

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2025
NAME OF PROVIDER OR SUPPLIER Birmingham Nursing and Rehabilitation Ctr LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Dugan Avenue Birmingham, AL 35214	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, review of a facility policy titled MEDICATION ADMINISTRATION - GENERAL GUIDELINES, review of the RESIDENT BILL OF RIGHTS and review of a Facility Reported Incident (FRI) received by the State Agency, the facility failed to protect Resident Identifier (RI) #1's right to refuse care and treatment on 09/19/2025 when Licensed Practical Nurse (LPN) #5 administered medication to RI #1 and placed his hand over RI #1's mouth and pinched RI #1's nose to prevent RI #1 from spitting out the medication, which was physically and mentally abusive to RI #1. The Certified Nursing Assistant (CNA) witness said, LPN #5 told RI #1 he/she was going to take the medications, and RI #1's face turned red as RI #1 struggled and pushed his/her head from side to side in response to LPN #5's force. Interview with other staff revealed a resident could aspirate when someone placed their hand over a resident's mouth to prevent the resident from spitting out medication. LPN #5 was suspended but returned to work on 09/24/2025 and continued to work in the facility without direct monitoring or oversight until 10/23/2025 during the survey. It was determined the facility's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.10 Resident Rights. On 10/24/2025 at 2:10 PM the Administrator (ADM), the Director of Nursing (DON), the [NAME] President (VP) of Operations and the Clinical Operations Nurse were provided a copy of the IJ template and notified of the findings of immediate jeopardy in the area of Resident Rights at F578-Request/Refuse/Discontinue Treatment; Formulate Advance Directive. The IJ began on 09/19/2025 and continued until 10/28/2025 when the facility implemented corrective action to remove the immediacy. On 10/29/2025 the immediate jeopardy was removed, F578 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 deficient practice affected RI #1, had the potential to affect all residents receiving medications from LPN #5, and was cited as the result of the investigation of complaint/report number 2623504. Findings Include: Cross Reference F600, F607, F609, F835 and F837. Review of a facility policy titled MEDICATION ADMINISTRATION - GENERAL GUIDELINES, dated 01/2015, revealed the following: POLICY: Medications are administered as prescribed, in accordance with good nursing principles and practices . RESPONSIBILITY: All Licensed Nursing Personnel/CMT (Certified Medication Technician) PROCEDURE: . 14. If a dose of regularly scheduled medication is . refused, . the space provided on the front MAR (Medication Administration Record) . for that dosage administration is initialed and circled . If several doses of a vital medication are . refused, the physician and responsible party are notified and documentation of this notification is made in the nursing notes . Review of the RESIDENT BILL OF RIGHTS, dated 11/2017, revealed the following: Each resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the Facility in a manner and in an environment that promotes maintenance or enhancement to (his/her) quality of life, regardless of diagnosis, severity of condition or payment source and to exercise those rights of the United States without interference, coercion, including those rights specified herein. A. Facility residents shall have the right to: . 6. Request, reuse and/or discontinue treatment. Any refusal and its reason shall be documented in the resident's medical record . 37. The right to be free from abuse . RI #1 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include Acute Respiratory Failure with Hypoxia, Dementia, Wheezing, Cerebrovascular Disease and Pain. RI #1's Quarterly Minimum Data Set assessment, with an Assessment Reference Date of 09/15/2025 documented a Brief Interview for Mental Status (BIMS) score of three indicating severely impaired cognition. RI #1 was also coded as not exhibiting any behaviors of resisting care during this assessment period. On 09/19/2025 at 12:41 AM an allegation involving abuse - mistreatment of RI #1, perpetrated by LPN #5, was received by the State Agency's Online Incident Reporting System; the alleged CNA #8 saw LPN #5, while administering medications to RI #1, use a paper towel to pinch RI #1's nose to ensure RI #1 would swallow medications; the report indicated an in-service was immediately started on the proper way to administer medications and all staff would be in-serviced on intervening if they observed a resident being mistreated. On 10/21/2025 at 2:54 PM CNA #8 said on 09/19/2025 LPN #5 was in RI #1's room to give RI #1 medications. CNA #8 said LPN #5 asked her (CNA #8) to go in the bathroom and get a paper towel and then told her to close the door . CNA #8 said she went to the</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, review of a facility policy titled ABUSE PREVENTION, review of a Facility Reported Incident (FRI) received by the State Agency, and review of a facility investigative file, the facility failed to ensure residents in the facility were free from physical and mental abuse perpetrated by staff. Specifically: The facility failed to ensure Resident Identifier (RI) #1 was free from abuse perpetrated by Licensed Practical Nurse (LPN) #5 on 09/19/2025 at approximately 8:45 AM when Certified Nursing Assistant (CNA) #8 witnessed LPN #5 physically abuse RI #1 when he placed his hand and a paper towel over RI #1's mouth and he pinched RI #1's nose, while telling RI #1 they were going to take medication. CNA #8 witnessed RI #1's face turning red as RI #1 struggled, pushing his/her head from side to side, while LPN #5 covered RI #1's nose and mouth to prevent RI #1 from spitting out morning medications. CNA #8 failed to protect RI #1 when she left the room, leaving RI #1 alone with LPN #5 at the time of the abuse. CNA #8 failed to report the abuse to anyone immediately and LPN #5 continued working his scheduled shift on 09/19/2025, until after 11:00 AM when administration was made aware. LPN #5 was suspended on 09/19/2025, but because facility administration failed to identify the incident as abuse and