNA #7 said, the intensity of the hit on a 0-10 scale was a five. CNA #7 said, the incident was physical abuse. CNA #7 said, this is the resident's home, and it would not be a good feeling to be hit in your own home.</p> <p>On 09/20/2024 at 11:47 AM the Administrator (ADM) was asked about the alleged physical abuse on 07/14/2024 involving RI #1 and RI #4. The ADM said, RI #1 walked near RI #4 and got into his/her personal space and RI #4 unexpectedly reacted by striking RI #1 in the forehead. When asked if striking a resident in the forehead was considered abuse, she said, yes, it could be. The ADM said, being hit in your own home would not be a good feeling.</p> <p>4) RI #4 was admitted to the facility on [DATE] and had diagnoses to include Schizophrenia.</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>RI #4's quarterly MDS assessment with an ARD of 07/19/2024 documented a BIMS score of three out of 15 indicating severely impaired cognition.</p> <p>RI #9 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] and had diagnoses to include Dementia.</p> <p>RI #9's annual MDS assessment with an ARD of 07/22/2024 documented a BIMS score of four out of 15 indicating severely impaired cognition.</p> <p>On 08/30/2024 at 4:41 PM the State Agency received an Online Incident Report (FRI) from the facility alleging physical abuse when RI #9 slapped RI #4 in the face around the mouth.</p> <p>The facility's investigative file was reviewed and contained a document dated 09/04/2024, signed by the Director of Nursing (DON), summarizing the incident as follows:</p> <p>. On 08/30/2024 . The DON was notified by (Licensed Practical Nurse/LPN #8) that (RI #9) had slapped (RI #4).</p> <p>(Certified Nursing Assistant/CNA #16) said (RI #9) wheeled up to (RI #4) and slapped (him/her) in the face on (his/her) lips.</p> <p>Conclusion:</p> <p>Our facility does confirm an incident between (RI #4) and (RI #9). However, we do not substantiate as abuse. (RI #9) did slap . (RI #4) in response to (RI #4) yelling out that had aggravated (him/her) .</p> <p>On 09/18/2024, at 2:56 PM CNA #16 was asked about the incident involving RI #4 and RI #9. CNA #16 said, RI #9 went toward the dayroom as RI #4 was coming out of the dayroom yelling out and RI #9 slapped RI #4 in the mouth. CNA #16 stated, she separated the residents and reported the incident to LPN #8. CNA #16 said, it was resident on resident abuse. CNA #16 said, no one deserved to be hit or abused and she would not like to be hit.</p> <p>On 09/18/2024 at 3:30 PM LPN #8 was asked about the incident involving RI #4 and RI #9 that occurred on 08/30/2024. LPN #8 said, she did not witness the incident, but CNA #16 told her, she witnessed RI #9 hit RI #4 in the mouth with his/her hand. LPN #8 said, she asked RI #9 why he/she hit RI #4 and RI #9 told her, he/she does it day and night, RI #4 makes noises. LPN #8 further stated, they were separated, and she reported the incident to the DON. LPN #8 was asked, what it was considered when RI #9 hit RI #4. LPN #8 said, resident on resident abuse, they cannot be fighting or hitting each other. LPN #8 was asked, how it would make a reasonable person feel about being slapped in the face around the mouth. LPN #8 said, it would make them angry, demeaned, shocked, and probably want to fight.</p> <p>On 09/18/2024 at 4:09 PM Social Services Director (SSD) was asked about the incident involving RI #4 and RI #9. The SSD said, she found out about the incident when the DON called and told her RI #9 slapped RI #4 because of RI #4 yelling out. When asked what it would be considered when RI #9 hit RI #4, the SSD said, physical abuse. The SSD said, she thought it would make someone feel terrible to be slapped in the mouth and she was surprised RI #4 did not react to being slapped.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48195</p> <p>Based on resident record reviews, interviews, review of facility investigative files, and a facility policy titled Abuse Prevention Policy, the facility failed to report allegations of abuse within two hours to the State Agency.