STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015200	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherokee County Health and Rehabilitation Center	877 Cedar Bluff Road Centre, AL 35960

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, recipe review and facility policy review, the facility failed to serve food that was palatable and at an acceptable temperature to four of five residents (Resident (R) 5, R47, R144, and R139) reviewed for food palatability out of 36 sampled residents. This failure had the potential to affect 156 residents who consumed food prepared from the facility's kitchen and could result in residents skipping meals and experiencing weight loss. Findings include:Review of the facility's policy titled, Timely Meal Service, dated 02/05/2024, indicated, Policy: Food will be delivered promptly to ensure safe, palatable, and high-quality food served at the proper temperature. Procedure . 6. Food will be served at preferable temperatures (hot foods hot and cold foods cold) as discerned by the patients/residents and customary practice (not to be confused with proper holding temperatures). Review of the facility's undated policy titled, Standardized Recipes, indicated, Policy: Standardized recipes will be used when preparing menu items. Procedure . 3. Cooks/chefs are expected to use and follow recipes provided.1. Review of R5's undated admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed R5 was admitted on [DATE].Review of R5's quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/02/2025 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a Brief Interview for Mental Score (BIMS) of nine out of 15 which indicated R5 was moderately cognitively impaired.During an interview on 12/09/2025 at 10:57AM, R5 stated that the hot foods on his/her meal tray tasted cold. He/she stated that he used to be in the last room on the hall, so his/her tray was always served last. He/she stated that now that he/she has moved to the middle of the hallway, the hot foods on his/her meal tray were maybe a little bit warmer.2. Review of R47's admission Record located in the resident's EMR under the Profile tab revealed R47 was admitted on [DATE]. Review of R47's quarterly MDS with an ARD of 11/04/2025 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 14 out of 15 which indicated R47 was cognitively intact.During an interview on 12/09/2025 at 9:40 AM, R47 stated that the hot foods on his/her meal tray tasted lukewarm.3. Review of R144's undated admission Record located in the resident's EMR under the Profile tab revealed R144 was admitted on [DATE].Review of R144's quarterly MDS with an ARD of 11/25/2025 revealed the facility assessed the resident to have a BIMS score of 13 out of 15 which indicated R144 was cognitively intact.During an interview on 12/09/2025 at 10:07 AM, R144 stated that the food on his/her meal tray did not taste good and that the hot foods on the tray tasted cold.4. Review of R139's admission Record located in the resident's EMR under the Profile tab revealed R139 was admitted on [DATE].Review of R139's quarterly MDS with an ARD of 11/04/2025 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated R139 was cognitively intact.During an interview on 12/08/2025 at 10:56 AM, R139 stated the hot foods on his/her meal tray do not taste hot. R139 stated the meatloaf and squash served last night tasted like they were raw. The resident also stated the food did not have any seasoning.Review of the facility's monthly (continued on next page)

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

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident Council Meeting minutes, provided by the facility, revealed the following food palatability concerns:During the 11/18/2025 meeting a resident voiced a concern that the fish served was tough. The dietary department's follow-up plans for this concern were, Spoke with cooks on cooking times.During the 06/24/2025 meeting a resident voiced a concern that the food was too salty. The dietary department's follow-up plans for this concern were, Making sure recipes are followed.4. Observation on 12/10/2025 at 12:16 PM revealed a requested test tray was placed in an enclosed meal delivery cart for the 300 and 500 hallways. Food temperatures on the kitchen tray line were monitored and were at acceptable levels of 135 degrees Fahrenheit (F) and above for the hot foods and 41 degrees F and below for cold foods. The food was placed on heated plates prior to being placed in the enclosed meal delivery cart. At 12:52 PM, the last resident meal was delivered. After the last resident meal was delivered, the test tray was removed from the enclosed delivery cart in the presence of the Dietary Manager (DM). Continued observation revealed the DM used a calibrated facility thermometer, obtained the temperatures of the food on the test tray, and tasted one of the food items. The chicken alfredo spinach flatbread on the test tray registered at 134.2 degrees F. This writer tasted the chicken alfredo spinach flatbread and had no concern with the temperature; however, it was very spicy. The DM also tasted the flatbread and stated it was spicy. The temperature of the [NAME] salad on the test tray, which contained feta cheese, was 63.0 degrees F. This writer tasted the salad, and it tasted warm. The DM declined to taste the salad; however, he/she stated it was his/her expectation salads be served to residents at a temperature of 50 degrees F or lower. The DM stated the temperature of the salad was too high.Review of the facility's recipe titled, Chicken Spinach [NAME] Flatbread, provided by the facility, revealed the ingredients used to prepare this menu item included baby spinach, flatbread, alfredo mix sauce, roasted chicken breast chopped into bite size pieces, and mozzarella cheese.During an interview on 12/10/2025 at 1:30 PM, [NAME] (C)1 stated he/she prepared the chicken spinach alfredo flatbread that was served during the 12/10/2025 lunch meal. C1 stated when he/she prepared this menu item, he/she used fajita chicken strips not roasted chicken breast as specified in the recipe. C1 also stated he/she added pepper, onion powder, garlic powder, and salt to the alfredo sauce mix, and added pepper, salt and garlic powder to the chicken fajita strips. These added seasonings were not listed on the recipe for this menu items. C1 confirmed he/she did not follow the recipe when preparing the chicken spinach alfredo flatbread. During an interview on 12/10/25 at 1:45 PM, the DM confirmed C1 did not follow the recipe when preparing the chicken spinach alfredo flatbread that was served during the 12/10/2025 lunch meal. The DM stated the staff were expected to follow recipes when preparing menu items.