STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015206	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Decatur Health & Rehab Center	2326 Morgan Avenue Southwest Decatur, AL 35603

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29671 Based on interviews, record review, and the facility's policy titled Notification of Changes, the facility failed to ensure Resident Identifier (RI) #497's physician was notified when RI #497 experienced a change in condition on 01/04/2025 at 1:24 PM when RI #497 had an elevated heart rate (HR) of 142 beats per minute (bpm). The facility further failed to notify the physician on 01/04/2025 at 9:22 PM when RI #497's heart rate continued to be elevated at 120 bpm. As a result of RI #497's physician not being notified upon the change in condition, no additional treatment or interventions were implemented which resulted in delayed treatment that was likely to result in serious injury, serious harm, impairment, or death. On 01/05/2025 at 4:10 AM RI #497's HR continued to be elevated between 120-150 bpm and RI #497 complained of chest pain and difficulty breathing and requested to be transferred to the emergency room . RI #497 was sent to the local emergency room and was treated in the Intensive Care Unit. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death. The Immediate Jeopardy (IJ) was cited in reference to 483.10 Resident Rights. On 02/01/2025 at 8:00 PM, the Administrator, the Director of Nursing (DON), the Executive [NAME] President of Operations, two Regional Director of Health Services nurses, the Regional Assessment Compliance Coordinator and the Chief Clinical and Regulatory Officer were provided a copy of the Immediate Jeopardy (IJ) template and notified of the finding of immediate jeopardy in the area of Resident Rights at F 580-Notify of Changes (Injury/Decline/ Room, Etc.). The IJ began on 01/04/2025 and continued until 02/01/2025 when the facility implemented corrective action to remove the immediacy. On 02/02/2025 the immediate jeopardy was removed, F 580 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This affected RI #497, one of six residents sampled for notification of change. This deficiency was cited as the result of the investigation of complaint/report number AL00049932. (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings include: Cross-Reference F 684 and F 658. A review of a policy titled, Notification of Changes, dated 12/31/2024 documented: Policy: The purpose of this policy is to ensure the facility promptly . consults the resident's physician; . when there is a change requiring notification . Definitions: Life-Threatening Conditions: Examples -Heart Attack or Stroke. Clinical Complications: - Examples- Development of stage 2 pressure injury, recurrent episodes of delirium, recurrent UTIs or onset of depression. Need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences . or commence a new form of treatment to deal with a problem . Compliance Guidelines: The facility must . consult with the resident's physician . when there is a change requiring such notification. Circumstances requiring notification include: . 2. Significant change in the resident's physical . condition such as deterioration in health . status, mental or psychosocial status. This may include: a. Life-threatening conditions, or b. Clinical complications . 3. Circumstances that require a need to alter treatment. This may include: a. New treatment. RI #497's ADMISSION RECORD indicated that RI #497 was admitted to the facility on [DATE], with diagnoses to include Chronic Obstructive Pulmonary Disease Respiratory Disorders in Diseases and Unspecified Atrial Fibrillation. The record indicated RI #497's Primary Physician was the Medical Director (MD). (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #497's Weight and Vitals Summary flow sheet, documented: . Pulse Summary . 12/27/2024 19:57 (7:57 PM) 60 bpm . 01/03/2025 14:01 (2:01 PM) 99 bpm . 01/03/2025 14:53 (2:53 PM) 99 bpm . 01/04/2025 13:24 (1:24 PM) 142 bpm (Irregular - chronic) 01/04/2025 21:22 (9:22 PM) 120 bpm . A review of RI #497's Progress Notes revealed a note electronically signed by Registered Nurse (RN) #14 dated 01/04/2025 at 11:56 AM. RN #14 documented that RI #497 had . Difficulty breathing noted. Shortness of breath noted. Registered Nurse (RN) #14 was interviewed on 01/31/2025 at 9:59 PM. During the interview, RN #14 was questioned regarding the medical documentation dated 01/04/2025, in which she recorded that RI #497 experienced shortness of breath. RN #14 could not remember if she notified anyone of RI #497's shortness of breath and indicated that there was no record of any notification being made. She acknowledged that she should have contacted either the doctor or the nurse practitioner. When asked about the potential concern, she stated that the resident might be at risk for a stroke or other medical conditions. On 01/30/2025 at 4:49 PM an interview was conducted with the Director of Nursing (DON). The DON said Licensed Practical Nurse (LPN) #16 documented RI #497's HR on 01/04/2025 at 9:22 PM. The DON said RI #497's HR was 120 bpm and she did not see that LPN #16 notified anyone. An interview was conducted on 01/30/2025 at 6:03 PM, with Certified Nurse Practitioner (CRNP) #15. The CRNP was asked if she assessed RI #497 on 01/04/2025. CRNP #15 replied that she saw RI #497 around 10:00 AM and she was fine. CRNP #15 reported that she had been contacted on 01/04/2025 regarding RI #497's heart rate of 142 bpm, at which point she instructed the staff to assess the patient, perform a manual heart rate check, and transfer the patient to the hospital for further evaluation if the heart rate did not decrease. CRNP #15 stated she did not receive a follow-up call after providing those instructions. CRNP #15 said she was not informed of RI #497's heart rate of 120 bpm at 9:22 PM on 01/04/2025. CRNP #15 was asked if she should have been contacted at 9:22 PM and she replied that the on-call provider should have been contacted, but she had already given an order for RI #497 to be sent to the hospital if his/her heart rate did not go down. CRNP #15 said she did not know why RI #497 was not transferred to the hospital until around 4:00 AM on 01/05/2025. An interview was conducted on 01/31/2025, at 6:05 PM with the Director of Nursing (DON). When asked who the staff should notify in the event of a resident's change in condition, the DON indicated that either the CRNP or the Medical Director should be contacted. Upon further questioning regarding the policy on this matter, she stated that it states the physician must be informed. RI #497's HISTORY AND PHYSICAL from the local hospital documented: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	.Date of Service 01/05/2025 . HPI (History of Present Illness): . was recently discharged from our service on 12-27-2024 after an admission of A-fib/RVR (Atrial Fibrillation/Rapid Ventricular Response) . he/she presents to ER today with 2 day of worsening dyspnea and heart palpitations . EKG (electrocardiogram) shows a-fib/RVR . PLAN: -Admit to ICU . -Diltiazem gtt (cardiac medication administered by IV drip) . -Cardiology consult . A Progress Note from the local hospital dated 01/06/2025 documented: . SUBJECTIVE: . He/She reports breathing much better and denies any palpitations. Currently requiring 2 L (liters) of oxygen by nasal cannula . ASSESSMENT AND PLAN: . Patient has been admitted to the hospital and to the intensive care unit because of atrial fibrillation with RVR . ********** On 02/02/2025, the facility submitted an acceptable removal plan, which document: ********** F-580-Resident Rights/Notify of Changes. The facility failed to ensure that RI#497's physician was notified when RI #497 experienced a change in condition on 1/4/2025 at 1:24 PM when he/she had an elevated heart rate of 142 bpm. The facility further failed to notify the physician on 1/4/2025 at 9:22 PM when RI#497's heart rate continued to be elevated at 120 bpm. A. Immediate action(s) taken for the resident(s) found to have been potentially affected include: 1. RI #497 was transferred to theER on [DATE] at 0410. 