take appropriate corrective action to protect residents, LPN #5 returned to work on 09/24/2025 and continued to be employed at the facility. The facility was not monitoring or supervising LPN #5. LPN #5 was observed during the survey on 10/21/2025 administering medications to vulnerable residents who were at risk of being abused by LPN #5. Staff who were familiar with RI #1 said RI #1 could have aspirated on the medications and LPN #5's actions were physically, emotionally, and psychologically abusive. RI #1's responsible party said having a hand placed over RI #1's mouth would have made RI #1 feel very fearful. It was determined the facility's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect and Exploitation. On 10/24/2025 at 2:10 PM the Administrator (ADM), the Director of Nursing (DON), the [NAME] President (VP) of Operations and the Clinical Operations Nurse were provided a copy of the IJ template and notified of the findings of substandard quality of care at the level of immediate jeopardy in the area of Freedom from Abuse, Neglect, and Exploitation at F600- Free from Abuse and Neglect. The IJ began on 09/19/2025 and continued until 10/28/2025 when the facility implemented corrective action to remove the immediacy. On 10/29/2025 the immediate jeopardy was removed, F600 was lowered to the severity level of no actual harm with a potential for more than minimal harm level 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 deficient practice affected RI #1, one of four residents sampled for abuse and was cited as the result of the investigation of complaint/report number 2623504. Finding Include:</p> <p>Cross-Reference F578, F607, F609, F835 and F837.</p> <p>Review of a facility policy titled, ABUSE PREVENTION, dated 01/2025 revealed the following:</p> <p>POLICY: The facility is committed to protecting the resident from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our resident, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual.</p> <p>DEFINITIONS:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>a) Abuse: Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish . Abuse may be resident-to-resident, staff-to-resident, family-to-resident, or visitor-to-resident .</p> <p>d) Physical Abuse: This includes but is not limited to hitting, slapping, punching and kicking .</p> <p>e) Mental Abuse: The use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear . agitation .</p> <p>j) Mistreatment means inappropriate treatment . of a resident .</p> <p>1) RI #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Acute Respiratory Failure with Hypoxia, Dementia, Unspecified Severity, without Behavioral Disturbance, Wheezing, Cerebrovascular Disease and Pain.</p> <p>Review of RI #1's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 09/15/2025 revealed RI #1 scored a 3 on the Brief Interview for Mental Status (BIMS) indicating RI #1 had severely impaired cognition. RI #1 was also coded as having no behaviors of resisting care during this assessment period.</p> <p>On 09/19/2024 at 12:41 PM an allegation involving Abuse &ndash; Mistreatment of RI #1, perpetrated by LPN #5, was received by the State Agency's Online Incident Reporting System. The report revealed CNA #8 alleged she saw LPN #5, while administering medications to RI #1, use a paper towel to pinch RI #1's nose to ensure RI #1 would swallow his/her medications. CNA #8 reported that RI #1 seemed mad. An in-service was immediately started on the proper way to administer medications. The report stated all staff would be in-serviced on intervening if they observed a resident being mistreated and timely reporting of the incident.</p> <p>Contained within the facility's investigative file was a handwritten statement, dated 09/19/2025, which was written and signed by CNA #8 and documented the following:</p> <p>I was in (number of RI #1's room) (name of LPN #5) was given (giving) meds . he told me to hand him a paper towel and close the door I didnt (didn't) close the door all the way because I was like Why So he took the paper towel and Placed it over (his/her) nose and pinched (his/her) nose (he/she) was turning Red he did that so (he/she) could swallow (his/her) meds thats (that is) what he was saying as I walking out the room .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/21/2025 at 2:54 PM an interview was conducted with CNA #8. When asked why she wrote the statement, CNA #8 said she told LPN #5 that morning RI #1 was wheezing really bad and LPN #5 said he would get to it. CNA #8 said she preceded to go to do her other rooms and when she went back to RI #1's room LPN #5 was in the room with RI #1's medications on the bedside table. CNA #8 said LPN #5 asked her to go in the bathroom and get a paper towel and told her to close the door. CNA #8 said she went to the bathroom, got a paper towel and handed LPN #5 the paper towel. CNA #8 said as she was turning around to go back to the bedside, she heard LPN #5 talking to RI #1 and telling RI #1 he/she was going to swallow the medications. CNA #8 said LPN #5 had the paper towel over RI #1's nose with his right hand and he had his other hand under RI #1's chin as if he was attempting to keep RI #1 from opening his/her mouth. CNA #8 said LPN #5 was pinching RI #1's nose, and RI #1 was turning red and turning his/her head from side to side. CNA #8 said she was panicking because of what she saw and left the room. CNA #8 said she went and told LPN #10 what she observed, and LPN #10 said she did not see it and did not want to be a part of it. When asked why she left LPN #5 in the room after she observed him do what she said, CNA #8 said she needed to tell someone because what LPN #5 did was not right. CNA #8 said LPN #5's actions of trying to make RI #1 swallow his/her medications would be considered abusive.</p> <p>On 10/22/2024 at 11:28 AM an interview was conducted with LPN #10. LPN #10 said on 09/19/2025, CNA #8 did come to the room where she was providing care for another resident and said she had to tell her something. LPN #10 said when she informed CNA #8 she was with another resident, CNA #8 walked out of the room.</p> <p>Contained within the facility's investigative file was a typed Witness Statement dated 09/23/2025 which was signed by CNA #11 which revealed the following:</p> <p>. Q: Did she (CNA #8) talk to you about seeing a nurse give medications that she was concerned about?