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to ensure two kitchen ovens, and two kitchen drawers' housing food preparation and service equipment were kept clean. Additionally, the facility failed to ensure food was stored off the floor and failed to label, date, and cover stored food. These failures had the potential to create an environment for food-borne illnesses which could affect 156 residents who consumed food prepared from the facility's kitchen.Findings include:Review of the facility's policy titled, Dietary Cleaning and Sanitizing Dietary Areas and Equipment, revised on 03/29/2010, indicated, Policy: All kitchen areas and equipment shall be maintained is [sic] a sanitary manner and be free of build-up of food grease or other soil. The facility will provide a sanitary foodservice that meets State and Federal regulations.Review of the facility's undated policy titled, Cleaning Instructions: Ovens, indicated, Policy: Ovens will be cleaned as needed and according to the cleaning schedule (at least one every two weeks). Spills and food particles will be removed after each use.Review of the facility's titled, Dietary Food Storage, revised on 09/15/2015, indicated, Policy: Sufficient storage facilities are provided to keep food safe, wholesome and appetizing. Food is stored, prepared and transported at an appropriate temperature and by methods designed to prevent contamination. Procedures: . 13. Food is stored a minimum of six (6) inches above the floor on clean racks, dollies or other clean surfaces, and is protected from splash, overhead pipes or other contaminations . 16. Refrigerated packaged foods that have not been completely used can be stored up to seven (7) days, and then must be discarded. Items will be dated with the date received, date opened, and date seven (7) days after opening. If item is placed in another container, it must also be clearly and accurately labeled.1. Observation on 12/08/2025 from 11:35 AM to 11:55 AM with the Dietary Manager (DM), during the initial kitchen inspection revealed the interior cooking compartments and doors of the kitchen's two convection ovens were unclean with a heavy accumulation of dried and burned food spills, grease, and debris. Additionally, the inner storage compartments of two kitchen drawers which had food preparation and service equipment stored in them including serving scoops, serving spoons, scissors, metal ice/food scoops, and thermometers were unclean with dried substances and loose food debris. Continued observation revealed the kitchen's walk-in refrigerator contained a box of sausage patties that were stored uncovered, open to air and was not protected from possible contamination. Also, cheese slices that had been removed from their original packaging were stored in an undated and unlabeled container. Observation of the kitchen's walk-in freezer revealed a box of bread sticks, a box of dinner rolls, a box of cheese omelets, and a box of churros were all stored directly on the freezer floor. During an interview on 12/08/2025 at 11:55 AM, the DM confirmed the observations. The DM stated the ovens and drawers should be cleaned each week and as needed. The DM also stated when staff placed food into storage, the food should be completely covered, dated, labeled, and stored off the floor.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of facility policy, the facility failed to identify a concern as a grievance for one of 36 sampled residents (Resident (R) 178). Family Member (F) 178 requested a meeting with the facility and voiced a concern on behalf of R178 related to the physical condition of the resident upon the resident's discharge from the facility; however, the facility did not identify the concern as a grievance and did not provide any resolution to the concern. The failure has the potential to affect resident and/or family members by not having their grievances/concerns resolved in a timely manner. This was cited as a result of the investigation of complaint #474077.Findings include:Review of the facility's policy titled Grievance Policy and Procedure – Investigation Procedure, dated August 2024 reads as follows .Any resident, their representative, sponsor, advocate, or family member may file a concern, complaint, or grievance regarding a resident's treatment, medical care, behavior of another resident, staff member, theft of property, etc., without fear of reprisal in any form.The [Facility Name] will assess and investigate all concerns, complaints and grievances voiced and filed with the facility.A copy of all reports must be signed and will be made available to the resident and/or sponsor, advocate or family member filling the grievance form.The resident and/or family member will be informed of the results of the investigation within ten working days of the date the grievance was received. Review of R178's admission Record, provided by the facility revealed the resident was admitted to the facility on [DATE] and discharged from the facility on 03/23/2023 to home with the services of home health. Review of the facility's Grievance/Concern Log for the year 2023 failed to reveal any grievances/concerns were filed for this R178. Review of the facility's undated administrative notes of the meeting held with the F178 revealed Unit Manager (UM) 2 interviewed all staff members