2. The Director of Nursing (DON) provided 1:1 in-service with the licensed nurse who failed to notify the physician; on physician notification when resident experiences change in condition and notification parameters on vital signs on 02-01-25. B. Identification of other residents having the potential to be affected: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. All residents in house most recent vital signs were reviewed by the DON, Regional Director of Health Services and Regional Assessment Coordinator for any change of condition as well as vital signs outside parameters that were set forth by the Medical Director on 1-28-25. 2. Any resident with a change of condition or vital signs outside the parameters, the provider was notified by DON, Unit Manager or Charge nurse for any additional orders or treatment on 2-1-25. C. Actions taken/systems to be put into place to reduce the risk of future occurrences include: 1. All licensed nurses, which are 31 in total, were educated on notification to the provider for change in condition, to include vital signs outside the parameters given on 2-1-25 by the DON and Staff Development Coordinator. Any licensed nurse who did not receive the in-service on 2-1-25 will not be allowed to work until the in-service has been provided. There is 1 LPN pending (on medical leave) and the DON is responsible to ensure they are educated before working ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 02/02/2025.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 48195 Based on interviews, resident record review, review of a facility investigative file, review of an Online Facility Reported Incident (FRI), review of a facility policy titled Abuse, Neglect, Misappropriation of Resident Property, Suspicious Injuries of Unknown Source, Exploitation, the facility failed to protect Resident Identifier (RI) #547's right to be free from abuse on 08/23/2024 when Licensed Practical Nurse (LPN) #21 was witnessed telling RI #547, a newly admitted resident with Dementia, to shut the fuck up. This was witnessed by Certified Nursing Assistant (CNA) #22, CNA #23, and CNA #24. Staff stated that what LPN #21 said to RI #547 was verbal abuse and would make someone in that situation feel afraid. The facility implemented corrective actions to correct the identified deficient practice and prevent recurrence; thus, past noncompliance was cited. This citation resulted from the investigation of complaint/report number AL00049364 and had the potential to affect RI #547, one of six residents sampled for abuse. Findings include: A facility policy titled Abuse, Neglect, Misappropriated of Resident Property, Suspicious Injuries of Unknown Source, Exploitation with an effective date of 07/01/2023 and revised date of 07/26/2024 documented: . Policy addresses the acts and occupancies that constitute abuse, neglect, exploitation and Misappropriation of resident property . A. Abuse. The definition of abuse encompasses a broad scope of behavior. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment . The following are definitions of specific types of abuse: 1. Verbal - Verbal abuse is the use of oral, written, or gestured communication or sounds that includes disparaging and derogatory terms to residents or families/ representatives, or within their hearing distance, regardless of their ages, abilities to comprehend, or the nature of their disabilities by any staff member . On 08/24/2024 at 12:10 AM the State Agency received a FRI from the facility alleging RI #547 was verbally abused on 08/23/2024 at 10:10 PM by LPN #21 who told RI #547 to stay in the fucking bed. On 08/23/2024 RI #547 was admitted to the facility with a diagnoses to include Dementia. RI #547's five-day Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 08/26/2024 documented RI #547 had severe cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's investigative file contained a form titled VERIFICATION OF INVESTIGATION for RI #547 with a date of incident 08/23/2024, that documented an allegation a nurse stated to a resident to stay in the fucking bed. The form also documented . Hospital records show severe dementia that required a sitter at home. The form included an Investigation Summary as follows: . After complete and thorough investigation, the facility is unable to substantiate abuse. The facility does have credible evidence that (LPN #21) used foul language, . (LPN #21) will be terminated . (RI #547) admitted yelling and cursing . (CNA #24 and CNA #22) were at the foot of the bed. (LPN #21) came into the room and it is reported that (LPN #21) said Shut the fuck up or stop fucking cussing, . (CNA #24) went to report to (LPN #10) about the cursing around the resident. The facility investigative file contained a typed statement dated 08/23/2024 signed by CNA #22 that documented: . I, (CNA #22) came into the room to help (CNA #24) change an aggressive patient, (RI #547) was yelling and cussing. I came into help and deescalate the position. (RI #547) was still fighting and cursing when the night nurse came in. We changed (his/her) brief, and (RI #547) was still fighting and cursing. (LPN #21) said, stop fucking cussing . (CNA #24) reported the incident to (LPN #10). On 01/29/2025 at 11:20 AM a telephone interview was conducted with CNA #22. When asked what occurred, CNA #22 said, she was asked to assist CNA #24 with incontinent care for RI #547, who was being combative and yelling. CNA #22 said, she attempted to calm RI #547 and then LPN #21 walked in the room and pointed his finger at RI #547 and said, shut the fuck up stop yelling you are disturbing residents. CNA #22 said, she considered what she heard to be verbal abuse. The facility's investigative file contained a typed statement dated 08/26/2024 signed by CNA #24 that documented: . Friday night we had a new resident (RI #547) who was extremely combative. I went into the room . (CNA #22 and CNA #23) came to help. CNA # 22 was explaining to the resident that we were putting a brief on (him/her). (He/she) was still combative . (LPN #21) came into the room and was trying to help. (LPN #21) stated, shut the fuck up, . they placed the brief on the resident and (LPN #21) left the room. I immediately went to tell (LPN #10). Attempts to contact CNA #24 during the survey were unsuccessful. The facility's investigative file contained a typed statement signed by CNA #23 dated 08/23/2024 that documented: (CNA #23) worked 8/23/24. She waked in the room and (CNA #24 and CNA #22) were in he room trying to calm (RI #547) down. (LPN #21) walked in the room and I walked out as I did not want to overwhelm the resident. As I walked out i heard someone say Fuck. On 01/30/2025 at 11:46 AM CNA #23 was asked to explain what she heard when exiting the room, CNA #23 said, she heard a voice say shut the fuck up. CNA #23 said, she turned around and went back into RI #547's room to see if help was needed. CNA #23 said, she heard a male voice, deep, and it sounded mean and vicious. When asked if the voice heard sounded abusive, CNA #23 said yes. When asked how a reasonable person may feel in this situation, CNA #23 said, scared, RI #547 was already in a new place. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility investigative file contained a typed statement dated 08/23/2024 signed by LPN #10 that documented: . Friday 8/23/24, I do not remember the time. (CNA #24) came to me and stated that she was giving care to the new resident (RI #547) and Nurse (LPN #21) came into the room and was trying to help. (LPN #21) stated, shut the fuck up, . they placed the brief on the resident and (LPN #21) left the room. On 01/29/2025 at 5:47 PM a telephone interview was conducted with LPN #10 and confirmed statement that CNA #24 reported to her that LPN #21 said shut the fuck up. LPN #10 said, this was immediately reported to the supervisor. On 01/29/2025 at 3:57 PM a telephone interview was conducted with RI #547's responsible party (RP). The RP said the facility notified the family that a staff member was witnessed cussing RI #547 and that the facility had reported the incident. On 01/30/2025 at 9:45 AM an interview was conducted with the DON who said she was notified by LPN #10 that evening around 10:00 PM that LPN #21 was witnessed using profanity to the new resident (RI #547). The DON said, in her interview with LPN #21, he told the DON it was so busy and hectic that night that he, LPN #21, did not remember using profanity, but LPN #21 also told the DON maybe he did because RI #547 was yelling and screaming since admission and they had to move the