

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  12/19/2024
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 - 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** 21055</b></p> <p>Based on interviews, residents record review, 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 ensure residents in the facility were free from abuse perpetrated by employees of the facility and other facility residents.</p> <p>Specifically,</p> <p>1) On 09/20/2024 Certified Nursing Assistant (CNA) #4, who was assigned to provide care for Resident Identifier (RI) #10, verbally and mentally abused RI #10 when other facility staff witnessed CNA #4 tell RI #10 not to shit in his/her brief or she would leave his/her big ass to sit in it.</p> <p>This deficiency was cited as the result of the investigation of complaint/report number AL00049007.</p> <p>2) On 11/04/2024 RI #10 was verbally abused by RI #13, a resident with a history of verbally aggressive behaviors, when RI #13 asked RI #10 if he/she could play with RI #10's titties. The facility failed to ensure RI #13 had a plan of care to address the level of supervision RI #13 required for facility staff to manage RI #13's behaviors for abuse prevention.</p> <p>This deficiency was cited as the result of the investigation of complaint/report number AL00049525.</p> <p>3) On 11/29/2024 RI #32 was physically abused by RI #33, a resident with a history of verbally aggressive behavior, when RI #33 slapped RI #32 multiple times on the right upper chest area. This was witnessed by facility staff who said this was physical abuse and it may have hurt or caused the resident to be distraught. RI #32 did not have any evidence of physical injury identified by the facility. The facility failed to ensure RI #33 had a plan of care to address the level of supervision RI #33 required for facility staff to manage RI #33's behaviors for abuse prevention.</p> <p>This deficiency was cited as the result of the investigation of complaint/report number AL00049664.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4) On 12/11/2024 RI #21 was verbally abused by RI #22 who told RI #21 to get the f**k out of his/her room. This was witnessed by staff and substantiated by the facility as verbal abuse. The facility failed to protect RI #21 from verbal abuse when RI #21 was placed in the room with RI #22, a resident who the Administrator said, was constantly cursing.</p> <p>This deficiency was cited as the result of the investigation of complaint/report number AL00049752.</p> <p>These deficient practices affected RI #32, #33, #10, #13 and RI #21, five of 18 residents sampled for abuse concerns.</p> <p>Findings include:</p> <p>A facility policy titled ABUSE POLICY dated December 2024, 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>Resident's Rights .</p> <p>Residents shall not be subjected to abuse by anyone, including facility staff, other residents .</p> <p>Definitions .</p> <p>Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .</p> <p>Verbal Abuse is the use of oral . or gestured language that includes disparaging and derogatory terms to residents .</p> <p>Physical abuse includes, but is not limited to, hitting, slapping, . or kicking . Mental abuse includes, but is not limited to, humiliation, . threats of punishment or deprivation .</p> <p>1) RI #10 was originally admitted to the facility on [DATE] and had diagnoses to include Memory Deficit following Cerebral Infarction.</p> <p>RI #10's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Data (ARD) of 09/10/2024 documented a Brief Interview for Mental Status (BIMS) score of 9 of 15 which indicated RI #10 had moderately impaired cognition.</p> <p>On 09/20/2024 the State Agency received an Online Incident Report (FRI) from the facility alleging CNA #4 verbally abused RI #10 when CNA #5 and CNA #6 heard CNA #4 tell RI #10 if he/she had a bowel movement in his/her pants, she would leave his/her big ass there. The report also documented the perpetrator was questioned, placed on suspension, and removed from facility; the Physician and CRNP (Certified Registered Nurse Practitioner), Ombudsman and APS (Adult Protective Services)/DHR (Department of Human Services) were notified; and a full investigation was to follow within five working days.</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>Contained within the facility's investigative file was a written statement given by CNA #5 dated 09/20/2024, which documented the following:</p> <p>. (1) Were you present or know of an incident where (CNA #4) spoke inappropriately to (RI #10)? If so, what was said?</p> <p>A. Yes, IF (He/She) boo boo (stool) on (him/herself) she was gonna leave (his/her) big ass there (meaning in soil brief) .</p> <p>(3) what care was being providing @ (at) the time of incident?</p> <p>A. check &amp; change .