present on the day of the resident's discharge. The document failed to include statements from the staff members present when the resident was discharged . The document failed to contain any information that F178 was informed of the results of the facility's investigation. During an interview on 12/09/2025 at 12:40 PM, F178 stated he/she requested a meeting with the administrative staff regarding the condition of R178 when he/she was discharged from the facility. F178 stated the facility failed to notify him/her that R178 had developed a pressure ulcer during the resident's five-day respite stay at the facility. F178 stated the resident was discharged from the facility wearing only a tee shirt and adult diaper. When the resident arrived home, he/she was completely saturated with urine. F178 also stated that he/she did not receive a response from the facility regarding the resolution of his/her concerns. During an interview on 12/11/2025 at 4:54 PM, the Director of Nursing (DON) stated F178 requested a meeting with administration to discuss his/her concern about the condition in which R178 was discharged from the facility and the fact that he/she did not receive notification that the resident had developed a pressure ulcer during the resident's stay. The (DON) stated F178's concern should have been considered a grievance. The Director of Nursing acknowledged the grievance procedure was not followed

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure the resident and resident representative (RP) received a written notice of transfer that included all required information for two of three residents (Resident (R) 6 and R60) reviewed for facility initiated emergent transfer to the hospital out of 36 sampled residents. In addition, the transfer notice document did not identify the specific reason the resident was being transferred to the hospital. This failure had the potential to affect the resident and/or RP not having the knowledge of where and why a resident was transferred.This was cited as a result of the investigation of complaint #474077.Findings include:Review of the facility's policy titled Transfer and Discharge including Against Medical Advice (AMA) dated 03/16/2025 indicated, .3. The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: a. The specific reason and basis for transfer or discharge.10. Emergency Transfer to Acute Care. G. Provide a notice of transfer.to the resident and representative. 1. Review of R6's admission Record located in the resident's electronic medical record (EMR) under the Profile tab revealed R6s was admitted to the facility on [DATE]. Review of R6's Progress Note, dated 12/08/2025 and located in the resident's EMR under the Progress Notes tab revealed on 12/08/2025 at 3:44 PM, R6's skin was red, blotchy, and the resident was itching all over. The resident also had some audible wheezing at this time. The resident's physician ordered the resident to be sent to the hospital emergency room (ER). Emergency Medical Service (EMS) arrived at approximately 8:00 PM and transported the resident to the hospital. Further review of R6's Progress Notes revealed no documentation that the resident and the RP were provided with the written transfer notice. During an interview on 12/09/2025 at 4:30 PM, the facility's Bookkeeper stated that nursing sends the documents with the resident to the hospital. He/she stated that the RP was notified via phone on 09/28/2025. During an interview on 12/09/2025 at 4:59 PM, the Director of Nursing (DON) confirmed that there was no documentation in the EMR that the written transfer notice was provided to the resident and the RP at the time of the transfer to the hospital. Review of R6's Notice of discharge date d 09/28/2025 and provided by the DON revealed that there was no documentation on the document that the resident and RP received the written transfer notice. The Notice of Discharge document indicated the RP was notified via phone on 09/28/2025. The Notice of Discharge document indicated the reason for transfer was Inability to meet resident's needs instead of the specific reason of experiencing an allergic skin reaction and difficulty breathing. 2. Review of R60's undated admission Record located in the resident's EMR under the Profile tab indicated R60 was admitted to the facility on [DATE]. Review of R60's Progress Note, dated 11/02/2025 and located in the resident's EMR under the Prog [Progress Notes] tab reflected R60 had been transferred to the emergency room (ER) on 11/02/25 for pallor, diaphoresis, lethargy, low blood pressure, and dark malodorous urine. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R60's Notice of Discharge, dated 11/02/2025 and provided by the facility, revealed the reason for discharge was Inability to meet resident needs. Discharge notice issued via phone.Copy of notice mailed to[blank] Review of R60's Progress Note, dated 12/03/2025 and located in the resident's EMR under the Prog Notes tab indicated R60 had been transferred to the ER on [DATE] at 1:50 PM for diaphoresis, lethargy, low blood pressure, and complaints of pain to the site of the urinary stent. Review of R60's Notice of Discharge, dated 12/03/2025 and provided by the facility revealed the reason for discharge was Inability to meet resident needs. Discharge notice issued via phone.Copy of notice mailed to [blank]. During the interview on 12/11/2025 at 6:57 PM, the DON stated it was his/her expectation that when a resident was transferred to the hospital, the nurse should document in the EMR Progress Notes that the resident and the RP were given the written transfer notice. The DON confirmed that there was no evidence in the EMR that the residents and the RPs received the written transfer notice for any of the residents who were transferred to the hospital.