</p> <p>A: Yes</p> <p>Q: What time was that?</p> <p>A: Before lunch, morning [morning] time .</p> <p>On 10/22/2025 at 8:53 AM a telephone interview was conducted with CNA #11. CNA #11 said she was doing her orientation with CNA #8 on 09/19/2025. CNA #11 said while she and CNA #8 were in RI #1's room, CNA #8 told her to stay in the room with RI #1 because she had to go and report something. When asked what CNA #8 said she was going to report, CNA #11 said about how the nurse (LPN #5) gave the resident (RI #1) the medicine. CNA #11 said CNA #8 said LPN #5 basically pinched RI #1's nose and tried to force RI #1 to take the medicine. CNA #11 said she thought this occurred before breakfast. CNA #11 said she was never in the room with LPN #5, and she believe as she and CNA #8 were going into the room LPN #5 was leaving out. CNA #11 said when they went in the room, RI #1 was in bed, and she observed RI #1's face to be red.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/21/2025 at 3:51 PM an interview was conducted with LPN #5. When asked what happened when he went in RI #1's room on the morning of 09/19/2025, LPN #5 said he went in RI #1's room to give RI #1 a breathing treatment because CNA #8 told him RI #1 was wheezing. LPN #5 said after RI #1 got the breathing treatment he gave RI #1 the morning medication. LPN #5 said he put the medication (Gabapentin) in RI #1's mouth, and RI #1 pursed his/her lips like he/she was going to spit the medication out. LPN #5 said he put his right hand over RI #1's mouth and started saying no, no, no, no because it looked like RI #1 was going to spit the medication out. LPN #5 said CNA #8 was in the room when this occurred. LPN #5 said as a nurse he should have allowed RI #1 to spit the medication out because that was his/her right. When asked when he placed his hand over RI #1's mouth what his actions could have been perceived as, LPN #5 said many negative things, like he was squeezing RI #1's face. LPN #5 said after he did what he did, he was sent home immediately and when he returned to work, he had a one-on-one in-service with the DON. LPN #5 said he also did an in-service in the computer about what he did could have been perceived as abuse. LPN #5 said he was not allowed to pass medications to RI #1 but could still pass medications to other residents. When asked was anyone monitoring him pass medications, LPN #5 said no.</p> <p>A review of RI #1's eMAR revealed on 9/19/2025 RI #1 received two puffs of Albuterol-Budesonide Inhalation at approximately 8:47 AM.</p> <p>On review of RI #5's Time and Attendance - Employee Punch History, LPN #5 was suspended and left the facility at 12:10 PM on 09/19/2025.</p> <p>Review of LPN #5's CATEGORY ONE VIOLATION EMPLOYEE CORRECTIVE COUNSELING MEMORANDUM form, dated and signed by LPN #5, the DON and the ADM on 09/23/2025, revealed LPN #5 was to return to work effective 09/24/2025 after one on one education described below:</p> <p>. 3. Supervisor: Describe the specific standards that must be met directly from Company, Employee Handbook, Collective Bargaining Agreement, etc. Employee must follow facility policy and nursing standard of practice for Medication Administration. Employee is to complete one:one education with the DNS (Director of Nursing Services) on 9/24/25 on Facility Abuse Policy and Medication Administration General and Narcotic and Resident Rights. The employee will also complete Relias Modules on Abuse, Dementia, Residents Rights, and Medication Administration with the DNS before being allowed to work the unit .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/23/2025 at 11:55 AM an interview was conducted with the DON. When asked what time on 09/19/2025 was she made aware an allegation was being made against LPN #5, the DON said CNA #8 came to her about 11:20 AM while she was in the dining room. The DON said CNA #8 said she needed to talk to her, and they went into the DON's office. The DON said CNA #8 said she had witnessed LPN #5 doing something he should not have done. The DON said CNA #8 said LPN #5 asked her to close the door to RI #1's room and get a napkin out of the bathroom. The DON said CNA #8 said she went to the bathroom, got the napkin and took the napkin to LPN #5 and he placed it over RI #1's nose, pinched his/her nose, and placed his other hand over RI #1's mouth and told RI #1 to not spit, but swallow the medication. The DON said CNA #8 said when she observed this she left out of the room. The DON said LPN #5 did say he asked CNA #8 to shut the door for privacy. The DON said LPN #5 did say RI #1 was trying to spit his/her medicine out and that he knelt down, and asked RI #1 to take the medication. The DON said LPN #5 said he gently tapped RI #1's mouth and told RI #1 to please not spit out the medicine. The DON said she told LPN #5 since he admitted to tapping RI #1's mouth that she had to call the police, and they did come to get a report. The DON said when a resident refuses their medication or attempt to spit the medication out the nurse needs to chart the resident refused the medication. When asked why LPN #5 was given a Corrective Counseling, the DON said LPN #5 did not follow the standard of practice for medication policy. The DON said RI #1 had the right to refuse, and nurses should not place their hand on a resident's mouth. The DON said when a nurse places their hand on a resident's mouth to get them to take their medication that would be an improper way to give medications. The DON said if staff observe a nurse doing this, the first thing they should do is make sure the resident was safe and get some help, by asking the person to leave the room or yell for help.</p> <p>On 10/22/2025 at 4:24 PM an interview was conducted with the Registered Nurse (RN) Unit Manager (UM) #15, the RN UM on the unit RI #1 resides on. When asked when she became aware of an allegation that LPN #5 put a paper towel over RI #1's nose and pinched it to make RI #1 swallow his/her medications on 09/19/2025, the RN UM said she was made aware when she was asked to count the cart LPN #5 worked on because LPN #5 was being sent home. The RN UM said if a resident refuses their medications or attempts to spit the medication out, the nurse should let the resident spit the medication out. The RN UM said it would be important to not force a resident to take their medications because they could aspirate. The RN UM said forcing a resident to take their medications could be perceived as abuse.