</p> <p>On 12/18/2024 at 7:36 AM, an interview was conducted with CNA #5. CNA #5 said the incident between CNA #4 and RI #10 occurred in the shower room. CNA #5 said, she and CNA #6 were in the shower room with another resident and the wound nurse when CNA #4 brought RI #10 into the shower room to change him/her. CNA #5 said RI #10 passed gas and CNA #4 told RI #10 if he/she boo booded on him/herself, she (CNA #4) would leave him/her (RI #10) in it. When asked how she thought a reasonable person would feel to be told if they had a bowel movement they would be left in it, CNA #5 said it would make the person feel bad about not being able to take care of themselves and what she witnessed CNA #4 say to RI #10 was verbal abuse.</p> <p>Within the facility's investigative file was a written statement given by CNA #6 dated 09/20/2024, which documented the following:</p> <p>. Q) Did you witness (CNA #4) providing care to (RI #10) today?</p> <p>A) yes, I did</p> <p>Q) If yes, give details as to what you heard?</p> <p>A) Resident was passing gas. I heard her (CNA #4) tell (RI #10) if you shit that (he/she) would have to sit in it and that she (CNA #4) was not going to change (him/her).</p> <p>On 12/18/2024 at 1:01 PM, an interview was conducted with CNA #6. CNA #6 said CNA #4 told RI #10 if he/she shit on him/herself he/she would have to sit in it and she (CNA #4) was not going to change him/her. CNA #6 said a reasonable person would not feel good about having to sit in their bowel movement. CNA #6 said this comment would be considered verbal and mental abuse.</p> <p>On 12/18/2024 at 10:39 AM, the surveyor conducted a telephone interview with CNA #4. CNA #4 said RI #10 passed gas and she told RI #10 not to shit in the diaper and not to shit in the chair. CNA #4 said RI #10 never had a bowel movement. CNA #4 said she should have said not to boo boo in the diaper. When asked what type abuse she would consider her comment to be, CNA #4 said verbal. CNA #4 said she made the comment in a joking manner. When asked did she think it was appropriate to joke with RI #10 that way, CNA #4 said no.</p> <p>Review of the facility's five day summary, dated 09/27/2024, and signed by the Administrator (ADM) revealed the following:</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>. Conclusion:</p> <p>Our conclusion in this investigation is that we will substantiate the allegation of verbal abuse. Although C.N. A. (CNA #4) admits that she did make the comment to (RI #10), she states she was joking with (RI #10) . There were . witnesses who heard (CNA #4) make the inappropriate comment . (CNA #4) will be terminated from our employment .</p> <p>On 12/19/2024 at 12:18 PM during an interview with the facility ADM, the ADM said, the facility substantiated the incident of verbal abuse that occurred on 09/20/2024 when CNA #4 told RI #10 not to shit in his/her brief and if he/she did he/she would have to sit in it. The ADM said, it would be demoralizing to be told that. The ADM said, CNA #4 was suspended, sent home, and later terminated.</p> <p>2) RI #13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Dementia, Severe with Psychotic Disturbances.</p> <p>RI #13's annual MDS assessment with an ARD of 07/30/2024 documented a BIMS score of 12 of 15 which indicated RI #13 had moderately impaired cognition.</p> <p>On 11/04/2024 the State Agency received an Online Incident Report from the facility alleging RI #13 verbally abused RI #10 when RI #13 said to RI #10 Let me play with your titties. The report also alleged RI #10 was assessed, RI #13 did not approach or touch RI #10, RI #13 was monitored 1:1, and would be visited by the Psychologist for verbally inappropriate comments/suggestions.</p> <p>Contained within the facility's investigative file was a typed statement given by CNA #7 dated 11/04/2024, which revealed the following:</p> <p>. I (CNA #7) was sitting in the Dayroom on TCU (Transitional Care Unit). Resident (RI #13) walked in and looked at resident (RI #10) and made the comment, Can I play with your titties. I explained to (RI #13) that (he/she) could not make those comments. (He/She) denied that (he/she) said it. (He/She) said that (he/she) was speaking to (him/her). I notified the Nurse (Licensed Practical Nurse (LPN) #8), and she removed (RI #10) to another table, out of (RI #13's) presence .</p> <p>On 12/17/2024 at 11:46 AM, an interview was conducted with CNA #7 who was sitting in the dayroom when RI #13 walked down the hall and came into the dayroom. CNA #7 said RI #10 was already sitting in the dayroom, and RI #13 walked up to RI #10 and asked RI #10 if he/she could play with his/her titties. CNA #7 said she told RI #13 he/she could not say those types of words. CNA #7 said RI #13 denied saying what he/she did and said he/she was just speaking to RI #10. When asked did RI #13 touch RI #10 in an inappropriate sexual manner, CNA #7 said no. CNA #7 said she informed LPN #8 of what RI #13 said to RI #10.