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure an accurate Minimum Data Set (MDS) was submitted to include the correct PASSAR Level II status for two of 36 sampled residents (Resident (R) 10, and R35). The failure to code the MDS correctly could potentially lead to inaccurate federal reimbursements, and inaccurate assessment and care planning of the residents.Findings include:Review of the facility's policy titled, Resident Assessment - Coordination with PASARR Program, revised 11/28/17, indicated Recommendations, such as any specialized services, from a PASARR level II determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care. Review of the RAI manual, dated 10/2024 and located at https://www.cms.gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf, revealed .It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.When determining the response to items that have a look-back period relating back to the Admission/Entry, Reentry, or Prior OBRA [Omnibus Budget Reconciliation Act] or scheduled PPS [prospective payment system] assessment, whichever is most recent, staff must only consider those assessments that are required to be submitted to iQIES. PPS assessments that are completed for private insurance and Medicare Advantage Plans must not be submitted to iQIES and therefore should not be considered when determining the 'prior assessment.'.Skilled Nursing Facility stays billable to Medicare Part A. Does not include stays billable to Medicare Advantage HMO (Health Management Organizations) plans.Skilled Nursing Facility stays billable to Medicare Part A. Does not include stays billable to other payers (e.g., Medicare Advantage plans) . 1. Review of R10's admission Record located in the resident's electronic medical record (EMR) under the Profile tab indicated the resident was admitted to the facility on [DATE] with diagnoses which included vascular dementia, post-traumatic stress disorder (PTSD), and bipolar disorder. Review of R10's significant change in status MDS located in the resident's EMR under the MDS tab with an Assessment Reference Date (ARD) of 10/10/2025 indicated the resident was unable to complete the Brief Interview for Mental Status (BIMS) and had an assessment of mental status conducted by staff that indicated moderate cognitive impairment. The assessment revealed Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? The facility marked No. Review of R10's PASRR [PASARR] Level II Service Determination, dated 11/07/2025 and located in the resident's EMR under the Misc [miscellaneous] tab revealed R10 had Serious Mental Illness (MI) diagnoses of bipolar disorder and PTSD. 2. Review of R35's admission Record located in the resident's EMR under the Profile tab indicated the resident was admitted to the facility on [DATE] with diagnoses of bipolar disorder, mood disorder, major depressive disorder, anxiety disorder, and panic disorder. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R35's annual MDS located in the resident's EMR under the MDS tab with an ARD of 01/28/2025 indicated the resident had a BIMS score of 14 out of 15 which indicated R35 was cognitively intact. The assessment revealed Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? [marked] No. Review of R35's PASRR Level II Service Determination, dated 03/18/2019 and located in the resident's EMR under the Misc tab revealed R35 had serious mental illness (SMI) diagnoses of PTSD, panic disorder, bipolar disorder, major depressive disorder, anxiety disorder, and mood disorder. During an interview on 12/11/2025 at 12:42 PM, the Social Services Director (SSD) reviewed R35's EMR and stated R35 did have a PASSR II. The SSD reviewed R35's annual MDS dated [DATE] and confirmed it was marked NO for PASSR Level II SMI. The SSD stated It should have been marked Yes. It is not accurate. During an interview on 12/11/2025 at 12:56 PM, Social Services Assistant (SSA) 2 reviewed R10's EMR and stated [R10] was admitted with a level I. SSA2 reviewed the PASRR Level II Service Determination form dated 11/07/24 and stated I don't know if it's a PASSR II. I don't know how to read it. SSA2 asked the SSD and stated [R10] is level II according to PASSR II signed [DATE]. SSA2 reviewed the MDS dated [DATE] and stated It was marked No for PASSR II and should have marked Yes. Most likely it was overlooked.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, interviews, record review, and facility policy, the facility failed to follow professional standards of practice when a Licensed Practical (LPN) Nurse prepared a resident's medications, and then another nurse administered the medications to the resident. administered medications that he/she did not personally prepare Additionally, the LPN documented on the medication administration record (MAR) the administration of the medications even though the LPN was not the nurse who administered the medications. The deficient practice could result in medication errors.Findings include:Review of the facility's policy titled, Medication Administration, dated 11/2022, revealed Observe the five R's [rights] in giving medications: Resident, Medication, Dosage, Time, and Method / Route of administration. The policy does not specify a strict policy that medications can only be administered by the nurse who prepared them or that the nurse who administered the medications was document the administration in the eMAR. Review of the Alabama Board of Nursing, Administrative Code, Chapter 610-X-6, Standards of Nursing Practice, 610-X-6-.07, dated 11/14/22, revealed The registered nurse or licensed practical nurse shall have applied knowledge of medication administration and safety, including but not limited to: Safety precautions, including but not limited to: Right patient, Right medication, Right time, Right dose, Right route, Right reason, Right documentation. Documentation of medication administration shall comply with the principles of documentation and include safety precautions of medication administration, controlled drug records per federal and state law, and facility policy. During an observation on 12/09/2025 at 9:16 PM of the medication administration being completed by LPN2 revealed the LPN prepared medications to administer to resident (R) 21. LPN2 prepared eight pills in