roommate because the roommate could not rest. The DON said, LPN #21 was suspended that night because the CNA said, he was really using the F word in front of the resident. The DON said, she directed staff to immediately remove LPN #21 from his duties and notified the Administrator (ADM). On 01/30/2025 at 2:28 PM an interview was conducted with the ADM who said she was notified by the DON around 10:30 PM on 08/23/2024 that LPN #21 was overheard cursing in RI #547's room. The ADM said, the CNAs in the room heard LPN #21 saying stay in the bed and lay the F down. The ADM said, the CNAs were trying to calm RI #547 down, and she was told it was working until LPN #21 came into the room and the behaviors escalated again. When asked what LPN #21 should have done in this situation, the ADM said, LPN #21 should have left the room and allowed RI #547 calm down. The ADM said, LPN #21 acted in an inappropriate and unprofessional manner in the presence of a resident. The ADM said according to the facility abuse policy, what LPN #21 said would be considered verbal abuse. The ADM said, a reasonable person in that situation would feel afraid. The facility investigative file contained a form titled Employee Termination Form with a termination effective date 08/30/2024 for LPN #21 for violation of resident's rights. ********** Facility's Corrective Actions: 8/23/24 Identified Issue(s): CNA reported to administration that a nurse used profanity during resident care and did not allow resident to refuse to wear incontinent brief. Safety Plan for Resident(s): (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33738 Based on record review, interviews, and the facility's policy titled, Admission Orders the facility failed to ensure an order for the use of oxygen was obtained for Resident Identifier (RI) #497 upon admission to the facility on [DATE]. This deficient practice affected one of 37 residents for whom physician's orders were reviewed. Findings Include: Review of the facility's policy titled, Admission Orders, with a revised dated of 12/31/24, revealed the following: . Policy . A physician, physician assistant, nurse practitioner or clinical nurse specialist must provide written and/or verbal orders for the residents' immediate care and needs . Policy Explanation and Compliance Guideline: 1. The written and/or verbal orders should include . b. Medication orders if indicated . 2. The orders should allow facility staff to provide essential care to the resident consistent with the resident's . physical status on admission . RI #497 was admitted to the facility on [DATE] with diagnoses of Unspecified Atrial Fibrillation, Respiratory Disorders in Disease Classified Elsewhere and (COPD) Chronic Obstructive Pulmonary Disease. RI #497's hospital records dated 12/27/2024 included an admission order, REHAB ORDERS . Oxygen: . to keep saturation greater than 88% . The facility's physician orders for RI #497 revealed there was no order upon admission for oxygen use. The physician orders revealed an order for Oxygen at 2L/MIN (liters per minute) VIA NC (nasal cannula) for COPD on 01/03/2025. Review of the Nurses Notes dated 12/27/2024, documented: Received patient to unit via stretcher . O2 (oxygen) on . per NC . Review of RI #497's Daily Progress Note , written by CRNP (Certified Registered Nurse Practitioner) #18, dated 12/28/2024, documented the following: . She/He is currently on room air however, wears supplemental oxygen at home at 2L (liters) via NC, 2L NC applied .Assessment/Plan: COPD: Continuous O2 (oxygen) at 2L NC . (continued on next page)

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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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of RI #497's Daily Progress Note by CRNP #18, dated 12/29/2024, documented the following: . Assessment/Plan: COPD: Continuous O2 at 2L NC . Review of RI #497's Daily Progress Note, by CRNP #18, dated 12/30/2024, documented the following: . Assessment/Plan: COPD: Continuous O2 at 2L NC . Review of RI #497's Daily Progress Note, by CRNP #18, dated 12/31/2024, documented the following: . Assessment/Plan . COPD Continuous O2 at 2L NC . Review of RI #497's Daily Progress Note, by CRNP #15, dated 01/01/2025, documented the following: . He/She is resting quietly in his/her room . Assessment/Plan . COPD: Continuous O2 at 2L NC . Review of RI #497's Daily Progress Note by CRNP #15, dated 01/02/2025, documented the following: . Assessment/Plan . COPD: Continuous O2 at 2L NC . During an interview with Registered Nursed (RN), Unit Manager (UM) #8 on 01/30/2025 at 10:46 AM, she stated RI #497 was admitted from the hospital with an order for oxygen but, did not see an order on that date. RN #8 was asked who was responsible for transcribing the order. She further stated the orders go through medical records and they transcribe them, but the admitting nurse was responsible for reviewing the orders to ensure all admission orders are transcribed. RN #8 said the order was not entered until on 01/03/2025. During an interview with CRNP #18 on 01/30/2025 at 12:35 PM, she was asked upon her assessment of RI #497 on 12/28/2024 she documented that resident was short of breath on room air and she applied oxygen. She said resident did not have oxygen applied and she applied oxygen to RI #497. CRNP #18 was asked if there was an order for oxygen at the time she placed the oxygen on the resident. CRNP #18, said no. Surveyor stated according to RI #497 medical record the order for oxygen was not transcribed until 01/03/2025, what would be the concern. CRNP #18 said, she had educated them (nurses) that oxygen was a medication that required an order. An interview was conducted with the Director of Nursing (DON) on 01/30/2025 at 4:49 PM and she was asked who was responsible for ensuring the oxygen order was transcribed for RI #497. The DON said the admitting nurse should have verified the orders from the hospital and the admitting nurse was RN #25. The DON said she did not see an order for RI #497's oxygen use on 12/28/2024. An interview was conducted with RN #25 on 01/30/2025 at 6:29 PM. RN #25 was asked what was the admission order for oxygen for RI #497. RN #25 stated, she/he needed to keep oxygen sats (saturation) at 88% or greater. RN #25 stated she was responsible for putting the admission order in but did not review the orders to see if the oxygen was transcribed into the facility's orders. When asked what was the concern with not implementing the oxygen orders, she stated it would not have been on the Medication Administration Record (MAR) for staff to apply and the resident might have became hypoxic. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Medical Director (MD) on 01/30/2025 at 6:09 PM, he was asked if RI #497 should have had orders put in the system for oxygen use on admission. He replied yes, RI #497 should have had a facility order upon admission for his/her oxygen use.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29671 Based on record review, interview, and review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to ensure Resident Identifier (RI) #38's completed Minimum Data Set (MDS) assessment was transmitted to the CMS system. This affected RI #38, one of 29 sampled residents whose MDS assessments were reviewed. Findings include: Review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2024, revealed the following: CHAPTER 5: SUBMISSION .OF THE MDS ASSESSMENTS Transmitting Data: Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. . Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days) . Resident Identifier (RI) #38 was admitted to the facility on [DATE] with diagnoses to include Type 2 diabetes mellitus without complications. RI #38 was discharged on [DATE]. An interview was conducted with the Minimum Data Set Coordinator (MDS-C) on January 29, 2025, at 3:12 PM. The MDS-C indicated that the MDS for RI #38, with an Assessment Reference Date (ARD) of October 15, 2024, was not submitted to the Centers for Medicare & Medicaid Services (CMS) within the required fourteen-day period following its completion. She noted that the MDS was ultimately submitted on January 29, 2025, by the Regional Assessment Compliance Coordinator due to the oversight. The MDS-C said the MDS should have been submitted within fourteen days after the ARD to ensure proper reporting to CMS.