</p> <p>On 12/17/2024 at 2:08 PM, the surveyor conducted an interview with LPN #8. LPN #8 said she too heard RI #13 ask RI #10 if he/she could touch his/her titties. LPN #8 said when she heard the comment RI #10 was moved to a different area in the dayroom and RI #13 went to his/her room and was placed on one-on-one then behavioral tracking was started. LPN #8 said she informed the supervisor and the Social Worker (SW) of the inappropriate comment RI #13 made to RI #10. When asked what type of comment would she consider the comment RI #13 made to RI #10 to be, LPN #8 said it was an inappropriate sexual comment.</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>Review of the facility's five day summary, dated 11/11/2024, and signed by the ADM revealed the following:</p> <p>. Conclusion:</p> <p>Our conclusion in this investigation is that we will substantiate the allegation of verbal abuse. Although (RI #13) denies having made the statement, a staff member heard (him/her) make the sexually inappropriate comment to (RI #10) . (RI #13) was placed on behavior tracking for making socially/sexually inappropriate behaviors. (RI #10) could not recall the statement being made and laughed when asked about the allegation . Care plans will be reviewed and revised as necessary .</p> <p>On 12/18/2024 at 4:19 PM the SW was asked about RI #13 and the incident that occurred on 11/04/2024. The SW said, RI #13 had impaired cognition, had Dementia, was forgetful, and had a history of verbally aggressive behavior. The SW said, what RI #13 said to RI #10 was verbal abuse, it was inappropriate and someone in that situation would not like being asked the question about their titties being touched.</p> <p>On 12/19/2024 at 6:22 PM a follow-up interview was conducted with the SW. When asked how residents with newly identified behaviors were assessed for their level of supervision, the SW said she did not know. The SW said she did not see anything on RI #13's behavior care plan that addressed the level of supervision RI #13 required, before and after, RI #13 made the sexual inappropriate comment to RI #10 on 11/04/2024. The SW said the level of supervision should be on the resident's care plan and she could not say why it was not.</p> <p>3) RI #32 was admitted to the facility on [DATE] and had diagnoses to include Dementia.</p> <p>RI #32's admission MDS assessment with an ARD of 09/16/2024 documented a BIMS score of 6 of 15 which indicated RI #32 had severely cognitive impairment.</p> <p>RI #33 was readmitted to the facility on [DATE] and had diagnoses to include Paranoid Schizophrenia, Major Depressive Disorder and Bipolar Disorder.</p> <p>RI #33's quarterly MDS assessment with an ARD of 09/23/2024 documented a BIMS score of 13 of 15 indicated RI #33 had intact cognition.</p> <p>On 11/29/2024 the State Agency received an Online Incident Report from the facility alleging RI #33 physically abused RI #32 when RI #32 was sitting in a recliner in the dayroom and RI #32 reached over and gently patted RI #33 on the leg and in response RI #33 slapped RI #32 with his/her open hand. The report alleged RI #32 was assessed and found to be without injury, did not recall details of events due to cognitive deficits, RI #33 was placed on 1:1 monitoring until receiving orders to send for an evaluation/treatment when the physician, Nurse Practitioner, Resident representatives, Ombudsman and Adult Protective Services (APS) were notified of the resident-on-resident contact.</p> <p>Review of the facility's five-day summary, dated 12/05/2024, and signed by the ADM revealed the following:</p> <p>. Conclusion:</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>Our conclusion in this investigation is that since there were witnesses to the slap, we will substantiate the allegation of physical abuse. Although (RI #33) states (RI #32) hit (him/her) first, there were no witnesses. (RI #33) was placed on 1:1 monitoring until he/she was discharged to the ER/Geri Psych (emergency room /Geriatric Psychiatric Care) for evaluation and treatment as necessary. (RI #33) had already been care-planned for verbal aggression.</p> <p>RI #33 had a care plan initiated on 10/30/2024 for behavior symptoms of cursing and verbal aggression toward staff with a 10/30/2024 approach documented as follows: Remove me from noisy or congested areas. The care plan did not include the level of supervision RI #33 needed.