</p> <p>On 10/24/2025 at 11:49 AM a follow-up interview was conducted with the DON. The DON said a nurse should never place their hand over a resident's mouth to get the resident to take their medication. When asked since LPN #5's return to work how he was being monitored to ensure he is not placing his hands over resident's mouths to make sure they take or do not spit out their medications, the DON said LPN #5 was not being monitored for that. The DON said one-on-one was done with LPN #5 when he returned to work and LPN #5 knows not to ever place his hand over a resident's mouth again. The DON said LPN #5 was no longer allowed to administer medications to RI #1. When asked what RI #1's cognition was, the DON said RI #1 had Dementia. When asked how the facility was ensuring other residents with Dementia who were receiving medication from LPN #5 were not being mistreated, by LPN #5 placing his hand over their mouths to get them to take or not spit out their medications, the DON said they were not. The DON said no one was observing LPN #5 administer medications to residents.</p> <p>On 10/21/2025 at 4:40 PM the surveyor observed LPN #5 administer medications to RI #15. There was no staff observing/monitoring LPN #5 during the medication pass administration.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/22/2025 at 5:26 PM an interview was conducted with LPN #12. When asked had RI #1 ever refused to take his/her medication, LPN #12 said there had been times when RI #1 would say no. LPN #12 said she would leave and come back, and RI #1 would say OK and take his/her medication. LPN #12 said when a resident refuses to swallow their medication tell them OK. When asked what it would be considered if a resident is forced to swallow their medications, LPN #12 said resident abuse. LPN #12 said a nurse should never place their hands over a resident's mouth to prevent the resident from spitting out their medication</p> <p>On 10/23/2025 at 8:03 AM a telephone interview was conducted with LPN #13. When asked what it would be considered if a resident is forced in any way to swallow their medications, LPN #13 said abuse. LPN #13 said it would never be appropriate for a nurse to place their hands over a resident's mouth to get them to swallow their medications.</p> <p>On 10/23/2025 at 3:20 PM an interview was conducted with the ADM. When asked what time on 09/19/2025 she was made aware that an allegation had been made against LPN #5, the ADM said it was after 11 AM. The ADM said CNA #8 said LPN #5 put his hand over RI #1's mouth to make RI #1 take his/her medication. The ADM said she and the DON immediately discussed what needed to be done like calling the police, notifying the Medical Doctor, the residents Responsible Party (RP), completing a body audit for the resident, looking to see if the resident had any physical or emotional changes, taking statements from both parties, and placing both parties on administrative leave. The ADM said while that was being done, she did the reportable. The ADM said the incident was reported as an allegation of abuse &ndash; mistreatment. When asked why the allegation was not substantiated, the ADM said it was not abuse. The ADM said LPN #5 admitted to placing his hands on the resident's lips without force. The ADM said although she thought it was inappropriate to place your hands on a resident mouth it did not rise to the level of abuse. The ADM said there no intent to harm the resident and the resident was not harmed. When asked should RI #1 had been treated that way, the ADM said no it was an inappropriate medication administration. The ADM said the concern of a nurse placing their hand over a resident's mouth to keep them from spitting the medication out was that it was an improper way to administer medications. The ADM said the resident has a right to refuse to take their medications. The ADM said LPN #5 should have allowed RI #1 to spit out the medication.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Birmingham Nursing and Rehabilitation Ctr LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Dugan Avenue Birmingham, AL 35214	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/24/2025 at 5:25 PM an interview was conducted with the VP of Operations. The VP of Operations said she was made aware of the reportable where LPN #5 placed his hand over RI #1's mouth the day the incident occurred. The VP of Operations said the ADM called and informed her of this. The VP of Operations said she told the ADM to go ahead and suspend per policy, start the investigation and get statements from all staff involved on the shift who could have possibly heard anything regarding the allegation. When asked what input did she give on whether to substantiate or unsubstantiate the allegation, the VP of Operations said the ADM felt since LPN #5 did not have any intent to harm RI #1, he was only trying to ensure that RI #1 swallowed his/her pain medication, and LPN #5 freely admitted to what he did was the rationale for not substantiating. The VP of Operations said she was told that RI #5 placed his hand over RI #1's mouth without force and was saying swallow your medicine, RI #1 was not in any distress at the time, RI #1 had no injury, was the facility's basis for not substantiating the allegation. When asked was she a part of the decision to allow LPN #5 to continue to pass medications with no monitoring or over site, the VP of Operations said she was told by the ADM that LPN #5 had been reeducated on medication administration, he understood the resident had the right to refuse to take the medication and LPN #5 said that he would let the resident spit the medication out from now on. The VP of operations said she and the ADM did not talk about LPN #5 being allowed to continue to pass medications without oversight. When asked how she thought it would make a reasonable feel to have someone put their hands over their mouth to prevent them from spitting out their medications, the VP of Operations said she did not think a reasonable person would like that. The VP of Operations said when LPN #5 placed his hand over RI #1's mouth she could see how that could be perceived as mistreatment of the resident. When asked did mistreatment fall under the definitions of abuse, the VP of Operations said it did. When asked did LPN #5 deliberately place his hand over RI #1's mouth to prevent RI #1 from spitting out his/her medication, the VP of Operations said yes.