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055 Based on interviews, review of Resident Identifier (RI) #497's medical records, and hospital record review, the facility failed to ensure: 1.) licensed staff followed standards of practice when Licensed Practical Nurse (LPN) #10 failed to completely and accurately transcribe an order. Specifically, on 01/04/2025 at 1:24 PM RI #497's HR was 142 beats per minute (bpm). LPN #10 notified Certified Registered Nurse Practicioneer (CRNP) #15 and received orders to check the resident's heart rate (HR) manually twice per day and send RI #497 to the emergency room (ER) if RI #497's HR did not decrease. LPN #10 entered into the electronic system for the manual HR assessment to begin at 8:00 PM and failed to transcribe the order to send the resident to the ER if the HR did not decrease. LPN #10 failed to manually assess RI #497's heart rate and RI #497's HR was not re-checked until 9:22 PM at which time it was 120 bpm. The facility did not implement any new interventions or take action to treat RI #497's elevated HR until 01/05/2025 at 4:10 AM when RI #497 requested to be transferred to the ER, complained of chest pain, and difficulty breathing. RI #497's HR continued to be elevated between 120 to150 bpm. 2.) Further the facility failed to have a system in place to ensure RI #497's HR was assessed per standards of practice before administering Digoxin. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death. The Immediate Jeopardy (IJ) was cited in reference to 483.21, Comprehensive Resident Centered Care Plan. On 02/01/2025 at 8:00 PM, the Administrator, the Director of Nursing (DON), the Executive [NAME] President of Operations, two Regional Director of Health Services nurses, the Regional Assessment Compliance Coordinator and the Chief Clinical and Regulatory Officer were provided a copy of the Immediate Jeopardy (IJ) template and notified of the finding of immediate jeopardy in the area of Comprehensive Resident Centered Care Plan at F658-Services Provided Meet Professional Standards. The IJ began on 01/04/2025 and continued until 02/01/2025 when the facility implemented corrective action to remove the immediacy. On 02/02/2025 the immediate jeopardy was removed, F 658 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This affected RI #497 one of six residents sampled for change in condition. This deficiency was cited as the result of the investigation of complaint/report number AL00049932. Findings include: Cross-Reference F 580 and F 684. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1.) RI #497 was admitted to the facility on [DATE], with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD), Respiratory Disorders in Diseases, Essential Hypertension, Obstructive Sleep Apnea, and Unspecified Atrial Fibrillation. RI #497's Admission Minimum Data Set assessment, with an Assessment Reference Date of 12/31/2024, identified RI #497 to score a 15 of 15 on the Brief Interview for Mental Status which indicated that RI #497 had intact cognition. RI #497's Weight and Vitals Summary flow sheet documented the following: . Pulse Summary . 12/27/2024 19:57 (7:57 PM) 60 bpm . 12/28/2024 07:41 (7:41 AM) 76 bpm . (12/29/2024 - 01/02/2025 No documented HRs) . 01/03/2025 14:01 (2:01 PM) 99 bpm . 01/03/2025 14:53 (2:53 PM) 99 bpm . 01/04/2025 13:24 (1:24 PM) 142 bpm (Irregular - chronic) . 01/04/2025 21:22 (9:22 PM) 120 bpm . No additional vital signs or pulse was documented. The facility's physician orders for RI #497's revealed a verbal order dated 01/04/2025 at 1:57 PM for vital signs and to check RI #497's pulse manually twice per day. This order was created by Licensed Practical Nurse (LPN) #10. On 01/31/2025 at 10:38 AM, an interview was conducted with LPN #10, the LPN assigned to care for RI #497 on 01/04/2025 on the 6 AM to 6 PM shift. LPN #10 said she reported RI #497's HR of 142 on 01/04/2025 at 1:24 PM to CRNP #15. LPN #10 said she did not see in RI #497's medical record that she reassessed RI #497's HR before she left. LPN #10 said not assessing RI #497 could put RI #497 at risk for a heart attack. On 01/31/2025 at 5:10 PM, a follow-up interview was conducted with LPN #10. LPN #10 said she entered the order for RI #497's HR to be checked twice a day to start at 8:00 PM. LPN #10 said she did not recall if she notified her relief (LPN #16) of the need to obtain RI #497's HRs manually. When asked since she had another four hours on her shift did she feel she needed to check RI #497's HR before she left, LPN #10 said she just put the order in for twice a day and the next HR check was for 8:00 PM. LPN #10 said she should have entered a progress note to inform the oncoming staff and others of RI #497's status, but did not. LPN #10 said the concern of not documenting in RI #497's progress notes about RI #497's care and HR was no one would know that a problem had occurred. LPN #10 said the concern of her not taking RI #497's HR after the order was given was RI #497's HR could have gone up a lot more. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/30/2025 at 11:55 AM, an interview was conducted with CRNP #15. CRNP #15 confirmed that nursing staff had contacted her when RI #497 had a HR of 142. CRNP #15 said she instructed staff to assess the resident, recheck the HR manually twice a day, and if the HR did not go lower to send RI #497 to the hospital. CRNP #15 said she did not know why RI #497 was not sent to the hospital until around 4:00 AM. On 01/30/2025 at 6:30 PM, a follow-up interview was conducted with CRNP #15. CRNP #15 said there should have been another assessment of RI #497's HR after she was informed of RI #497's HR was 142 and gave the order to check it manually twice a day. On 01/30/2025 at 6:09 PM, a telephone interview was conducted with the Medical Director (MD). The MD said RI #497 should have been sent out for the HR of 142 if RI #497 was symptomatic. RI #497's Progress Notes, dated 01/05/2025 at 12:36 AM, documented: . Difficulty breathing noted. Nurse reported labored breathing . This note was written by LPN #16. On 01/31/2025 at 5:49 PM, a telephone interview was conducted with LPN #16, the LPN providing care to RI #497 on 01/04/2025 on the 6 PM to 6 AM shift. LPN #16 said more than likely she assessed RI #497's HR on 01/04/2025 at 9:22 PM, but she did not remember what was done for RI #497's elevated HR until he/she was sent to the ER. The document titled [NAME] (Eastern Hospital Medicine) providerLink conversation which was initiated on 01/05/2025 at 3:51 AM by LPN #16 and sent to CRNP #30, documented the following: . Chest pain. Dyspnea. Pulse 120-150. Can't breath. Copd. Sending to ER per resident request . RI #497's Progress Notes dated 01/05/2025 at 4:10 AM electronically signed by LPN #16, revealed the following: . Sent to (name of local hospital) per resident request . on call CRNP aware . Resident is dyspneic. Unable to catch (his/her) breath. Unable to talk. Pulse 120-150 . 