STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015408	A. Building B. Wing	11/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walker Rehabilitation Center, Inc	350 Northeast 4th Street Carbon Hill, AL 35549

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39580 48195 47408 44165 Based on interviews, reviews of residents' medical records, review of a facility policy titled ABUSE PREVENTION, review of Facility Reported Incidents (FRIs) received by the State Agency, and review of the facility's investigative files, the facility failed to protect the rights of residents to be free from abuse perpetrated by employees of the facility and by other residents of the facility. Specifically: 1) On [DATE] Resident Identifier (RI) #5 was verbally abused by Certified Nursing Assistant (CNA) #8 when CNA #8 yelled and cursed Damn you . at RI #5 and slammed the bathroom door with RI #5 in the bathroom. RI #5 cried while explaining to staff what happened. On [DATE] RI #98 was verbally and mentally abused by CNA #8 when CNA #8 withheld and refused to provide RI #98 a lunch tray for disciplinary reasons. CNA #8 ensured that RI #98 was served last while others around RI #98 were eating already. CNA #9, CNA #26, and Dietary Manager (DM) #15 witnessed CNA #8 refusing to serve RI #98's meal and failed to intervene to protect RI #98, stop the abuse, and report the abuse immediately. CNA #8 withholding RI #98's meal in the dining room was likely to cause RI #98 to experience humiliation and dehumanization. 2) On [DATE] RI #99 was physically and mentally abused by CNA #9 when CNA #9 hit RI #99 with a package of wipes, held RI #99's arm down between her legs to restrain RI #99's arm, and threatened to break RI #99's arm. CNA #22 witnessed the abuse and did not intervene to protect RI #99 at the time she witnessed the abuse. CNA #22 did not report the abuse to anyone until the next day on [DATE]. Facility staff said, RI #99 was physically and mentally abused and what RI #99 experienced would make someone fearful. 3) On [DATE] RI #20 was physically and mentally abused when CNA #24 roughly and aggressively, jerked, pulled, and picked up RI #20 in the wheelchair, causing RI #20 to be tearful and visibly upset, as witnessed by Dietary Aid (DA) #23. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Incidents of physical, mental, and verbal abuse are likely to result in serious harm especially when perpetrated by staff members in which the residents rely on to provide care. These incidents resulted in residents crying and was likely to result in fear, humiliation, and dehumanization. It was determined the facility's noncompliance with one or more requirements of participation had 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 at F 600-Free from Abuse and Neglect. On [DATE] at 5:12 PM, the Administrator (ADM) and Director of Nursing (DON) 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 Freedom from Abuse, Neglect, and Exploitation at F 600- Free from Abuse and Neglect. The IJ began on [DATE] and continued until [DATE] when the survey team verified onsite that corrective actions had been implemented. On [DATE] the immediate jeopardy was removed, F 600 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. Additional abuse occurrences cited during the survey not rising to the jeopardy level include the following: 4) The facility failed to provide adequate supervision to residents in a dining area to prevent RI #36 from physically abusing RI #8 on [DATE] when RI #36 slapped RI #8 on the shoulder with an open hand. This was witnessed by Registered Nurse (RN) #21 who said, someone in that situation would feel hurt, sad, scared, or maybe mad. 5) The facility failed to ensure RI #6 was not neglected and verbally abused by CNA #27 on [DATE] when CNA #27 yelled at RI #6 to get himself/herself dressed and left RI #6 to dress themselves. CNA #27 was aware that RI #6 was care planned for assistance of one staff for dressing. RI #6 said CNA #27 communicated that way often and it made RI #6 feel humiliated. These deficient practices were cited as a result of the investigation of complaint/report numbers AL00044702, AL00044741, AL00045507, AL00047853, and AL00049753. These deficient practices affected RI #5, RI #98, RI #99, RI #20, RI #8, and RI #6, six of eight residents sampled for abuse. Findings include: A facility policy titled ABUSE PREVENTION, with a revised date of [DATE] documented: . I. PURPOSE To identify actual or potential abuse and process reports to thoroughly investigate, resolve, follow-up and prevent abuse in our facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Abuse