</p> <p>On 10/25/2025 at 9:55 AM a telephone interview was conducted with RI #1's RP. When asked how she thought it made RI #1 feel to have someone place their hand over RI #1's mouth to prevent RI #1 from spitting out his/her medications, RI #1's RP said it would have made RI #1 feel very fearful.</p> <p>*****</p> <p>On 09/28/2025, the facility submitted the following as their removal plan for the identified Immediate Jeopardy:</p> <p>*****</p> <p>1. Immediate Corrective Action for the Affected Resident</p> <p>RI #1 was immediately assessed for distress and mental abuse by the Director of Nursing (DON) and Unit Manager on 9/19/25 through interview questions. No mental injury was identified by DON. The interview on 9/19/25 revealed resident was smiling and talkative with no signs of any distress or agitation. Body audit was completed on 9/19/25 by Unit Manager and DON, to assess for physical injury. RI #1's body audit (head to toe assessment) determined no physical abuse as evidenced by no unknown redness edema, or discoloration observed. On 10/24/25 another body audit (head to toe assessment) was completed by Wound Nurse to assess for physical injury. Body audit determined no physical abuse as evidenced by no unknown redness edema or discoloration observed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>CNA was suspended from resident care pending investigation on 9/19/25. The CNA was educated by the Administrator on 9/22/25 on types of abuse, to include mistreatment, and reporting. Any type of abuse must be reported immediately to the Abuse Coordinator (Administrator) whose telephone number is posted in the lobby; Administrator is on call 24/7 if not in the facility. Residents cannot be left alone in unsafe situations, stay with resident, intervene, and call for help. 1:1 education was provided to LPN, who on 9/19/25 did not follow up to concerns of LPN #5 placing his hand over RI #1's mouth, to ensure RI #1 swallowed the medication, on 10/24/25 by the Director of Nursing on the need to follow up on concerns that could be considered abuse.</p> <p>CNA was returned to resident care on 9/22/25 after education training completed. On 10/24/25 due to substantiation of abuse of RI #1 by LPN #5, CNA was terminated due to failure to protect RI #1 and failure to immediately report to the abuse coordinator.</p> <p>Abuse education provided to the facility Director of Nursing, Administrator, and [NAME] President of Operations on 10/24/25 at 12:30 pm, per [NAME] President of Clinical Services. This education was to ensure understanding of facility abuse policy, and implementation of policy, including reporting timeliness within 2 hours of the abuse. Also to identify occurrences, patterns and trends that may constitute abuse (such as suspicious bruising of residents, including LPN #5 placing his hand and a paper towel over RI #1's mouth and pinching RI #1's nose in order to prevent RI #1 from spitting out medications) and to determine the direction of the investigation and substantiate abuse (Suspected or substantiated cases of resident abuse, neglect, misappropriation of property, or mistreatment shall be thoroughly investigated, documented, and reported to the physician, families, and/or representative), to provide protection of residents from perpetrators of abuse. (All allegations of abuses, neglect, misappropriation or exploitation against any employee must result in his/her immediate suspension to protect the resident.) [NAME] President of Clinical Operations educated the DON and the Administrator on 10/24/25 to utilize a Supervisor Investigation Checklist Form on any allegation of abuse. This checklist will include: providing protection of the resident, monitoring of aggressor, notification of abuse. The [NAME] President of Operations will use this checklist to ensure oversight of each allegation of abuse is completed accurately and to achieve correct outcome after thorough investigation. If any concerns with the checklist are found by the [NAME] President of Operations, the [NAME] President of Operations will guide the facility Administrator on how to implement the abuse policy to identify abuse and protect residents from perpetrators of abuse.</p> <p>On 10/1/25 an employer report was completed to the Alabama Board of Nursing (ABON) to include counseling and disciplinary action regarding improper medication administration to RI #1. On 10/14/25 subpoena received from the ABON for entire investigation related to RI #1, to include written reports of counseling, warnings, disciplinary actions, termination notice, job description, employment application, recent performance appraisal, orientation checklist, verification of employment, medication dispensing reports related to complaint, reports of adverse incidents/ occurrences, and any other reports that are pertinent to the license of LPN #5's practice of nursing. This information was sent to the ABON on 10/20/2025. Resignation of LPN #5 was accepted on 10/24/25.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident complaint/mistreatment poll for 29 residents was completed 9/19/25 on the unit LPN #5 worked, this was completed by Social Services. This poll was completed to determine if other residents had concerns or issues with medication administration by LPN #5 placing his hand over the residents mouth to get the resident to swallow their medication. This poll was obtained through interviews. Then on 9/22/25 Administrator completed complaint/mistreatment poll on 111 residents in facility to determine if any resident in the facility had issues or concerns from mistreatment or any nurse placing their hands over the resident's mouth to force resident to swallow medication. This poll was obtained through 1 on 1 interviews with residents. A new complaint/mistreatment poll was conducted by Director of Nursing on 10/24/25, this poll was obtained through resident interview for 109 residents to determine mistreatment. Nine residents who were unable to communicate were assessed by body audits (head to toe assessment) these audits determined no evidence of physical abuse as evidence by no unknown redness edema, or discoloration observed. The body audits were completed by Nurse Managers on 10/24/25.