</p> <p>The facility investigative file contained a witness statement dated 12/03/2024 signed by LPN #13 that documented: . yes I saw (RI #33) hit (RI #32) multiple times open handed to the right arm/shoulder . (LPN #13) made sure residents were separated, assessed (RI #32) for injuries, notified (the ADM) . I have heard (RI #33) be verbally abusive to other residents . LPN #13's witness statement also documented LPN #13 was only about five feet away from the residents when she witnessed the abuse.</p> <p>On 12/17/2024 at 12:10 PM an interview was conducted with LPN #13. She said at the time of the incident between RI #33 and RI #32 she was sitting at the nurses' station, RI #32 was in a recliner across from nurses' station and RI #33 came down the hall and sat on his/her rollator next to RI #32. LPN #13 said, she was documenting and looked up from the desk and saw RI #33 hit RI #32 with an open hand to RI #32's right upper chest about three to five times. LPN #13 said, someone in that situation would feel confused and hurt. LPN #13 stated she considered the incident to be physical abuse.</p> <p>Contained within the facility's investigative file was a statement given by CNA #14, dated 12/03/2024, which revealed the following:</p> <p>. I was standing in the dayroom and (RI #33) hit (RI #32) three times in the upper chest area on the right side . CNA #14's witness statement also documented CNA #14 was only about three to five feet away from the residents when she witnessed the abuse.</p> <p>On 12/17/2024 at 12:27 PM an interview was conducted with CNA #14 who said, she was in the dayroom and saw RI #32 sitting down and RI #33 hit RI #32 three times in the right upper chest area. CNA #14 said, she did not witness RI #32 hit RI #33. CNA #14 said, what she witnessed was physical abuse and someone in that situation would not feel good about it.</p> <p>Contained within the facility's investigative file was a statement given by CNA #15 dated 12/04/2024, which revealed the following: . (RI #33) and (RI #32) were both sitting in the dayroom, (RI #32) lightly touched (RI #33), that's when (RI #33) slapped (RI #32's) chest about three times real hard and loud. it was open handed.</p> <p>On 12/17/2024 at 2:42 PM an interview was conducted with CNA #15. CNA #15 said, RI #32 and RI #33 were sitting side by side in the dayroom when RI #33 hit RI #32 three to five times with his/her open hand. CNA #15 said the slapping sound was loud. CNA #15 said, what she witnessed was physical abuse.</p> <p>On 12/17/2024 at 3:04 PM RI #33's responsible party was asked about the incident involving RI #33 and RI #32. RI #33's responsible party said RI #33 did not like people in his/her personal space.</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>An interview was conducted on 12/18/2024 at 5:35 PM with the SW. The SW stated she was responsible for initiating behavior tracking on residents and she was responsible for all behavior care plans. The SW said RI #33 had exhibited abusive behaviors prior to the incident and RI #33 was care planned for behaviors. The SW said behavior care plans for RI #33 were initiated on 10/30/2024. The SW said, if she had been slapped in the chest she would be upset, angry or confused and what happened to RI #32 was physical abuse.</p> <p>On 12/19/2024 at 5:30 PM a follow-up interview was conducted with the SW and she was asked about RI #33 not wanting people in his/her personal space. The SW responded, RI #33 stayed to himself/herself and only interacted with a few residents. When asked why RI #33's care plan did not specify RI #33 not wanting people in his/her personal space, the SW stated, she did not realize it. The SW was asked about the reason RI #33 was not removed from the congested area on 11/29/2024, as specified in RI #33's plan of care. The SW said she could not answer that question. The SW said, RI #33 could have been monitored more closely to prevent the abuse from occurring. The SW said, the level of supervision required should be listed on the plan of care and the multidisciplinary team would discuss what level of supervision was needed.</p> <p>An interview was conducted on 12/19/2024 at 3:30 PM with the Administrator (ADM). The ADM said following the incident RI #32 was assessed and found to be without injuries and did not recall the events and RI #33 was placed on 1:1 monitoring until an order was received from the Nurse Practitioner to send RI #33 to the hospital for evaluation and possible geriatric psychiatric treatment. The ADM was asked for what type of behaviors RI #33 was being monitored. The ADM said, verbal aggression toward staff and another resident. The ADM said the situation with RI #33 and RI #32 was substantiated as physical abuse and someone in that situation might feel hurt and possibly distraught.</p> <p>4) RI #21 was admitted to the facility on [DATE] and had a diagnosis to include Adjustment Disorder with Depressed Mood.</p> <p>RI #21's Admission MDS assessment with an ARD of 09/24/2024 documented RI #21's BIMS was 12 of 15 which indicated that RI #21 had moderately impaired cognition.