2.) RI #497's Order Summary Report (Physicians Orders) revealed RI #497 had a Physicians Order for Digoxin Oral Tablet 125 MCG (micrograms) Give 125 mcg by mouth one time a day every other day. This order had a start date of 12/28/2024. Davis's Drug Guide identifies Digoxin as a high-risk medication. The Guide includes assessment instructions to monitor apical pulse for one full min before administering and to hold the dose if pulse rate is less than 60 bpm in an adult. A review of RI #497's December 2024 electronic Medication Administration Record (eMAR) revealed RN #14 administered RI #497's Digoxin at 8:00 AM on 12/30/2024. There was no evidence RI #497's HR had been checked before he/she received the Digoxin. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/01/2025 at 5:52 PM, an interview with was conducted with RN #14 who said the standard of practice nurses use before administering Digoxin was to follow the doctor's orders. RN #14 said she did not check RI #497's HR on 12/30/2024 because there were no doctor's orders to check the HR. RN #14 said there was no place to document the HR on the December 2024 eMAR. A review of RI #497's January 2025 eMAR revealed LPN #28 administered RI #497's Digoxin at 8:00 AM on 01/01/2025. There was no evidence RI #497's HR had been checked before he/she received the Digoxin. On 02/02/2025 at 1:23 PM, a telephone interview was conducted with LPN #28, the LPN assigned to care of RI #497 on 01/01/2025. LPN #28 said the standard of practice nurses use before administering Digoxin was to check the apical pulse. LPN #28 said evidence she had checked RI #497's pulse on 01/01/2025 would be on the January eMAR. On 02/01/2025 at 4:55 PM, an interview was conducted with the Director of Nursing (DON). The DON said the standard of practice for administering Digoxin was to administer medication as ordered. The DON said the facility's protocol for assessing a resident's HR was done per doctor's order. When asked how would the staff know when to assess the HR of residents before administering Digoxin, the DON said it would be on the physician's orders and eMAR. On 02/01/2025 at 3:33 PM, a telephone interview was conducted with the Medical Director (MD). The MD said it was standard of practice to check the HR of a person receiving Digoxin before administering the medication. The MD said if an order had not been written to check the heart rate before administering the Digoxin he would have written one, but it was just standard or practice for the nurse to assess resident's HR before administering Digoxin. A review of RI #497's Weight and Vitals Summary flow sheet and RI #497's Progress Notes revealed there was no evidence RI #497's HR had been checked on 12/30/2024 or on 01/01/2025 before RI #497 was administered the Digoxin. ********** On 02/03/2025 the facility submitted an acceptable removal plan, which documented: A. Immediate action(s) taken for the resident(s) found to have been potentially affected include: 1. The facility failed to ensure licensed staff followed standards of practice and completely and accurately transcribed an order received from a CRNP to send RI#497 to the emergency room if heart rate did not go down. The nurse also did not communicate the order to the oncoming nurse. The nurse further failed to re-assess RI #497's heart rate at the time the order was provided to ensure RI#497 did not need to be transferred to the ER. The facility further failed to ensure process was in place to ensure resident's HR was checked prior to administration of digoxin. 2. RI #497 was transferred to theER on [DATE] at 0410. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	C. Actions taken/systems to be put into place to reduce the risk of future occurrences include: 1. Vital Sign threshold alerts were updated to the electronic medical record for all residents by the DON and RDHS on 2-1-25. 2. The RDHS revised the New Admit/Readmit Checklist on 2-1-25 to include setting the vital sign parameter thresholds set forth by the Medical Director and Pharmacist related to Clonidine, Amiodarone, and digoxin orders have heart rate and or BP parameters for monitoring, holding of medication and notification of MD/NP. 3. All licensed nurses (31 licensed nurses), were provided with education by the DON and Staff Development Coordinator on 2-1-25. Any licensed nurse who did not receive this education will not be allowed to work until the education has been provided (there is 1 pending nurse on medical leave and the DON is responsible to ensure they are educated before working). Education included completely and accurately transcribing an order received from a physician or CRNP, following up on an order and communicating new orders to the oncoming nurse that require follow up, and assessing residents' heart rate and or BP prior to administering Clonidine, Amiodarone and Digoxin, the updated procedures including entering the order for assessment and documentation of HR monitoring for newly ordered digoxin and HR and blood pressure for Amiodarone and blood pressure monitoring for Clonidine. The nurses were educated that the thresholds for VS was posted at the nurses station on 1-28-25 by the DON, additionally the specific instructions are included on the MAR to notify the MD/NP if the VS are out of the parameters. The facility requests for the IJ removal plan to be effective on 2-2-25. This plan was written by the Executive VP of Operations and the Regional Director of Health Services. ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 02/02/2025.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47408 Based on interviews and resident record reviews the facility failed to ensure: 1) a system was in place to ensure newly admitted residents vital signs were assessed at a frequency expected by the Physician/Certified Registered Nurse Practitioner (CRNP); and 2) resident specific vital sign parameters were established including when the physician should be notified of abnormal values. Specifically, RI #497 was admitted to the facility on [DATE] after being admitted to the hospital on 12/17/2024 with Atrial Fibrillation with RVR (Rapid Ventricular Response). The facility's orders indicated RI #497's vitals were to be assessed every month and no parameters were established. The physician/CRNP reported they expected vitals to be assessed at least daily for newly admitted residents. On 01/04/2025 at 1:24 PM RI #497's heart rate (HR) was 142 beats per minute (bpm). The CRNP was notified and gave an order to send him/her to the hospital if his/her HR did not decrease. On 01/04/2025 at 9:22 PM RI #497's HR was 120 bpm. No action was taken until the RI #497 complained of chest pain, shortness of breath, and requested to be transferred to the hospital. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death. The Immediate Jeopardy (IJ) was cited in reference to 483.25, Quality of Care. On 02/01/2025 at 8:00 PM, the Administrator, the DON, the Executive [NAME] President of Operations, two Regional Director of Health Services nurses, the Regional Assessment Compliance Coordinator and the Chief Clinical and Regulatory Officer were provided a copy of the Immediate Jeopardy (IJ) template and notified of the finding of substandard quality of care at the immediate jeopardy level in the area of Quality of Care, F 684. The IJ began on 01/04/2025 and continued until 02/01/2025 when the facility implemented corrective action to remove the immediacy. 02/02/2025 the immediate jeopardy was removed, F 684 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This affected RI #497 one of six residents sampled for change in condition. This deficiency was cited as the result of the investigation of complaint/report number AL00049932. Findings include: Cross-Reference F 580 and F 658. RI #497's hospital DISCHARGE SUMMARY dated 12/27/2024 included REHAB ORDERS which documented that RI #497 was to have routine vital signs. (continued on next page)