</p> <p>To protect RI #1s right's to refuse care and treatment, on 10/25/25 RI #1's plan of care for medication administration was reviewed and revised by IDT (MDS Nurse and Social Services) and family member. Interventions in place starting 08/21/2025: may crush meds and add in applesauce, yogurt or pudding. The facility added a new intervention on 10/25/25: may use sweets as positive reinforcement to take medications, and when administering medications allow ample time to swallow medications. Licensed Nursing Staff notified of care plan revisions on 10/25/25 via 24 hour nursing report that remains on the nursing unit.</p> <p>2. Identification of Other Residents Who Could Be Affected</p> <p>No other residents were identified as affected or at risk for abuse, mistreatment or right to refused care and treatment. This was determined through complaint/mistreatment poll that was conducted by Director of Nursing on 10/24/25, this poll was obtained through resident interview for 109 residents. Nine residents who were unable to communicate were assessed by body audit (head to toe assessment). These audits determined no evidence of physical abuse as evidence by no unknown redness, edema, or discoloration observed. The body audits were completed by Nurse Managers on 10/24/25.</p> <p>Ninety eight residents were educated of their right to refuse medications and treatments through handouts of Resident's Rights by Social Services and Business Office Staff on 10/24/25. Residents acknowledged they understood their Rights to include refusal of medication by signing Resident's Rights form. Facility notified family members of 14 residents that are unable to communicate and discussed resident's right to refuse medication on 10/24/25 by Social Services. If Social Services were unable to contact a family member by phone, a copy of Resident's Rights were sent via certified mail on 10/25/24 to 6 family members of residents.</p> <p>3. Systemic Changes to Prevent Recurrence</p> <p>Education was provided to 36 licensed nurses (27 in person, 9 via telephone) on the Medication Administration Policy, resident's right to refuse medication, and staff follow-up after receiving resident information that could be considered abuse which included placing a hand and a paper towel over residents mouth and pinching residents nose in order to prevent residents from spitting out medications on 10/24/25 by Director of Nursing, Unit Managers and Staff Development Coordinator (SDC).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Abuse Prevention Policy was educated to 140 staff, (80 in person, 60 via telephone) emphasizing that any act of coercion or force (forcefully/making resident take medication against his/her will) is considered abuse. Abuse must be reported immediately to the Abuse Coordinator. Resident cannot be left alone in a potential abuse situation/unsafe situation, stay with resident, intervene, and call for help. This education was completed on 10/25/25, by DON, Unit Managers, and Staff Development Coordinator. One CNA has not completed education, she/he has been removed from the time clock and will not be allowed to work until education is completed.</p> <p>In the event employee cannot get a response from Abuse Coordinator (Administrator) employee will notify Director of Nursing and/or Human Resource Director. This education was completed on 10/25/25, by DON, Unit Managers and SDC. This was education to 140 staff (80 in person, 60 via telephone). No employee will be allowed to work without completion of this education. Telephone numbers of Abuse Coordinator, DON, and Human Resource Director was posted at the time clock.</p> <p>4. Monitoring to Ensure Ongoing Compliance</p> <p>DON and Weekend Supervisor observed 5 nurses pass 5 resident's medication on 10/25/25, to ensure compliance with resident rights and medication administration procedures. No issues or concerns were identified with medication administration or the resident's right to refuse medication (including covering the mouth or pinching the nose to force a resident to take medication).</p> <p>A Quality Assurance Meeting held on 10/24/25 to review F-tag 578, 600, 607, 609, 835, and 837 at scope[</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review and review of a facility policy titled ABUSE PREVENTION, the facility failed to implement their abuse policy and take appropriate actions to protect Resident Identifier (RI) #1 from abuse on 09/19/2025 after Licensed Practical Nurse (LPN) #5 physically and mentally abused RI #1 and LPN #5 was observed during the survey on 10/21/2025 continuing to administer medications to residents, placing residents at risk of being abused by LPN #5. Certified Nursing Assistant (CNA) #8 who witnessed LPN #5 abuse RI #1 on 09/19/2025 at approximately 8:47 AM failed to ensure RI #1 was protected from LPN #5 after he placed his hand over RI #1's nose and mouth to force RI #1 to swallow medications, placing RI #1 at risk of aspiration of the medications and being fearful. CNA #8 left RI #1's room leaving RI #1 alone with LPN #5. RI #1's roommate was also on the other side of the room with the curtain pulled. CNA #8 failed to report the abuse to anyone until 11:20 AM while LPN #5 continued to work his shift. Although LPN #5 was suspended, the facility failed to identify and substantiate abuse during their investigation and failed to take action to protect residents and remove LPN #5 from access to residents in the facility and instead, the facility allowed LPN #5 to continue employment and have access to residents at the facility until 10/23/2025 during the survey. It was determined the facility's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect and Exploitation. On 10/24/2025 at 2:10 PM the Administrator (ADM), the Director of Nursing (DON), the [NAME] President (VP) of Operations and the Clinical Operations Nurse were provided a copy of the IJ template and notified of the findings of substandard quality of care at the level of