</p> <p>RI #22 was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis to include Adjustment Disorder with Mixed Anxiety and Depressed Mood.</p> <p>RI #22's Admission MDS assessment with an ARD of 08/26/2024 documented that RI #22 had a BIMS of 15 of 15 which indicated that RI #22 was cognitively intact.</p> <p>On 12/11/2024 the State Agency received an Online Incident Report from the facility revealing the following:</p> <p>. Incident Type . Abuse - Verbal .</p> <p>Incident Detail .</p> <p>Name(s) of resident(s) involved: (RI #21 and RI #22) .</p> <p>Name of alleged perpetrator(s): (RI #22) .</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>Narrative summary of incident: (RI #21) reported that (his/her) roommate, (RI #22) cursed (him/her) out today .</p> <p>Action(s) taken by the facility in response to the incident. (RI #21) was assessed and found to be without injury. (RI #21) wanted a room change and that is being done now .</p> <p>Contained within the facility's investigative file was a statement given by RI #21 to Social Service Designee (SSD) #10, dated 12/11/2024, which revealed the following:</p> <p>. Summoned to (room number) by resident. (RI #21) said (he/she) no longer wants to be in (his/her) current room because (his/her) roommate cursed (him/her) out. (RI #21) said (RI #22) asked (him/her) to leave the room but (he/she) did not want to leave . Resident said (RI #22) told (him/her) to get then F*** out of this room and if you don't I'll have you put out. Resident reports (CNA #9) and (CNA #11) being present during altercation .</p> <p>On 12/18/2024 at 2:38 PM, the surveyor conducted an interview with RI #21 who said he/she had to move to a different room because his/her roommate cursed him/her out. RI #21 said his/her roommate called him/her M*F* and things like that. RI #21 said staff were in the room and heard this.</p> <p>Contained within the facility's investigative file was a written statement by SSD #12, dated 12/11/2024, which documented the following:</p> <p>. (CNA #9) said that (RI #22) told (RI #21) to get the F*** out.</p> <p>During the survey unsuccessful telephone attempts were made to contact CNA #9.</p> <p>On 12/19/2024 at 9:15 AM, the surveyor conducted an interview with SSD #10 and SW #12. SW #10 said RI #21 said RI #22 cursed him/her and told him/her to get the f*** out of this room. When asked what type of abuse this would be considered, both SW #10 and SW #12 said verbal.</p> <p>Review of the facility's five-day summary, dated 11/17/2024, and signed by the ADM revealed the following:</p> <p>. Conclusion:</p> <p>Our conclusion in this investigation is that we will substantiate the allegation of verbal abuse. After following up with (RI #21), (he/she) feels that the language used by (RI #22) was abusive to (him/her) . The five-day summary also documented that RI #21 was only in the room with RI #22 for about three hours before RI #21 was verbally abused.</p> <p>On 12/19/2024 at 12:18 PM during an interview with the ADM, the ADM said, the incident was investigated, RI #21 was removed from the room, RI #21 was assessed, and assigned a new room. The ADM said, since there was a witness, the abuse was substantiated. The ADM said, RI #22 was constantly cursing.</p> <p>47408</p>		

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  12/19/2024
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055</b></p> <p>Based on interviews, review of a facility policy titled, ABUSE POLICY, review of the facility's investigative file and review of a Facility Reported Incident (FRI) received by the State Agency, the facility failed to ensure an allegation of verbal abuse involving Certified Nursing Assistant (CNA) #4 and Resident Identifier (RI) #10 was reported to the Administrator (ADM) immediately and within two hours of the incident after the incident occurred on 09/20/2024.</p> <p>This deficient practiced affected one of 11 FRIs reviewed, and one of 18 residents sampled for abuse.</p> <p>This deficiency was cited as a result of the investigation of complaint/report number AL00049007.</p> <p>Findings include:</p> <p>Review of a facility policy titled, ABUSE POLICY, dated 12/2024, revealed the following:</p> <p>. Procedure for Documentation and Investigation of Resident Abuse .</p> <p>4. Notify . Administrator . immediately .</p> <p>RI #10 was admitted to the facility on [DATE].</p> <p>The Alabama Department of Public Health Online Incident Reporting System form, submitted on 09/20/2024 documented:</p> <p>. Incident Type . Abuse - Verbal .</p> <p>Incident Detail:</p> <p>Name(s) of resident(s) involved: (RI #10) .</p> <p>Name of alleged perpetrators): (CNA #4) .</p> <p>time of when administrator was notified of the incident:</p> <p>Time: 02:30 PM .</p> <p>Date and time of alleged incident: 09/20/2024</p> <p>Time: 10:45 AM .</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Crowne Health Care of Eufaula		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Rivers Avenue Eufaula, AL 36027	