definition: the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual including a caretaker, of goods and services that are necessary to attain or maintain physical, mental, and psychosocial wellbeing. Neglect: failure of the facility, its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Verbal abuse the use of oral . or gestured language that willfully includes disparaging or derogatory terms to residents . or that is uttered within the hearing distance of residents or their families, regardless of their age, ability to comprehend, or disability. Physical abuse any willful act directed at a resident that is intended to result in or that is likely to result in injury or pain. Physical abuse includes slapping, . shoving, and corporal punishment of any kind. Mental abuse any willful act directed at a resident that is intended to result in or that is likely to result in mental distress or mental anguish. It includes humiliation, harassment, threats of punishment, and threats of deprivation. II. POLICY Each resident, . has the right to be free from abuse by anyone, in any form . Each resident has the right to be free from physical . restraints imposed for the purpose of discipline or convenience and that are not required to treat the resident's medical symptoms. IV. RESPONSIBILITY 1. Every employee is responsible to recognize and report abuse. 1) On [DATE] the State Agency received an Online Incident Report from the facility alleging verbal abuse occurred on [DATE] when CNA #8 was assisting RI #5 in the bathroom and CNA #8 told RI #5 that she could not lift RI #5 and CNA #8 cussed at RI #5, Damn you ., and slammed the door while RI #5 was still in the bathroom. The report continued that this hurt RI #5 deeply, RI #5 had been crying, and this was verbal, mental, and emotional abuse. The report also included another allegation of verbal and mental abuse that occurred on [DATE] when CNA #8 withheld a lunch tray from RI #98 until all other lunch trays had been passed out to other residents. The report documented RI #98 had asked for his/her tray prior to the other residents receiving their trays, CNA #9 had attempted to give RI #98 a lunch tray, but CNA #8 yelled and told her not to give RI #98 a tray. The facility observed camera footage and found this was true. CNA #8 was suspended pending further investigation. RI #5 was admitted to the facility on [DATE] and most recently readmitted on [DATE]. RI #5 had diagnoses of Hemiplegia and History of Falls. RI #5's Annual Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of [DATE] indicated RI #5 had a Brief Interview for Mental Status (BIMS) score 15 of 15 which indicated RI #5 had intact cognition. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's investigative file contained a handwritten statement dated [DATE] signed by CNA #14 that documented what RI #5 told her as follows: This morning I walk into (RI #5's) room to pick up (his/her) breakfast tray and (he/she) tells me (he/she) had a bad weekend and (he/she) was happy to see me. (He/she) told me (he/she) had asked (CNA #8) for a while to take (him/her) to the bathroom and she acted like she didn't want to so when (he/she) finally gets on the toilet and uses the bathroom (he/she) hit (his/her) call light to have help back in (his/her) chair she walked in and said damn you (RI #5's name) (RI #5) was in tears . explaining this to me said that really hurt me. On [DATE] at 6:18 PM a telephone interview was conducted with CNA #14. She stated that RI #5 told her that CNA #8 had cussed him/her when he/she asked her for help to the bathroom. CNA #14 stated RI #98 was in tears while talking about the incident. CNA #14 stated she told DON #2 and ADM #5 after RI #5 reported it to her. RI #98 was admitted to the facility on [DATE] and was most recently readmitted on [DATE] and had diagnoses to include Dementia and Diabetes Mellitus. RI #98 expired on [DATE]. RI #98's Admission MDS assessment with ARD of [DATE] indicated RI #98's BIMS score was 13 of 15 which indicated RI #98 had intact cognition. The facility's investigative file contained a typed statement signed by the current DON #2 and former ADM #5 that documented: . It was reported to me (DON #2) on [DATE] at 2:00 pm, that (CNA #8) had withheld the lunch tray from resident (RI #98) in the Dining Room on [DATE] until all other lunch trays were passed out. (RI #98) had asked for (his/her) tray prior to the other residents receiving their trays. (CNA #9) attempted to place the tray in front of . (RI #98) and (CNA #8) yelled at her from across the room and told her not to. Another resident was seated at the table with . (RI #98) and had received (his/her) tray and was eating during this occurrence. After observing camera footage from the Dining Room camera, this was in fact the case. This occurrence was found to be substantiated. After obtaining a statement from . (RI #5) and reviewing video footage from the Dining Room camera, both occurrences were found to be substantiated. On [DATE] at 1:15 PM a phone interview was conducted with CNA #8 who stated that residents were supposed to be served their trays at the same time if they were at the same table. When asked about the incident, CNA #8 said RI #98 had acted out and she told RI #98 that he/she had to wait just like everybody else. CNA #8 said she quit after the incident and denied wrong doing because RI #98 was served the meal. On [DATE] at 12:35 PM a phone interview was conducted with CNA #9 who recalled the incident on [DATE] with RI #98. CNA #9 stated that RI #98 said he/she was going to start throwing stuff if he/she did not get his/her tray. CNA #9 stated she attempted to give RI #98's tray to him/her and CNA #8 told her not to give RI #98 the tray. CNA #9 stated she would feel horrible and humiliated if she did not get a tray when everyone else did. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 10:15 AM a telephone interview was conducted with CNA #26. She stated she recalled an incident when RI #98 did not receive his/her meal tray. CNA #26 stated CNA #9 and CNA #8 told her that RI #98 was not getting a tray because of him/her being so demanding. CNA #26 stated RI #98 was at a table with another resident that had his/her meal tray. CNA #26 stated she told CNA #8 and CNA #9 that RI #98 should have a tray. CNA #26 stated that she brought RI #98 back to his/her room after the meal and RI #98 stated CNA #8 and CNA #9 were mean and he/she did not want them to care of him/her anymore. RI #98 further told CNA #26 that he/she was very upset, and it made him/her feel bad the way they treated him/her. CNA #26 stated the way RI #98 was treated by CNA #8 and CNA #9 was abuse. CNA #26 stated that she would have been embarrassed and humiliated to watch other people eating and not have food. She further stated that nobody should be treated that way. On [DATE] at 10:00 AM the former Dietary Manager, DM #15, was interviewed by phone. DM #15 said, she was standing in the kitchen and witnessed CNA #8 and CNA #9 saying RI #98 could not have his/her lunch tray even though RI #98 kept asking for it. DM #15 said, she went to the dining room and RI #98's tray was still not given to RI #98. DM #15 said, RI #98 was very upset when he/she could not have the lunch tray and kept asking why. DM #15 stated, CNA #9 also had every opportunity to grab the tray and give it to RI #98. DM #15 said the incident that occurred when RI #98 was not provided a meal tray while other residents had been provided their meals would make her feel horrible, because it would be belittling and embarrassing and she would feel like she was not good enough to be provided a tray or that she was being punished. DM #15 said CNA #8 should not be able to take care of anyone. On [DATE] at 12:00 PM a phone call was made to the former Administrator, ADM #5, who was the Administrator of the facility at the time of the incidents. ADM #5 said, the video was reviewed for the incident with RI #98. ADM said the video showed that CNA #9 was going to give a tray to RI #98 and CNA #8 told her not to touch that tray. ADM #5 said the incident was substantiated and CNA #8 was terminated. ADM #5 said, RI #98 was neglected, and RI #5 was verbally abused. On [DATE] at 3:01 PM an interview was conducted with the current DON, DON #2, who said the abuse against RI #5 and RI #98 was emotional and verbal. The DON said, if she was in RI #5's position and someone cussed at her it would make her fearful of that person. The DON said, if she was in RI #98's position, it would make her feel like the staff did not like and she would feel fearful. The facility's investigative file also contained a Disciplinary Action form dated [DATE] for CNA #8 that documented CNA #8's termination: . Date of Violation: [DATE] . Employee spoke to resident in the dining Room in a loud and hateful manner and slammed the Bathroom door while loudly cursing another resident. Employee purposefully withheld tray from resident making (him/her) wait until last to be served with another resident eating at the same table. Employee is terminated due to facility . policy . that residents are to be free from any form of abuse. 