a medication cup and a cup of clear fluid and handed them to Unit Manager (UM) 5. UM5 was standing in front of the medication cart across from LPN2. UM5 entered R21's room and administered the medications to R21. UM5 did not observe LPN2 prepare the medications or verify medications in the cup or the cup of clear fluid. The cup of clear fluid contained polyethylene glycol mixed with water. The pill cup contained nitrofurantoin 100 milligrams (mg), vitamin C 500mg, atorvastatin 40mg, famotidine 20mg, sertraline 100mg, buspirone 7.5mg, memantine 10mg, and propranolol 20mg. LPN2 then asked UM5 if R21 had taken all of the medications. LPN2 then signed off the medications as administered in the electronic medication administration record (eMAR). During an interview on 12/09/2025 at 9:18 PM, LPN2 stated UM5 administered the medications because he/she was helping out due to a time crunch. During an observation on 12/09/2025 at 9:44 PM of the medication administration being completed by LPN2 revealed the LPN prepared medications to administer to R132. LPN2 prepared six pills and an inhaler and handed them to UM5. UM5 was standing in front of the medication cart across from LPN2. UM5 entered R132's room and administered the medications to R132. UM5 did not observe LPN2 prepare the inhaler or verify pills in the cup. LPN2 remained in the hallway at the medication cart. The pill cup contained atorvastatin 10mg, two 5mg tablets of melatonin, fenofibrate 160mg, hydrocodone-acetaminophen 10/325mg, and sucralfate 1gm. The inhaler was Bryna (budesonide/formoterol fumarate) 160mg/4.5 micrograms (mcg) and administered 2 puffs. LPN2 then asked UM5 if R132 had taken all the medications. LPN2 then signed off the medications as administered in the eMAR. During an interview on 12/09/2025 at 9:44 PM, when asked why UM5 administered the medications to R132, LPN2 stated [he/she] don't want this [racial slur] in his/her room. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/2025 at 2:59 PM, the Director of Nursing (DON) revealed nurses were expected to administer medications that he/she prepared themselves and not to administer medication prepared by someone else. During an interview on 12/10/2025 at 3:41 PM, the Administrator stated she was not sure if a nurse could hand another nurse a cup of pills to administer to a resident. During an interview on 12/11/25 at 2:45 PM, the Assistant Director of Nursing (ADON) stated nurses could not administer medication if they could not verify all the rights of medication administration.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to honor resident requests to be transferred from the bed to the wheelchair for one of five residents (Resident (R) 7) reviewed for Activities of Daily Living (ADL) assistance out of 36 sampled residents. This failure had the potential for the resident to experience a decline in mobility and increased depression.Findings include:A review of R7's admission Record located in the resident's electronic medical records (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included stage IV sacral ulcer, klebsiella pneumonia, muscle weakness, and difficulty walking. Review of 7's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 10/23/2025 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of eleven out of 15 which indicated the resident was moderately cognitively impaired. The resident was dependent on staff for all areas of care and required two plus people for transfers with the aid of mechanical lift. Review of R7's Care Plan located in the resident's EMR under the Care Plan tab revealed the care plan directed staff to encourage the resident to attend activities, peer socialization, utilize a mechanical lift for all transfers, and that the resident preferred to sit in bed or chair. The resident was not care planned for refusal of care/transfers. Review of R7's Physicians Order, dated 08/25/2025 and located in the resident's EMR under the Orders tab revealed the resident was to use the mechanical lift for transfers. Review of R7's Documentation Survey Report, dated for September 2025 and October 2025, provided by Unit Manager (UM) 2 revealed there was not documented evidence the resident had been transferred from the bed to his/her wheelchair via mechanical lift. Continued review revealed no documented evidence that the resident had refused to be transferred from the bed to wheelchair. Review of R7's Activities of Daily Living Sheet, dated November 2025 and located in the resident's EMR under the Tasks tab revealed the resident was dependent on staff for all care needs and did not refuse any cares. Review of R7's Restorative Notes, dated from 11/17/2025 through 12/11/2025 and provided by the Restorative Aide failed to reveal any documentation that he/she had recommended the resident increase his/her strength by occasionally getting out of bed or the resident's refusal of the recommendations. During an interview on 12/08/2025 at 12:45 PM, R7 stated he/she had been in bed since his admission to the facility a few months ago. The resident expressed a desire to be out of bed and in his/her wheelchair Observation on 12/08/2025 at 12:50 PM revealed R7 was sitting in bed with head of bed (HOB) elevated at 45 degrees, bilateral side rails in upright position. Observation on 12/08/2025 at 1:30 PM revealed R7 was in bed in a high position with bilateral side rails up. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/09/2025 at 10:00 AM revealed R7 was in bed with bilateral side rails. Observation on 12/09/2025 at 2:23 PM revealed R7 remained in bed positioned on his/her right side with a positioning device facing the door. Observation on 12/10/2025 at 11:56 AM revealed R7 was sitting up in bed with bilateral side rails in place. During a subsequent interview on 12/10/2025 at 11:56 AM, stated he/she was still agreeing to transfer to the wheelchair via mechanical lift for short periods of time so that he/she can use his/her computer in the room. During a follow-up interview on 12/10/25 at 2:00 PM, R7 stated that none of the staff had offered to assist. During an interview on 12/10/2025 at 8:45 AM, Certified Nurse Aide Restorative, Restorative Aide (RA) 1 revealed that he/she provided passive range of motion exercises to the resident twice a week. The RA stated that he/she has encouraged the resident to increase his/her activity by transferring from the bed to the wheelchair with the mechanical lift, but the resident has refused. However, the RA stated that he/she had failed to document the guidance he/she had given the resident about being out of bed and did not document the resident's refusals. During an interview on 12/10/2025 at 10:30 AM, with Student Nurse (SN) 1 stated that he/she had provided care to R7 on 12/09/25 on the day shift. SN1 stated that he/she offered the resident to get up but the resident refused. The SN stated the resident's refusal was not documented. During an interview on 12/11/2025 at 12:35 PM, the Unit Manager (UM) 1 stated the staff should offer to assist the resident with transfers from the bed to the wheelchair via the mechanical lift. The UM stated it was important to encourage the resident to increase his/her mobility to prevent a decline. If the resident refuses any aspect of care such as transfers from bed to wheelchair the staff must document the refusal. UM1 reviewed the resident's activity sheet and realized the staff had not documented any transfer refusals made by R7. UM1 stated he/she was unaware that the resident had requested assistance to get up so that he/she could utilize the computer in his/her room.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to ensure that one of one resident reviewed for restorative services (Resident (R) 5) out of 36 sampled residents, received the restorative care prescribed by physical therapy (PT) and occupational therapy (OT) during the restorative nursing program. This deficient practice had the potential for the resident to experience a decline in physical abilities.Findings include:Review of the facility's policy titled, Restorative Nursing Documentation dated 06/08/2023 indicated, Purpose: The facility maintains complete, accurate, and organized documentation of restorative treatments and the response to those treatments. Policy, 2. Treatment provided as part of a restorative nursing program will be documented on a daily basis.b. if the treatment is refused or withheld, the documentation will reflect the reason for not providing treatment. During an interview on 12/09/2025 at 11:06 AM, R5 stated that he/she went to rehab; however, they spend 55 minutes doing arm and leg exercises but only five minutes letting the resident stand up. R5 stated that he/she wanted to work on standing and pivoting to his/her chair. During an interview on 12/10/2025 at 8:43 AM, the Rehab Director stated that R5 was currently receiving restorative nursing. He/she stated that R5 was discharged from physical therapy (PT) on 09/26/2025 and from occupational therapy (OT) on 09/11/2025. Review of R5's Care Plan located in the resident's electronic medical record (EMR) under the Care Plan tab revealed that R5 was to participate in the restorative program of OT 2x/week x 12 [two times a week for 12 weeks] dated 09/12/2025 and was to receive PT restorative program 2x week x 12 weeks dated 09/29/2025. Interventions indicated to document effectiveness of restorative program and encourage the resident to perform strengthening exercise per PT and OT guidelines. Review of R5's PT Functional Maintenance Program dated 09/26/2025 and provided by the Rehab Director revealed, Restorative would have resident perform seated therapeutic exercised to tolerance with 1-2 [pound] weights. Resident to perform sit to stand transfers x [times] 3 with max assist x 2. Attempt to ambulate to tolerance with RW [rolling walker] and max [maximum] assist x 2 with wheelchair close by. The document indicated the Certified Nurse Aide-Restorative Aide (CNRA) had been instructed in the above maintenance plan with his/her signature and dated 09/30/2025. Review of R5's OT Therapy Maintenance Program dated 09/11/2025 and provided by the Rehab Director revealed, Resident to complete stretching of green/blue theraband 3 x 15 reps [repetitions], resident to complete bending of red/green therapy bar 3 x 20 [reps], resident to complete bicep curls 3 x15 [reps] with 2 pound weights and resident to complete pegboard exercise with wrist weights .5 pound to one pound. The document indicated the CNRA had been instructed in the above maintenance plan with his/her signature and dated 09/12/2025. Review of R5's Restorative Nursing Care assessment dated [DATE] and provided by the CNRA revealed the resident refused to participate; however, there was no documentation as to why the resident refused to participate. Review of R5's Restorative Nursing Care assessment dated [DATE] and provided by the CNRA indicated 25 minutes of Range of Motion (ROM) and 15 minutes of transfer exercises were provided. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The note at the bottom of the document indicated R5 stood two times at the handrail and attempted to stand more but was unable to. The assessment further indicated R5 did chest and shoulder, bicep curls with dumbbell, flex bar, chest pulls with theraband, leg kicks, marching and ankle pumps with ankle weights. Review of R5's Restorative Nursing Care assessment dated [DATE] and provided by the CNRA indicated 25 minutes of ROM and 15 minutes of transfer exercises were completed. The note at the bottom of the document indicated R5 stood two times at the handrail. The assessment also indicated the resident completed chest and shoulder exercises, bicep curls with dumbbells, flex bar, peg board, chest pulls with theraband, leg kicks, marching and ankle pumps with ankle weights. Review of R5's Restorative Nursing Care assessment dated [DATE] and provided by the CNRA indicated 25 minutes of ROM and 15 minutes of transfer exercises were completed. The note at the bottom of the document indicated that the resident stood