immediate jeopardy in the area of Freedom from Abuse, Neglect, and Exploitation at F607-Develop/Implement Abuse/Neglect, etc. Policies. The IJ began on 09/19/2025 and continued until 10/28/2025 when the facility implemented corrective action to remove the immediacy. On 10/29/2025 the immediate jeopardy was removed, F607 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 deficient practice affected RI #1, one of four residents sampled for abuse and was cited as a result of the investigation of complaint/report number 2623504. Findings Include: Cross Reference F 578, F600, F609, F835 and F837. A facility policy titled ABUSE PREVENTION dated 01/2025, documented the following: POLICY: The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, .DEFINITIONS:a) Abuse: Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.d) Physical Abuse: This includes but is not limited to hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.e) Mental Abuse: The use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation .j) Mistreatment means inappropriate treatment or exploitation of a resident. PROCEDURE:A. STEPS TO PREVENT, DETECT AND REPORT: .PREVENTION:1. Staff members, volunteers, family members and others shall be encouraged to report incidents of abuse. When an incident of resident abuse is suspected or determined, such incident must be reported to facility management regardless of the time lapse since the incident occurred.IDENTIFICATION:1. Identify events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation .PROTECTION:1. Any allegation of abuses, neglect, misappropriation or exploitation against any employee must result in his/her immediate suspension to protect the resident.3. It is the responsibility of all staff to provide a safe environment for the residents. Resident care and treatments shall be monitored by all staff, on an ongoing basis, so that residents are free from abuse, neglect, or mistreatment. Care will be monitored so that the resident's care plan is followed.On 09/19/2024 at 12:41 PM the State Agency received a FRI alleging Abuse and Mistreatment after CNA #8 reported having witnessed LPN #5 use a paper towel to pinch RI #1's nose to ensure RI #1 would swallow medications; CNA #8 reported RI #1 was mad; the administrator was made aware at 11:24 AM; the facility started in-service on the proper way to administer medications and on intervention for mistreatment of residents, and timely reporting.RI #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Acute Respiratory Failure with Hypoxia, Dementia, Wheezing, Cerebrovascular Disease, Seizures and Pain</p>

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and review of a facility policy titled ABUSE PREVENTION, the facility failed to ensure Certified Nursing Assistant (CNA) #8 immediately reported abuse she observed when Licensed Practical Nurse (LPN) #5 placed his hands over RI #1's mouth and nose to prevent RI #1 from spitting out medication on 09/19/2025 at approximately 8:47 AM, placing RI #1 at risk of aspirating the medications and being fearful, as RI #1 struggled, pushing his/her head from side to side and turning red in the face. CNA #8 said she tried to tell LPN #10, but LPN #10 did not want to be involved. CNA #8 failed to understand the importance of reporting immediately to facility administration about abuse she observed and instead waited until 11:20 AM to report to the Director of Nursing (DON), while LPN #5 continued working his shift. The abuse was not reported to the State Agency until 12:41 PM on 09/19/2025. LPN #5 was suspended but returned to work on 09/24/2025 and continued to work in the facility without direct monitoring or oversight until 10/23/2025 during the survey. The IJ began on 09/19/2025 and continued until 10/28/2025 when the facility implemented corrective action to remove the immediacy. On 10/29/2025 the immediate jeopardy was removed, F609 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 deficient practice affected RI #1, one of four residents sampled for abuse. This deficiency was cited as the result of the investigation of complaint/report number 2623504. Findings Include: Review of a facility policy titled, ABUSE PREVENTION, dated 01/2025, revealed the following: POLICY: The facility is committed to protecting the residents from abuse by anyone including, but not necessarily to: facility staff, other residents. DEFINITIONS: a) Abuse: Willful infliction of injury. d) Physical Abuse: This includes but is not limited to hitting, slapping, pinching and kicking. e) Mental Abuse: The use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear. PROCEDURE: A. STEPS TO PREVENT, DETECT AND REPORT: . REPORTING: . Alleged violations involving abuse, neglect, exploitation or mistreatment, including injures of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made. to the administrator of other officials. RI #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Acute Respiratory Failure with Hypoxia, Dementia, Unspecified Severity, without Behavioral Disturbance, Wheezing, Cerebrovascular Disease and Pain. Review of RI #1's Quarterly Minimum Data Set assessment, with an Assessment Reference Date of 09/15/2025 revealed RI #1 scored a three on the Brief Interview for Mental Status indicating RI #1 had severely impaired cognition. On 09/19/2024 at 12:41 PM an allegation involving Abuse - Mistreatment of RI #1, perpetrated by LPN #5, was received by the State Agency's Online Incident Reporting System. The report revealed CNA #8 observed LPN # 5 the morning of 09/19/2024 administering medications to RI #1 and used a paper towel to pinch RI #1's nose to ensure RI #1 would swallow the medication; the incident was reported to the ADM at 11:24 AM; and all staff would be in-serviced on intervening if they observed a resident being mistreated and timely reporting of the incident. On 10/21/2025 at 2:54 PM an interview was conducted with CNA #8 regarding the incident on 09/19/2024. CNA #8 said while assisting residents with care that morning, LPN #5 was passing medications; LPN #5 was in RI #1's room and asked CNA #8 to go in the bathroom and get a paper towel and to close the door. CNA #8 said she went to the bathroom, got a paper towel and gave it to LPN #5; as she was leaving the room, CNA #8 heard LPN #5 telling RI #1 he/she