2) On [DATE] at 11:49 AM the State Agency received an Online Incident Report from the facility alleging physical abuse occurred on [DATE] at 4:30 PM when CNA #22 witnessed CNA #9 being verbally and physically abusive to RI #99. CNA #9 was observed being rough, smacking RI #99 with a package of wipes, and grabbing RI #99's arm, placing it down as far as it would go, between the CNA's knees, and CNA #9 told RI #99 she would break his/her arm. RI #99 was admitted to the facility on [DATE] and had diagnoses to include: Heart Failure, Respiratory Failure, Convulsions, Encephalopathy, Muscle Weakness, Aphasia, and Contracture of the Right Hand. RI #99 expired on [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RI #99's Quarterly MDS assessment with an ARD of [DATE] indicated RI #99 was unable to be assessed using the BIMS assessment because he/she was rarely understood. The MDS indicated RI #99 had both short- and long-term memory impairment. RI #99's Annual MDS with an ARD of [DATE] was reviewed and the MDS did not include a BIMS assessment or assessment of memory. The MDS did indicate RI #99 had not had an acute change in mental status. The facility investigative file contained a handwritten statement dated [DATE] signed by the former DON, DON #17, that documented: . (CNA #22) came to me on [DATE] and reported that (CNA #9) was witnessed [DATE] by her being verbally and physically abusive to . (RI #99). (CNA #22) stated (CNA #9) was being rough with . (RI #99) and smacking (RI #99) with a package of wipes and grabbed (his/her) arm placing it as far down as it would go and put between her knees and told (him/her) if (he/she) kept on she would break (his/her) arm. (CNA #9) was terminated on [DATE] due to allegation of abuse were founded. On [DATE] at 2:44 PM a telephone interview was conducted with CNA #22. She stated she recalled an incident with RI #99 and CNA #9. She stated that CNA #9 was aggressive during care with RI #99 and told RI #99 that if he/she did not stop when RI #99 grabbed at her, she would break RI #99's arm. CNA #22 stated that CNA #9 pulled RI #99's arm down to her knees and although RI #99 was non-verbal CNA #22 could tell that he/she was hurting because RI #99's legs were coming off the bed. CNA #22 stated that CNA #9 hit RI #99 with a full pack of wipes every time RI #99 grabbed at her. The facility investigative file contained a typed statement that documented CNA #9 was terminated on [DATE]. RI #99's nurses notes contained an entry dated [DATE] that documented RI #99 had a purplish bruise on the left outer wrist area and was a little restless. On [DATE] at 12:35 PM CNA #9 was interviewed via phone. CNA #9 said she was no longer employed at the facility because the facility said she beat RI #99 with baby wipes, and they terminated her. CNA #9 said she was terminated the day after the incident occurred after working the remainder of the shift on [DATE] and about half the shift on [DATE]. CNA #9 stated that she admitted to the police that she held RI #99's arm down and hit RI #99 with the package of wipes. On [DATE] at 2:59 PM DON #2 was interviewed. DON #2 said that CNA #22 should have stopped CNA #9 from being abusive to RI #99 and pulled her out of the room and reported immediately to the supervisor. The DON said, CNA #22 did not report the incident until the next day. DON #2 said, the abuse to RI #99 was physical and mental because it could make a resident fearful. 3) On [DATE] the State Agency received an Online Incident Report from the facility alleging physical abuse occurred when CNA #23 witnessed CNA #24 grab and pull RI #20 back in the chair and then roughly pick up RI #20 twice under the arms and pull RI #20 back in the chair and CNA #24 told RI #20 to stay in the chair or she was putting RI #20 to bed. The incident occurred in the hallway beside a dining room. The report documented RI #20 was observed crying. CNA #24 was immediately removed from the area, suspended, and left the premises. RI #20 was readmitted to the facility on [DATE] and had diagnoses to include Alzheimer's Disease, Anxiety, Osteoporosis, Muscle Weakness, and Abnormal Posture. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RI #20's Quarterly MDS assessment with ARD of [DATE] indicated RI #20's BIMS was 13 of 15 which indicated intact cognition. RI #20's Quarterly MDS with ARD of [DATE] indicated RI #20 BIMS was 08 of 15 which indicated impaired cognition. The facility investigative file contained a handwritten statement dated [DATE] signed by Dietary Aid (DA) #23 that documented the abusive behavior CNA #24 perpetrated against RI #20 as follows: I, (DA #23), on Friday [DATE], at approximately . (5:40 PM), witnessed a disturbing incident . I witnessed (CNA #24) and (RI #20) at the end of the hallway. (RI #20) was in (his/her) wheelchair in a leaned over position. (CNA #24) proceeded to place her arms under the armpit area of (RI #20) and aggressively picked (RI #20) up and slammed (him/her) back into the rear of the wheelchair. (RI #20's) feet appeared to leave the floor. (RI #20) was still slightly slouched down in the chair. Again, (CNA #24), while still at this time not removing her arms from (RI #20), again picked (RI #20) up and this time slamming (his/her) bottom into the chair (CNA #24) kept her arms under (RI #20) and pressed aggressively into (his/her) upper arm pit/chest area, it was during this incident while (RI #20) was being picked up I heard (CNA #24) say to (RI #20) in a very threatening manner, stay in this wheelchair! If you can't stay in it, I'm putting you to bed! (CNA #24) then pushed (RI #20) in (his/her) chair against the wall facing the ICU hallway. At this point (CNA #24) walked away and appeared very agitated. I came into the kitchen and immediately began to look for the Administrator, . to report what I had witnessed. As I came out of the kitchen, (RI #20) was still seated in the hallway. I spoke to (him/her) and asked are you ok? (He/she) reached out for my hand and replied, I think (guess) so. I noticed (RI #20) was still visibly upset from the incident because (he/she) had tears swelling up in (his/her) eyes. I continued to (ADM #5's) office walking . I saw (CNA #24) . (going) into the back room and closing the door. The facility investigative file contained a handwritten statement dated [DATE] signed by CNA #24 that documented CNA #24's version of events: I . thought (RI #20) was falling on (his/her) head from a sitting position in (his/her) chair. I grabbed the back of (his/her) shirt to get (him/her) up right again and then . (put) my arms under (his/hers) and pulled (him/her) back in (his/her) chair. And ask (him/her) to stay in (his/her) chair. The facility investigative file contained a typed statement titled with CNA #24's name dated [DATE] signed by DON #2 that documented a summary of the abuse and video footage viewed by the facility to include: On [DATE], I received a call . stating that it had been reported to (ADM #5) by a staff member that (CNA #24) had been seen grabbing . (RI #20) by the back of (his/her) shirt and jerking (him/her) back in (his/her) wheelchair. (CNA #24) then proceeded to place her arms under . (RI #20's) arms and roughly pull (him/her) back in the wheelchair twice. She then proceeded to lean down in the resident's ear and appear to be speaking to (him/her) angrily. Then she pushed (him/her) rapidly down the hall toward the resident's room. (CNA #24) was suspended immediately pending investigation. (ADM #5 and DON #16) had already reviewed the video footage and it is on the recording that the CNA did exactly what was described by the employee. I went to the facility immediately to file the First Report to ADPH. (Local Law Enforcement) was notified and a report was filed with them. A complete body audit was performed by (DON #16) with no areas of redness or discoloration noted to neck, chest, arms, or under (his/her) arms. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's investigative file contained a typed statement titled Conclusion signed by DON #2 that documented: On [DATE], . (RI #36), (RI #8) and another resident were sitting at the table on the . Unit. The 3rd resident was eating a bag of cheese puffs and . (RI #8) was getting some of them . (RI #36) yelled loudly at (RI #8) to stop. This was heard by . (RN #21) who immediately left his office . Upon approaching the 3 residents sitting at the table, he saw . (RI #36) bring (his/her) right arm back and open hand slap . (RI #8) on the left shoulder. We went to . (RI #36's) room . I asked (him/her) What happened a few minutes ago? (RI #36) stated, (He/She) kept taking the other (resident's) gum. I told (him/her) several times to stop, and (he/she) didn't so I hit (him/her) on the shoulder. A police report was also filed . In conclusion, this occurrence was founded due to being witnessed by . (RN #21) and the statement of admission by . (RI #36). On [DATE] at 4:08 PM the DON #2 was asked about the incident on [DATE]. The DON said the incident was physical abuse and was intentional. The DON said the incident could have made someone in that situation feel hurt, sad, mad, or tearful. The DON said, RI #36 was obsessive of possessions at times and could be demanding. The DON stated, if RI #36 had been moved from the table to another area when he/she started yelling, the incident could have possibly been prevented. 