</p> <p>1) On 07/30/2024 at 6:00 PM Certified Nursing Assistant (CNA) #17 heard a slap in Resident Identifier (RI) #1 and RI #3's room and the alleged physical abuse was not reported to the State Agency until 07/30/2024 at 8:30 PM, two and a half hours later.</p> <p>2) On 08/20/2024 at 9:45 PM RI #1 was found to have injuries as a result of a tussle with roommate (RI #2). The incident of alleged physical abuse was reported to the State Agency the next morning on 08/21/2024 at 10:42 AM, over 12 hours later.</p> <p>3) On 09/13/2024 at 3:00 PM RI #20 alleged physical abuse of being hit in the back by RI #1. The allegation of abuse was not reported to the State Agency until 09/18/2024, five days later.</p> <p>This deficient practice was cited a result of the investigation of complaint/report numbers AL00048506 and AL00048629, and an allegation of abuse received during the survey and had the potential to affect RI #1, RI #2, RI #3, and RI #20, four of 12 residents reviewed for abuse concerns.</p> <p>Findings include:</p> <p>A facility policy titled Abuse Prevention Policy with an effective date of October 2022 documented:</p> <p>Procedure for Documentation and Investigation of Resident Abuse</p> <p>. 8. The facility will ensure that all alleged violations involving abuse, neglect . are reported immediately, but not later than 2 hours after the allegation is made .</p> <p>1) RI #1 was readmitted to the facility on [DATE].</p> <p>RI #3 was admitted to the facility on [DATE].</p> <p>On 07/30/2024 at 8:30 PM the State Agency received an Online Incident Report (FRI) from the facility alleging physical abuse after CNA #17 heard a slapping sound and RI #1 had a pink area on his/her face and RI #3 was near RI #1. The alleged time of the incident was 6:00 PM.</p> <p>The facility's investigative file was reviewed and contained a document dated 08/06/2024, signed by the Administrator, summarizing the incident as follows:</p> <p>. On 07/30/2024, at approximately 06:00 PM, residents/roommates, (RI #3 and RI #1) were in their room . She (CNA #17) heard a slap and turned around. (RI #1) was holding (his/her) cheek standing near (RI #3). (RI #3) said, I did what I had to do.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The investigative file indicated the residents were separated and RI #3 was placed on one-on-one monitoring.</p> <p>On 09/20/2024 at 11:47 AM the Administrator (ADM) was asked about the alleged physical abuse reported on 07/30/2024. The ADM said she became aware of the incident on 07/30/2024 at 6:19 PM. The ADM said, it was reported because there could have been a slap even though no one actually witnessed the slap.</p> <p>On a follow up interview on 09/20/2024 at 5:15 PM, the ADM said, the timeframe to report alleged physical abuse allegations was within two hours and the allegation on 07/30/2024 was reported late.</p> <p>2) RI #1 was readmitted to the facility on [DATE].</p> <p>RI #2 was readmitted to the facility on [DATE].</p> <p>On 08/21/2024 at 10:42 AM the State Agency received an Online Incident Report (FRI) from the facility alleging physical abuse after staff became aware of the incident the night before, on 08/20/2024 at 9:45 PM and the ADM became aware of the incident on 08/20/2024 at 9:50 PM. The Narrative Summary of the incident reported to the State Agency alleged RI #2 and RI #1 began a tussle over a reach extender tool (reacher) resulting in RI #1 had a hematoma inside his/her ear, two small bruises on his/her left forearm, a small scratch on his/her scalp, both residents had broken fingernails, and both were separated immediately for the rest of the night.</p> <p>The facility's investigative file was reviewed and contained a document dated 08/26/2024 summarizing the incident as follows:</p> <p>. On 08/20/2024, at approximately 09:45 PM, residents (RI #1 and RI #2) were possibly involved in an altercation. The staff reported that (RI #1) had some scratches and a minor hematoma to (his/her) ear. They reported that while no one witnessed the event, (RI #2) said that (RI #1) was on (RI #2's) side of the room messing with (RI #2's) items and when (RI #1) took (RI #2's) reacher, the two residents started tussling with the reacher and that's how the scratches and bruise occurred. The incident was reported by the nurse to the Administrator but was not determined to be physical abuse as (RI #2) had denied hitting (RI #1) and there only minor injury that would be expected with a tussle of a reacher. the residents were separated for the night.