three times at the handrail but was attempted several times, did chest and shoulder exercises, bicep curls with dumbbells, flex bar, chest pulls with theraband, peg board, leg kicks, marching and ankle pumps with ankle weights. Review of R5's Restorative Nursing Care assessment dated [DATE] and provided by the CNRA indicated 25 minutes of ROM and 15 minutes of transfer exercises were completed. The note at the bottom of the document indicated that the resident stood two times at the handrail but was attempted several times, did chest and shoulder, bicep curls with dumbbell, flex bar, chest pulls with theraband, leg kicks, marching and ankle pumps with ankle weights. Review of R5's Restorative Nursing Care assessment dated [DATE] and provided by the CNRA indicated 25 minutes of ROM and 15 minutes of transfer exercises were completed. The note at the bottom of the document indicated that the resident stood two times at the handrail but was attempted several times, did chest and shoulder press, bicep curls with dowel, flex bar, chest pulls with theraband, peg board, leg kicks with ankle weights. Review of R5's Restorative Nursing Care assessment dated [DATE] provided by the CNRA indicated 25 minutes of ROM and 15 minutes of transfer exercises were completed. The note at the bottom of the document indicated that resident stood three times at the handrail but was attempted several times, did chest and shoulder press exercises, bicep curls with dowel, flex bar, chest pulls with theraband, peg board, leg kicks with ankle weights. Review of R5's Restorative Nursing Care assessment dated [DATE] and provided by the CNRA indicated 25 minutes of ROM and 15 minutes of transfer exercises were completed. The note at the bottom of the document indicated resident had doctor's appointment and when the resident returned from the doctor's appointment, he/she told the Certified Nurse Aide (CNA) it was to late for therapy and then he/she went and played BINGO. During an interview on 12/10/2025 at 8:50 AM, CNRA stated that R5 usually came to the restorative program on Tuesdays and Thursdays. During restorative, he/she got arm and leg exercises and if R5 felt strong, he/she tried to stand. During an interview and record review on 12/10/2025 at 1:17 PM, R5's restorative documentation was discussed with the CNRA. Review of the PT and OT Functional Maintenance program specific instructions for R5's restorative nursing revealed that the restorative documentation did not indicate how many repetitions for each exercise was to be completed, what color of TheraBand was used, or (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what weight of the dumbbell was used. The CNRA confirmed that the restorative documentation did not indicate what color of therabands were used, what the weight of the ankle weights was, how many repetitions were completed for each exercise, and if the resident wore hand weights when using the peg board. In addition, the restorative documentation note did not indicate why the PT instruction to ambulate to tolerance with the rolling walker and max assist of two persons with the wheelchair close by was not documented as attempted or the reason why it was not attempted. During the review of the dates of the documentation to support when restorative nursing was provided, the CNRA confirmed that R5 had not received restorative nursing two times week. During an interview on 12/10/2025 at 1:30 PM, the Director of Nursing (DON) reviewed R5's PT and OT therapy maintenance program and the specific guidelines indicated by PT and OT for R5 to complete during his/her restorative nursing session. The DON confirmed that the restorative nursing documentation lacked specific information to indicate that the PT and OT maintenance program instructions were being implemented as directed and R5's response to the recommended exercise or refusal of the exercises and the reason for the refusal. The DON confirmed that based on the lack of specific documentation from restorative, it would be difficult to determine and evaluate resident's progress.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and policy review, the facility failed to document the monitoring and assessing of residents' dialysis access site and failed to document on residents' condition for one of one resident reviewed for dialysis (Resident (R) 5) when he/she returned to the facility post dialysis treatment out of 36 sampled residents. The facility's deficient practice had the potential for the resident to experience a decline in his/her medical condition.Findings include:Review of the facility's policy titled Dialysis dated 09/10/2025 indicated, Purpose: To provide a continuance of care for the resident while he/she is receiving dialysis and promote communication between the SNF [Skilled Nursing Facility] and dialysis center. Procedure: J. Vital signs should be done prior to leaving and on return from dialysis.K. Dialysis access site should be assessed or dressing checked for bleeding, signs of infection and any abnormalities. During an interview on 12/09/2025 at 11:05 AM, R5 stated that he/she goes to the dialysis center on Monday, Wednesday, and Friday. During an interview on 12/10/2025 at 10:30AM, Unit Manager (UM) 1 stated that a folder was sent with [R5] to take to the dialysis center with him/her and if the folder did not come back, the nurse was to call the dialysis center. Review of R5's undated admission Record located in the resident's electronic medical record (EMR) under the Profile tab indicated R5 was admitted on [DATE] and readmitted on [DATE] with diagnoses which included End Stage Renal Disease (ESRD). Review of R5's Physician Orders located in the resident's EMR under the Orders tab revealed and order dated 08/26/2025 of Obtain vital signs prior to and upon return from dialysis on Monday, Wednesday, and Friday. Observe pressure dressing to left upper arm x [times] 2 hours post return from dialysis.for s/s [signs and symptoms] of increased bleeding. Review of the R5's Care Plan located in