5) On [DATE] at 7:50 AM surveyor was in the conference room of the facility and heard yelling I told you to get dressed, why are you not dressed yet, get dressed. Surveyor walked out of the conference room and observed CNA #27 in the hallway yelling in the doorway at RI #6 you have a doctor's appointment, you have to get dressed. RI #6's clothes were observed on his/her bed. RI #6 was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis to include Alzheimer's Disease with Late Onset, Cervical Disc Degeneration at C4-C5 Level, Unsteadiness on Feet, Muscle Weakness, and Unilateral Primary Osteoarthritis, Left Hip. RI #6 was care planned for self-care/Activities of Daily Living (ADL) deficit related to impaired mobility, impaired hearing and vision, decreased endurance and recent surgery related to fall with fracture of humerus. Care plan interventions for RI #6 was assistance times one for dressing, toileting, and bathing. A review of Quarterly Minimum Data Set (MDS) with an assessment date of [DATE] revealed: Section B Hearing, Speech, and Vision: adequate no difficulty in normal conversation, social interaction, listening to television for hearing. Section GG - Functional Abilities GG0130 Self-Care: Upper body dressing: partial/moderate assistance-Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. Lower body dressing Substantial/maximal assistance- On [DATE] at 7:55 AM RI #6 was asked how he/she felt about the way CNA #27 talked to him/her. RI #6 stated that he/she did not like the way he/she had been talked to and CNA #27 talked to him/her like that all the time. RI #6 further stated that it made him/her feel humiliated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 7:58 AM an interview was conducted with CNA #27. She stated that she had been talking loudly to RI #6 to get up and get dressed because he/she had a doctor's appointment. CNA #27 stated RI #6 could dress himself/herself. She further stated RI #6's care plan for Activities of Daily Living (ADLs) was to supervise with assistance times one. She stated she did not follow the care plan because she was picking up trays, and that RI #6 could get ready while he/she was getting dressed. CNA #27 stated that there was a risk that RI #6 would fall by not following his/her care plan. CNA #27 stated leaving RI #6's clothes on the bed and leaving the room without supervision or assistance could be considered neglect. She further stated that she did not supervise or offer any assistance for RI #6 to get dressed. ********** On [DATE] the facility submitted an acceptable Removal Plan for F 600 which documented: 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 [DATE]. 1. A. Verbal abuse was submitted to the state on [DATE]. The allegation was that CNA #8 verbally abused RI #5 on [DATE]. C.N.A #8 was placed on administrative leave and terminated on [DATE]. RI #5 had a skin evaluation on [DATE]. RI #5 was assessed on [DATE] no indication of emotional distress. B. Verbal abuse was submitted on [DATE] to the state. The allegation was that CNA #8 verbally and mentally abused RI #98 on [DATE]. C.N.A #8 was placed on administrative leave and terminated on [DATE]. No documentation of any assessment or notifications. RI #98 expired on [DATE]. C. Physical and mental abuse submitted to state on [DATE]. The allegation was CNA #8 physically and mentally abusing RI #99. The incident was witnessed by CNA #22 on [DATE]. C.N.A #9 was terminated on [DATE]. Skin evaluation performed on [DATE], DON entered a progress note concerning the event on [DATE]. Medical Director was notified. D. Physical and mental abuse submitted to state on [DATE]. CNA #24 was placed on administrative leave on [DATE] and terminated on [DATE]. On [DATE] the following was done: skin evaluation performed, Medical Director, family and police department was notified. 2. All residents have the potential to be affected by deficient practice. Performed an audit by asking every resident with a BIMS of 8 or higher if they had been a victim of abuse or witnessed suspected abuse that has not been reported and/or investigated on [DATE] to ensure no other residents were affected by the deficient practice. Responsible parties were contacted for all residents with a BIMS' of 7 or less. Forty-three residents reviewed. Zero were found to be affected. 3. Director of Clinical Services trained the Director of Operations on [DATE] the abuse policy and how to conduct a thorough investigation, how to identify contributing factors and take corrective action to prevent further abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Director of Operations trained the Administrator, DON and RN Supervisor on [DATE] ensuring facility's abuse policies are implemented on how to conduct a thorough investigation, identifying contributing factors and take corrective action to prevent further abuse. Ensure during investigations all witness statements are collected, and the Administrator is the abuse coordinator and is responsible for all reporting of allegations and ensuring completion of the investigation. 5. After revision of