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Decatur Health & Rehab Center	2326 Morgan Avenue Southwest Decatur, AL 35603

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #497 was admitted to the facility on [DATE] with diagnosis to include Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, and Essential Hypertension. A review of RI #497's Order Summary Report revealed on 12/27/2025, an admission order was input for RI #497's vital signs to be checked once a month and as indicated. There were no parameters given at this time as to when the Physician or CRNP were to be notified when the resident's vital signs were out of normal range. A review of RI #497's Weights and Vitals Summary flow record indicated there was no evidence RI #497's vital signs were assessed on 12/29/2024, 12/30/2024, 12/31/2024, 01/01/2025, nor 01/02/2025, five of ten days RI #497 was a resident at the facility. RI #497's pulse was documented on 01/04/2025 at 1:24 PM as 142 bpm and on 01/04/2025 at 9:22 PM 120 bpm. During an interview on 01/30/2025 at 6:29 PM with Registered Nurse (RN) #25, the nurse who entered RI #497's admission orders, RN #25 said the standard for checking vital signs on new admissions should be every shift until discharged . An interview was conducted on 01/30/2025 at 10:46 AM with the RN/Unit Manager (UM) #8. She was asked how often vital signs were to be assessed for RI #497 and she stated as often as prescribed, per orders. She further stated that she entered an order on 01/03/2025 for vital signs every shift for blood pressure, heart rate, and oxygen sats every shift for three days. On 01/30/2025 at 6:29 PM an interview was conducted with RN #25, House Supervisor. RN #25 reported that newly admitted residents should have vitals assessed each shift until discharged . During an interview with the Director of Nursing (DON) on 01/30/2025 at 4:49 PM, the DON stated RI #497's orders were entered on 12/27/2024 for RI #497's vitals to be assessed once a month. The DON stated newly admitted residents should have vital signs assessed at least daily. The DON said there was no evidence that RI #497's vital signs were assessed from 12/29/2024 through 01/02/2025. During an interview with CRNP #15 on 01/30/2025 at 1:15 PM the CRNP stated the standing order was for vital signs to be assessed each shift for newly admitted residents. CRNP #15 said vital signs were assessed once per month for long-term residents who were stable. On 01/30/2025 the DON presented a Vital Signs Parameter guideline implemented on 01/28/2025, which was signed by the Medical Director (MD). The parameter for the Pulse indicated a pulse of 110 was considered High. Documented on the form were instructions to Please call MD (Medical Director)/NP (Nurse Practitioner) when vital signs are out of parameters. ********** On 02/03/2025 the facility submitted an acceptable removal plan, which documented: 1. Immediate action(s) taken for the resident(s) found to have been potentially affected to include: A. The facility failed to ensure: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1) A system was in place to ensure newly admitted residents vital signs were assessed at a frequency expected by the physician/CRNP. 2) Resident specific vital sign parameters were established including when the physician should be notified of abnormal values. B. The Director of Nursing contacted the Medical Director on 01-28-25 for guidance on updating vital sign thresholds for notification. C. On 2-1-25, the Medical Director was contacted by the DON on his expectations on vital sign monitoring. 2. Identification of other residents having the potential to be affected: A. All newly admitted residents have the potential to be affected B. The Regional Director of Health Services (RDHS), Director of Nursing (DON), and Regional Assessment Coordinator reviewed all vital signs on all residents newly admitted to the facility in the last 30 days had an order to monitor vital signs per the Medical Directors expectations. This was completed on 2-1-25. 3. Actions taken/systems to be put into place to reduce the risk of future occurrences include: A. An updated New Admit/Readmit Checklist was implemented to ensure vital sign frequency and parameters are established at the time of admission. Completed on 2-1-25. B. The vital sign monitoring policy was updated on 2-1-25 by the RDHS to require at least daily vital signs for all newly admitted or readmitted residents for 2 weeks. The changes to the VS Monitoring Policy were based on discussion and recommendation of The Medical Director on 2-1-2025. C. The Director of Nursing contacted the Medical Director on 1-28-25 for guidance on updating vital sign thresholds for notification. D. On 2-1-25, the Medical Director was contacted by the DON on his expectations on vital sign frequency. E. Vital sign parameter thresholds and frequency were updated for all newly admitted or readmitted residents over the last 30 days, vital sign orders on 2-1-25 by the RDHS and DON. The facility parameters were discussed with The Medical Director on 2-1-2025 and were updated. In addition, it was noted by The Medical Director that there will be residents that may require specific parameters based on clinical need. F. The Daily Clinical Meeting form was revised on 2-1-25 by RDHS to include review of vital signs outside physician ordered parameters with follow up documentation. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	G. The DON and Staff Development Coordinator on 2-1-2025 provided education for licensed staff on the updated VS Monitoring Policy, monitoring residents' vital signs at least daily for 2 weeks following an admission or re-admission and vital signs thresholds that require physician notification, and process to document vitals, notification, and physician recommendations. The facility requests for the IJ removal plan to be effective on 2-2-25. This plan was written by the Executive VP of Operations and the Regional Director of Health Services. ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 02/02/2025.