was going to swallow the medications. CNA #8 said LPN #5 had the paper towel over RI #1's nose with his right hand and he had his other hand under RI #1's chin as if he was attempting to keep RI #1 from opening his/her mouth. CNA #8 said she was panicking because of what she saw and left the room. CNA #8 said she went and told LPN #10 what she observed, and LPN #10 said she did not see it and did not want to be a part of it. CNA #8 said, she then walked down the hall to report the incident to the DON and she was in a meeting, so she did not actually report it to administration until she told the DON at 11:20 AM. Contained within the facility's investigative file was a typed Witness Statement dated 09/23/2025 signed by CNA #11 which revealed the following: . Q: Did she (CNA #8) talk to you about seeing a nurse give medications that she was concerned about? A: Yes. Q: What time was that? A: Before lunch, morning [morning] time. . On 10/22/2025 at 8:53 AM a telephone interview was conducted with CNA #11 who CNA #8 had told about the abuse. CNA #11 said she was doing her orientation with CNA #8 on 09/19/2025. CNA #11 said while she</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2025
NAME OF PROVIDER OR SUPPLIER Birmingham Nursing and Rehabilitation Ctr LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Dugan Avenue Birmingham, AL 35214	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Based on interviews, review of the Administrator's (ADM) and Director of Nursing (DON) Job Responsibilities, and review of the facility's ABUSE PREVENTION policy, the facility's ADM and DON failed to provide oversight and guidance to facility staff to ensure the facility's abuse policy was implemented to identify abuse, report suspected abuse, and take corrective actions to protect residents following an incident of abuse. On 09/19/2025 Resident Identifier (RI) #1 was abused by Licensed Practical Nurse (LPN) #5 when LPN #5 placed his hand over RI #1's mouth and pinched RI #1's nose to prevent RI #1 from spitting out medication during medication administration. Two staff reported that RI #1's face was red after the incident. The Certified Nursing Assistant (CNA) who witnessed the incident left RI #1 alone with LPN #5 at the time of the abuse and failed to report immediately. The CNA reported to a nurse who did not act to intervene but instead did not want to be involved. LPN #5 continued working at the facility without any oversight or monitoring and was observed during the survey administering medications on 10/21/2025. Nurses interviewed stated what occurred was abuse and RI #1 was likely to aspirate the medications during the abuse. The facility's administration failed to ensure staff: 1) intervened to protect RI #1 from further potential abuse suspected abuse; 2) reported suspected abuse to the ADM or DON timely; 3) understood the protocol and importance of reporting allegations of abuse immediately (including the CNA witness and the nurse who did not want to be involved); 4) understood the residents' right to refuse treatment. Further, the ADM and DON failed to identify the incident as abuse and develop and implement appropriate corrective actions to ensure RI #1 and other residents were protected when LPN #5 was allowed to return to work and administer medications to residents. The facility did not have a plan to monitor LPN #5 to ensure residents' safety. It was determined the facility's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.70 Administration. On 10/24/2025 at 6:58 PM the Administrator (ADM), the Director of Nursing (DON), the [NAME] President (VP) of Operations and the Clinical Operations Nurse were provided a copy of the IJ template and notified of the findings of immediate jeopardy in the area of Administration at F835-Administration. The IJ began on 09/19/2025 and continued until 10/28/2025 when the facility implemented corrective action to remove the immediacy. On 10/29/2025 the immediate jeopardy was removed, F835 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 deficient practice affected RI #1 and had the potential to affect all residents residing the facility. This deficiency was cited as the result of the investigation of complaint/report number 2623504. Findings Include: Cross-Reference F578, F600, F607, F609 and F837. Review of a facility policy titled, ABUSE PREVENTION, dated 01/2025 revealed the following: POLICY: The facility is committed to protecting the resident from abuse by anyone including, but not necessarily limited to: facility staff, other residents, . DEFINITIONS: a) Abuse: Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish . Abuse may be resident-to-resident, staff-to-resident, . d) Physical Abuse: This includes but is not limited to hitting, slapping, punching and kicking . e) Mental Abuse: The use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear . agitation . j) Mistreatment means inappropriate treatment. of a resident . IDENTIFICATION: . 2. The Executive Director and the Director of Nursing Services must be promptly notified of suspected abuse or incidents of abuse . PROTECTION: 1. Any allegations of abuses, . against any employee must result in his/her immediate suspension to protect the resident . 3. It is the responsibility of all staff to provide a safe environment for the residents. Resident care and treatments shall be monitored by all staff, on an ongoing basis, so that residents are free from abuse . or mistreatment . REPORTING: . Alleged violations involving abuse, . or mistreatment . are reported immediately, but no later than 2 hours after the allegation is made, . to the administrator of the facility and to other officials (including State Survey Agency .) Review of the Executive Director's Job Description, signed and dated by the ADM on 04/03/2020, revealed the following: General Description The Executive Director leads and directs the overall operation of the Facility in accordance with resident needs, government regulations and Facility policies so as to maintain quality care for the residents while achieving the Facility's business objectives . Essential Duties . 13. Demonstrates knowledge of all State Department of Health rules and regulations and provides adequate instruction regarding such rules and regulations to appropriate staff</p>		