the resident's EMR under the Care Plan tab revealed, [R5] has Potential for complications related to dialysis with interventions Check vital signs and shunt, when resident returns from dialysis, observe for elevated blood pressure, SOB [short of breath], or chest pain, observe for nausea and vomiting, observe for signs of infection or clotting of the access area, observe for swelling, pain, redness, or drainage of the shunt, observe skin for discolorations, dryness, or pruritis, perform post dialysis blood pressure upon return to the facility every hour x 2 readings, then every 4 hours x2 readings. Observation on 12/10/2025 at 3:09 PM revealed R5 returned form the dialysis center. Review of his/her Dialysis Binder provided by the facility revealed a Communication Form dated 12/10/2025 at 9:00AM which indicated vitals were taken before the resident went to dialysis; however, there was no documentation of the resident's vitals or any assessment when he/she returned. Review of R5's undated next Communication Sheets located in the binder upon the resident's return from the dialysis center revealed no documented evidence that the resident was assessed including obtaining his/her vital signs. Review of R5's Communication Sheets dated 12/01/2025, 11/28/2025, 11/26/2025, 11/24/2025, 11/21/2025, 11/19/2025, 11/17/2025, 11/15/2025, 11/12/2025, 11/10/2025, 11/05/2025, (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/31/2025, 10/27/2025, 10/22/2025, 10/08/2025, 10/06/2025, 09/24/2025, 09/19/2025, 09/17/2025, and 09/12/2025 located in the Dialysis Binder provided by the facility revealed R5's pre-dialysis assessment and vital signs were completed; however, there was no documented evidence the resident received the ordered post-dialysis assessment of his/her condition including vital signs upon his/her return to the facility. Review of R5's Dialysis Binder provided by the facility revealed an undated document titled Dialysis Communication Log which had handwritten instructions that indicated, vitals are to be taken before the resident leaves facility. Vital signs are to be taken upon arrival from dialysis. These are to be charted upon departure and arrival. If sheet does not return from dialysis, call and have them fax it over. Please always sign the 'Facility Representative' line. During an interview on 12/10/2025 at 10:49 AM, UM1 reviewed the communication sheets and confirmed that the nurses failed to follow the instruction sheet and complete a post assessment of the resident upon return to the facility which included the resident's vital signs and assessment of the resident's dialysis access site.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure a medication error rate of less than 5%. Observations during medication administration revealed 35 opportunities with two total medication errors, resulting in an error rate of 5.71%. During observations, Licensed Practical Nurse (LPN) 2 administered bothR147 and R42 incorrect dosages of medications. These failures had the potential to cause adverse drug reactions in the event of overdosing or lack of effectiveness of the medications in the event of underdosing.Findings include:Review of the facility's policy titled, Medication Administration, dated 11/2022, revealed, Medications are prepared, administered, and documented only by Licensed Nurses in accordance with current Alabama Board of Nursing Licensure, Licensed Pharmacist or other persons authorized by law and regulations as ordered by the physician. 1. Review of R147's Medication Administration Record (MAR), dated December 2025 and located in the resident's EMR under the Orders tab revealed he/she was admitted to the facility on [DATE], with diagnoses including anxiety disorder, hypokalemia, dysphagia, edema, major depressive disorder, and dementia. Review of R147's December 2025 MAR revealed the order for potassium chloride extended release (ER) (potassium supplement), 40 milliequivalent (meq) daily at bedtime, which originated on 10/05/2025. During an observation on 12/09/2025 at 9:27 PM of the medication administration completed by LPN2 revealed the LPN pulled a medication card out of the medication cart for R147 that contained potassium chloride 10-meq capsules. LPN2 entered R147's room and administered two 10-meq capsules of potassium chloride to the resident, then returned to the cart and signed the administration of the medication as completed. During an interview on 12/09/2025 at 11:00 PM, LPN2 confirmed he/she administered two 10-meq capsules of potassium chloride to R147 and confirmed the order on the MAR and in the resident's record was 40 meq. LPN2 confirmed he/she should have administered 40 meq of potassium chloride to R147 instead of 20 meq. 2. Review of R42's MAR, dated December 2025, revealed he/she was admitted to the facility on [DATE] with diagnoses including mood disorder and anxiety disorder. Review of R42's December 2025 MAR revealed the orders for fluticasone propionate nasal suspension (for nasal congestion) 50 microgram/activation (mcg/act), two sprays in nostril two times daily for nasal congestion, which originated on 08/01/2024. During an observation on 12/09/2025 at 9:35 PM of a medication administration completed by LPN2 revealed the LPN pulled a container out of the medication cart for R42 that contained fluticasone 50 mcg. LPN2 entered R42's room and administered one spray of fluticasone each nostril, then returned to the cart and signed the order as completed. He/she then moved on to the next resident. In an interview on 12/09/2025 at 10:22 PM, LPN2 confirmed he/she had administered only one spray of fluticasone to each nostril. LPN2 confirmed he/she should have administered two sprays in each nostril of R42. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherokee County Health and Rehabilitation Center	877 Cedar Bluff Road Centre, AL 35960

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/10/2025 at 2:59 PM, the Director of Nursing (DON) stated medications were to be administered as ordered by the physician.