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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>Narrative summary of incident: Narrative summary of incident: (CNA #4) took Resident (RI #10) to shower to change (him/her). (CNA #5) &amp; (and) (CNA #6) were in the shower room with another resident. (CNA #5) reports that (CNA #4) told resident (RI #10) that if (he/she) boo [NAME] in (his/her) pants, she would leave (his/her) big ass there .</p> <p>Contained within the facility's investigative file was an EMPLOYEE CORRECTIVE ACTION REPORT dated 09/30/2024, signed by CNA #5, which revealed the following:</p> <p>. (CNA #5) is given this verbal Reprimand in regards to failure to report suspected abuse timely .</p> <p>On 12/18/2024 at 7:36 AM an interview was conducted with CNA #5 who said after the incident occurred she went to lunch and informed the supervisor of the incident after she returned from lunch. When asked when she should have reported the incident, CNA #5 said immediately.</p> <p>Another EMPLOYEE CORRECTIVE ACTION REPORT in the facility's investigative file, dated 09/30/2024, and signed by CNA #6 revealed the following: . (CNA #6) is given this verbal reprimand in regards to failure to report suspected abuse timely .</p> <p>On 12/18/2024 at 1:01 PM an interview was conducted with CNA #6 who said she did not report the incident to anyone. CNA #6 said she should have reported the incident to the ADM immediately after she heard what was said.</p> <p>On 12/19/2024 at 12:18 PM, an interview was conducted with the ADM. The ADM said the CNAs should have immediately reported the incident to their supervisor and the supervisor would have immediately informed her of the incident.</p> <p>*****</p> <p>After retrospective Quality Assurance review it was determined that the facility took immediate action to correct the noncompliance by:</p> <p>CNA #5 and CNA #6 were reprimanded for failure to report suspected abuse on 09/30/2024.</p> <p>The facility Administrator was educated by the Regional Consultant on the reporting requirement in accordance with the regulatory requirement and facility policies and procedures on 10/09/2024.</p> <p>An audit of all allegations of abuse/neglect/misappropriation that have occurred since 09/20/2024 was completed on 10/11/2024 to ensure that all allegations of abuse/neglect/misappropriation have been reported timely as applicable.</p> <p>Training for all facility staff to include contracted staff on F 609, the facility Abuse Policy and Procedure, with special emphasis on timely reporting beginning on was completed on 10/15/2024.</p> <p>(continued on next page)</p>		

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  12/19/2024
NAME OF PROVIDER OR SUPPLIER  Crowne Health Care of Eufaula		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Rivers Avenue Eufaula, AL 36027	
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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>A new system will be implemented by the facility on 10/11/2024 to ensure accessibility and timeliness of reporting of all allegations of abuse/neglect/misappropriation within the proper timeframe to the State Agency. The Administrator will have a designated electronic device that has Wi-Fi/cellular connection and access to the State Agency portal with appropriate passwords to report any allegations timely. The DON will serve as the designee in the absence of the Administrator/Abuse Coordinator. If after hours, once the allegation is submitted, the confirmation will be emailed to the reporter to print when a printer is accessible for facility records.</p> <p>The Regional Consultant monitored to ensure reporting requirements were followed by reviewing all allegations of abuse/neglect/misappropriation weekly x 4 weeks then monthly x 5 months to ensure timely reporting by the facility. This will be documented on a monitoring tool by the Regional Consultant and provided to the facility Administrator, responsible for implementing the acceptable plan of correction and will be placed in the plan of correction binder located in Administrator's office. Monitoring to began on 10/15/2024.</p> <p>*****</p> <p>After review and verification of the information provided in the facility's corrective action plan, inservice/education records, monitoring tools and the facility's investigation, as well as staff interviews, the survey team determined the facility implemented corrective actions from 09/20/2024 through 10/18/2024 with ongoing monitoring implemented; thus, past noncompliance was cited.</p>		