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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. 20304 Based on observation, interview, the facility's policies for Food Safety Requirements and Date Marking for Food Safety, and the United States (U.S.) Food and Drug Administration (FDA) 2022 Food Code; the facility failed to ensure frozen chicken was safely thawed and two boiled eggs in the Reach-in Cooler had a use-by date on 01/27/2025. This had the potential to affect 100 of 100 residents receiving meals from the facility's kitchen. Findings include: The U.S. FDA 2022 Food Code included the following: . 3-501.13 Thawing. . TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be thawed: (A) Under refrigeration that maintains the FOOD temperature at 5 [degrees] C [Centigrade/Celsius] (41 F [Fahrenheit]) or less .; or (B) Completely submerged under running water: (1) At a water temperature of 21 C (70 F) or below ., (2) With sufficient water velocity to agitate and float off loose particles in an overflow ., and (3) For a period of time that does not allow thawed portions of READY-TO-EAT FOOD to rise above 5 C (41 F) ., or (4) For a period of time that does not allow thawed portions of a raw animal FOOD requiring cooking . to be above 5 C (41 F), for more than 4 hours including: (a) The time the FOOD is exposed to the running water and the time needed for preparation for cooking ., or (b) The time it takes under refrigeration to lower the FOOD temperature to 5 C (41 F) .; (C) As part of a cooking process if the FOOD that is frozen is: (1) Cooked . or (2) Thawed in a microwave oven and immediately transferred to conventional cooking EQUIPMENT, with no interruption in the process . 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(A) . refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 [degrees] C [Centigrade/Celsius] (41 F [Fahrenheit]) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. The facility's policy for Food Safety Requirements, dated 09/01/2024, included the following: . Policy: . Food will also be stored, prepared, . in accordance with professional standards for food safety. Policy Explanation and Compliance Guidelines: 1. Food safety practices shall be followed throughout the facility's entire food handling process. Elements of the process include the following: . b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms. c. Preparation of food, including thawing, . 3. Facility staff shall . ensure timely and proper storage. c. Refrigerated storage . iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or . discarded . 4. When preparing food, staff shall take precautions in critical control points in the food preparation process to prevent, reduce, or eliminate potential hazards. a. Thawing - approved methods for thawing frozen foods include thawing in the refrigerator, submerging under cold water, thawing in a microwave oven, or as part of a continuous cooking process. Thawing at room temperature is not acceptable. The facility's policy for Date Marking for Food Safety, dated 09/01/2024, included the following: . Policy: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food. Definitions: 'Time/temperature control for safety food' (formerly potentially hazardous food) includes an animal food that is raw or heat-treated, . Policy Explanation and Compliance Guidelines for Staffing: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Refrigerated, ready-to-eat, time/temperature control for safety food (i.e. perishable food) shall be held at a temperature of 41 F or less for a maximum of 7 days. 2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. During the initial kitchen observation on 01/27/2025 at 5:14 PM, clear plastic bags of chicken were observed in a prep (preparation) sink while staff were engaged in the residents' supper trayline. At 5:55 PM, during the initial tour with the Dietary Manager, three clear plastic bags of frozen chicken pieces were observed defrosting in the Meat Prep Sink. There was no water in the sink, no water running, and the bags of chicken were not in any container to be submerged in water. The supper menu for 01/27/2025 did not include chicken. At 6:10 PM on 01/27/2025, while touring the kitchen with the Dietary manager, two boiled eggs were observed in a plastic container without a use-by date in the Reach-in Cooler. During an interview on 01/29/2025 at 4:02 PM, the Assistant Dietary Manager was asked why the frozen chicken was in the Meat Prep Sink on Monday evening (01/27/2025). The Assistant Dietary Manager said that is where we put the frozen meat when transferring it from the Freezer to the Cooler, to try to thaw it a little bit. The Assistant Dietary Manager further said we leave it in there about an hour and a half to get a head start on defrosting, before placing the bags in the Cooler. The Dietary Manager was interviewed on 01/29/2025 at 4:13 PM. When asked why the frozen chicken was in the Meat Prep Sink on Monday evening (01/27/2025), the Dietary Manager said I had just pulled it out of the Freezer when someone said State was in the building. Upon being asked how the frozen chicken should have been thawed, the Dietary Manager said underneath water with the water running or else in the Cooler. When asked about the two hard boiled eggs in the Reach-in Cooler seen on Monday evening (1/27/2025), the Dietary Manager said I think the AM [NAME] was going to use them in a salad, but she did not. When asked the concern with the two hard boiled eggs not having a use-by date, the Dietary Manager said it could be potentially dangerous. The Dietary Manager further said it could be potentially harmful to our residents because, without a date, you do not know how long it has been there and there is a potential for Food Borne Illness. The Registered Dietitian (RD) was interviewed on 01/29/2025 at 4:24 PM. The RD said the concern with the frozen chicken was that it was not being properly thawed; so Time/Temperature Control would be the problem and it could lead to Food Borne Illness, if it sat out too long in the Temperature Danger Zone. The RD also said the lack of a use-by date meant there was no way to prove how long the two boiled eggs had been in the Reach-in Cooler.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 20304 Based on observation, interview, the facility's policy for Disposal of Garbage and Refuse, and the United States (U.S.) Food and Drug Administration (FDA) 2022 Food Code; the facility failed to ensure two of two dumpsters were closed and food-related trash was not strewn on the ground around the dumpster area on 01/27/2025. This had the potential to affect 100 of 100 residents receiving meals from the facility's kitchen. Findings include: The U.S. FDA 2022 Food Code included the following: . 5-501.15 Outside Receptacles. (A) Receptacles and waste handling units for REFUSE, . with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers. (B) Receptacles and waste handling units for REFUSE . shall be installed so that accumulation of debris and insect and rodent attraction and harborage are minimized and effective cleaning is facilitated around . the unit. 5-501.113 Covering Receptacles. Receptacles and waste handling units for REFUSE, . shall be kept covered: . (B) With tight-fitting lids or doors if kept outside the FOOD ESTABLISHMENT. 5-501.115 Maintaining Refuse Areas and Enclosures. A storage area and enclosure for REFUSE, . shall be . clean. The facility's policy for Disposal of Garbage and Refuse, dated 09/01/2024, included the following: . Policy: The facility shall properly dispose of kitchen garbage and refuse. Policy Explanation and Compliance Guidelines: . 7. Refuse containers and dumpsters kept outside the facility shall be designed and constructed to have tightly fitting lids, doors, or covers. Containers and dumpsters shall be kept covered when not being loaded. Surrounding area shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10. Storage areas, enclosures, and receptacles for refuse shall be maintained in good repair and cleaned at a frequency necessary to prevent them from . becoming attractants for insects and rodents. During the initial kitchen tour with the Dietary Manager on 01/27/2025 at 5:31 PM, the outside Dumpster Area was observed. There were two dumpsters, one dumpster with a side door left open and the other dumpster with a broken lid. In addition, food-related trash was observed on the ground around the dumpster area. The observed food-related trash included two plastic spoons, one plastic knife, one food container with a lid, two condiment packages, four straws, more than six gloves, one empty juice cup, two cup lids, and additional items. Upon being asked the concern with the dumpsters being open and the food related trash on the ground, the Dietary Manager said it could attract rodents. When asked the potential danger to the residents, the Dietary Manager said the rodents could get into the facility. The Registered Dietitian (RD) was interviewed on 01/29/2025 at 4:24 PM. When asked the concern with one dumpster having a side door open, the other dumpster having a broken lid, and food related trash strewn around on the ground of the dumpster area; the RD said it can attract pests and rodents. Upon being asked how this could affect the residents, the RD said pests and rodents could potentially enter the facility's kitchen.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39580 Based on interviews, resident record review, and review of a facility policy titled Documentation in Medical Record, the facility failed to ensure Resident Identifier (RI) #447's Medication Administration Records (MAR) accurately reflected administration of insulin administered to RI #447. Licensed Practical Nurse (LPN) #27 documented she administered Lantus Insulin on RI #447's MAR when she did not administer the insulin. This deficient practice affected RI #447, one of 29 sampled residents. Findings include: A facility policy titled Documentation in Medical Record with a review date of 12/31/2024, documented: . Policy Explanation and Compliance Guidelines . 