</p> <p>Review of RI #1's departmental notes documented the following injuries found after the event: . 8/20/2024 11:38 PM . Resident obtained injuries from tussling over (his/her) roommate's reacher according to (his/her) roommate. Roommate denies hitting resident. Resident has three bruises to inside of right forearm with an open area to one of them. Cleaned with normal saline pat dry and applied dressing. Blood filled blister to top inner of left ear. A scratch to left side of face and left side of neck. Laceration to top of left side of head.</p> <p>Review of RI #2's departmental notes documented the following account of the event: . 8/20/2024 11:28 PM . Resident states that (his/her) roommate went over to (his/her) bed and grabbed (his/her) reacher and they started tussling over the reacher. Resident stated it happen so fast that (he/she) don't know what happen. Resident states (he/she) broke a couple of finger nails.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/20/2024 at 11:47 the ADM was asked about the alleged abuse on 08/20/2024. The ADM said, she was notified of the incident with RI #1 and RI #2 on 08/20/2024 at 9:50 PM. The ADM said, she was notified of a possible resident to resident physical abuse allegation where RI #1 and RI #2, who were roommates, were involved in a tussle over a reacher. ADM said, she was notified of the incident the night of 08/20/2024 of a possible scratch from the tussle.</p> <p>On 09/20/2024 at 5:15 PM in a follow up interview with the ADM she was asked to clarify when she was notified of the incident. The ADM said, on 08/20/2024 at 9:50 PM it was reported to her of a resident-to-resident physical abuse in which there was a tussle between RI #1 and RI #2 over a reacher. The ADM said, she was notified of an injury including a scratch. The ADM said, the incident was reported to the State Agency the next morning on 08/21/2024 at 10:42 AM. The ADM said, the time frame for reporting physical abuse was within two hours.</p> <p>3) RI #1 was readmitted to the facility on [DATE].</p> <p>RI #20 was admitted to the facility on [DATE].</p> <p>On 09/18/2024 at 12:15 PM during observations of the lunch meal, RI #20 approached Activity Coordinator (AC) and said, I want to know if an incident report was done about the (man/woman) who hit me in the back.</p> <p>On 09/18/2024 at 12:23 PM RI #20 was asked about the incident and said he/she did not remember who or when it was, but it happened last week and he/she reported it.</p> <p>On 09/18/2024 at 12:34 PM the surveyor informed the Administrator of the allegation.</p> <p>On 09/18/2024 at 4:43 PM the State Agency received an Online Incident Report (FRI) from the facility alleging physical abuse occurred, five days before, on 09/13/2024 at 3:00 PM, and the Administrator was made aware of the incident on 09/13/2024 at 3:15 PM after RI #1 entered RI #20's room, RI #20 told RI #1 to leave and guided RI #1 to the door and when RI #1 walked past RI #20 in the doorway, RI #1 hit RI #20 in the back.</p> <p>The facility's investigative file was reviewed and contained a handwritten statement dated 09/13/2024, signed by the AC, that documented: . Friday September 13, 2024 3:30 - (RI #1) . was in (RI #20's) Room, and (RI #20) yell for someone to come and get (RI #1). I . (AC) went to get (RI #1) and (RI #20) stated (RI #1) had hit (him/her) in the Back .</p> <p>On 09/23/2024 at 2:07 PM a telephone interview was conducted with the ADM to further question the incident of 09/13/2024. The ADM said, she became aware of the incident between RI #1 and RI #20 on 09/13/2024 at 3:15 PM but did not report it at that time because there was conflicting information as to whether the resident was hit or pushed by the other resident. The ADM was asked when it was reported to the State Agency. The ADM replied, on 09/18/2024 after resident (RI #20) had said something again about it to the nurses and to the surveyor.</p>		