4. Principles of documentation include, . a. Documentation shall be factual, objective . i. False information shall not be documented . b. Documentation shall be accurate, relevant, and complete . RI #447 was admitted to the facility on [DATE] with diagnoses to include Diabetes Mellitus with Hyperglycemia. RI #447's nursing note dated 11/02/2024 at 9:34 AM signed by LPN #27 documented: . Lantus was not given this AM. I mistakenly charted that the insulin was given. Review of RI #447's November 2024 Medication Administration Record revealed an entry on 11/02/2024 at 8:00 AM for which LPN #27 initialed as having administered Lantus Insulin to RI #447 at that time. On 01/29/2025 at 08:52 AM an interview was conducted with LPN #27 and she was asked about RI #447's insulin administration for 11/02/2024. LPN #27 stated, she did not give the insulin RI #447 on 11//02/2024 because RI #447 was not eating or drinking. LPN #27 said, she accidentally hit the wrong key when she documented. LPN #27 said, she should have hit the key indicating the insulin was not required at that time. LPN #27 stated, if the medication was not documented accurately the MAR would not be complete and accurate. LPN #27 said, she did not follow facility policy for documentation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/29/2025 at 10:13 AM the Director of Nursing (DON) was asked about the facility's policy on documentation of a medication. The DON stated, staff did not administer a medication, the staff would document the medication as not administered and the reason. The DON said, the potential concern of not following the facility's policy on documentation was an inaccurate record of treatment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055 Based on observations, interviews, and review of a facility policy titled Infection Prevention and Control Program, the facility failed to ensure a Licensed Practical Nurse (LPN) #20 administered medications and obtained vital signs in a manner to prevent the spread of infection between himself and residents; and resident to resident. LPN #20 handled Resident Identifier (RI) #61's medication with his bare hands and LPN #20 failed to clean, disinfect, and properly store equipment used for obtaining resident vital signs prior to using the equipment on RI #70. These deficient practices had the potential to affect RI #61 and RI #70, two of 29 sampled residents. Finding include: Review of a facility policy titled, Infection Prevention and Control Program, 09/01/2024, revealed the following: Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Policy Explanation and Compliance Guidelines: . 2. All staff are responsible for following all policies and procedures related to the program. 4. Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. 10. Equipment Protocol: a. All reusable items and equipment requiring . disinfection . shall be cleaned in accordance with our current procedures governing the cleaning . of . contaminated equipment. RI #61 was admitted to the facility on [DATE]. RI #70 was admitted to the facility on [DATE]. On 01/29/2025 at 10:55 AM LPN #20 was observed preparing medications for administration to RI #61. LPN #20 punched pills from two bubble pack medication cards into his bare hands, placed the pills into a medication cup, and then administered the medication to RI #61 by mouth. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/29/2025 at 11:23 AM LPN #20 placed a blood pressure cuff, pulse oximeter, and thermometer on the bed of a resident, used the medical equipment to check the resident's vital signs, then placed the medical equipment on top of the medication cart. On 01/29/2025 at 11:52 AM LPN #20 used the medical equipment, that had not been cleaned or disinfected, from the top of the medication cart to assess RI #70's vital signs. After assessing RI #70's vital signs, LPN #20 placed the medical equipment back on top of the medication cart without cleaning or disinfecting the equipment. On 01/29/2025 at 12:09 PM LPN #20 was asked about administering medications. LPN #20 said, he normally wore gloves when punching pills but had not worn gloves when preparing medications for RI #61. LPN #20 said, the concern with touching a resident's medications with his bare hands was infection control. LPN #20 said, he should have placed the medication card over the medication cup and allowed the pill to drop into the cup. LPN #20 was asked what was the concern when he placed the blood pressure cuff, the pulse oximeter, and the thermometer on a resident's bed. LPN #20 said, infection control. LPN #20 said, he should have placed the medical equipment on a barrier. LPN #20 was asked what was the concern when he placed the medical equipment back to the medication cart. LPN #20 said, infection control. LPN #20 was asked what should he have done with the medical equipment before using it with another resident. LPN #20 said, he should have sanitized it. On 01/31/2025 at 11:32 AM, an interview was conducted with the Director of Nursing (DON). The DON said when pills are removed from the bubble pack, they should be placed over the medication cup and popped into the cup. The DON said medications should not be touched with the bare hand. The DON said when medical equipment is taken into a resident's room it was not ok to place the equipment on the bed. The DON said the medical equipment should be placed on a barrier. The DON said when medical equipment is used, and brought out of a resident's room, the equipment should be sanitized and allowed to air dry before being used again. The DON said, medical equipment should never be taken out of a resident's room and placed on the medication cart without sanitizing it and letting it air dry. The DON said when these things are not done there were concerns for contamination. On 02/02/2025 at 6:31 PM a telephone interview was conducted with the Registered Nurse (RN)/Infection Preventionist (IP). The IP said, the bubble pack should be held over the medication cup when pressing out the pill and pill should not be touched with bare hands. The IP said, staff touching medications with their bare hands would be an infection control concern. The IP said, at no time should staff place medical equipment on a resident's bed. The IP said, there was no way to know what was on a bed and placing medical equipment on a resident's bed was not sanitary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015206	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Decatur Health & Rehab Center	2326 Morgan Avenue Southwest Decatur, AL 35603

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 20304 Based on observation, interview, and the United States (U.S.) Food and Drug Administration (FDA) 2022 Food Code; the facility failed to ensure the Tilt Skillet and the Double Steamer were in working order and had not been inoperable for over a year. In addition, there was an operation issue with the two Stove Ovens. This had the potential to affect 100 of 100 residents receiving meals from the facility's kitchen. Findings include: The U.S. FDA 2022 Food Code included the following: . 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair . During the initial kitchen tour on 01/27/2025 at 5:51 PM, the Dietary Manager revealed the Tilt Skillet had been out of order for about four years and it was currently being used as a countertop. The Double Steamer was also found to be out of order. The Dietary Manager said it had stopped working in 2023. At 6:14 PM, the Dietary Manager said the two Stove Ovens (below the Stovetop and Griddle) can work, but the pilot lights go out when the doors are shut. The Maintenance Director was interviewed on 01/29/2025 at 3:32 PM. When asked about the Tilt Skillet, the Maintenance Director said the previous company owning the facility was told it was going to be cheaper to replace it than to fix it. The Maintenance Director further said the new company owning the facility just had a guy come in to look at it (Tilt Skillet) and he told them the same thing, it was going to be cheaper to replace than to fix. The Maintenance Director was unsure how long the Tilt Skillet had been broken, but he knew it had been more than a year. The Maintenance Director said the Double Steamer was in the same category as the Tilt Skillet. He said the problem was water dripping down from the Steamer's tank onto the gas flames beneath. The Maintenance Director further said the repair person brought in today by the new company owner had said it would be best to get a new one (Double Steamer). The Maintenance Director said he had been asked several times to light the pilots of the Stove Ovens, but the ovens work fine. The Maintenance Director said staff was using fans to dry the floor quickly and that would blow out the oven pilot lights. The Maintenance Director said he reported major equipment issues to the corporate office for a decision, because of the money involved. The Maintenance Director further said the change in management meant some things had fallen through the cracks. When asked the problem with having broken, major cooking equipment unrepaired for long periods of time, the Maintenance Director said cooking could be delayed, by having back-up equipment the risk was less. If there were two pieces of equipment and one went down, they would have a back-up. If both went down, they would have a problem. The Dietary Manager was interviewed on 01/29/2025 at 4:13 PM. When asked the problem with having broken, major cooking equipment going unrepaired for long periods of time, the Dietary Manager said they would not have anything to cook off of if other equipment went down. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015206	A. Building B. Wing	02/03/2025

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Registered Dietitian (RD) was interviewed on 01/29/2025 at 4:24 PM. When asked the problem with having broken, major cooking equipment going unrepaired for long periods of time, the RD said inadequate equipment for preparing food for the residents.