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37292 44165 Based on interviews, medical record reviews, review of a facility policy titled ABUSE PREVENTION, and review of the facility investigative file, the facility failed to ensure policies and protocols were implemented to immediately intervene to protect residents and stop abuse, and immediately report the abuse. 1.) Specifically, on 07/09/2023 Certified Nursing Assistant (CNA) #9 and CNA #26 witnessed CNA #8 intentionally withholding RI #98's meal tray in the dining room for disciplinary reasons. CNA #8 told CNA #9 to not serve RI #98. The facility further failed to ensure staff who witnessed the abuse, CNA #9 and CNA #26, intervened to protect RI #98, stop the abuse, and report the abuse immediately to Administration. The abuse was not reported or acted on until 07/10/2023. Residents in the facility were not protected from CNA #8 who continued to work in the facility that day on 07/09/2023. 2.) On 09/06/2023 CNA #22 witnessed CNA #9 hit RI #99 with a package of wipes and hold RI #99's arm down between her legs while threatening to break RI #99's arm. CNA #22 witnessed the abuse occur and failed to intervene, take action to stop the abuse, and protect RI #99 immediately. CNA #22 also failed to report the abuse to anyone until the next day on 09/07/2023 while CNA #9 continued to work in the facility and have access to residents. Serious harm is likely to result when the facility's staff fail to identify incidents of abuse, immediately act to stop abuse, protect residents, and report abuse to Administration for corrective actions to be taken. It was determined the facility's noncompliance with one or more requirements of participation had 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 at at F 607- Develop/Implement Abuse/Neglect, etc. Policies. On 11/27/2024 at 5:12 PM, the ADM was provided a copy of the Immediate Jeopardy (IJ) template and notified of the finding of immediate jeopardy and substandard quality of care in the area of Freedom from Abuse, Neglect, and Exploitation at F 607- Develop/Implement Abuse/Neglect, etc. Policies. The IJ began on 07/09/2023 and continued until 11/29/2024 when the survey team verified onsite that corrective actions had been implemented. On 11/30/2024 the immediate jeopardy was removed, F 607 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 deficiency was cited as the result of the investigation of complaint/report number AL00044741 and AL00045507 and affected Resident Identifier (RI) #98 and RI #99. Findings include: (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Cross-Reference F 600, F 609, F 610, F 835, F 837, and F 867. A facility policy titled ABUSE PREVENTION, dated, 01/06/2023 documented: . I. PURPOSE To identify actual or potential abuse and process reports to thoroughly investigate, resolve, follow-up and prevent abuse in our facility. Abuse definition: the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Verbal abuse the use of oral . or gestured language that willfully includes disparaging or derogatory terms to residents . Physical abuse any willful act directed at a resident that is intended to result in or that is likely to result in injury or pain. Physical abuse includes slapping, . shoving, and corporal punishment of any kind. Mental abuse any willful act directed at a resident that is intended to result in or that is likely to result in mental distress or mental anguish. It includes humiliation, harassment, threats of punishment, and threats of deprivation. II. POLICY Each resident, . has the right to be free from abuse by anyone, in any form . IV. RESPONSIBILITY 1. Every employee is responsible to recognize and report abuse. 2. Administrator is responsible to ensure that all aspects of this program are effectively implemented. On 07/10/2023 the State Agency received an Online Incident Report (FRI)from the facility alleging verbal, mental and emotional abuse occurred on 07/09/2023 when CNA #8 withheld a lunch tray from RI #98 until all other lunch trays had been passed out to other residents. The report documented RI #98 had asked for his/her tray prior to the other residents receiving their trays, CNA #9 attempted to give RI #98 a lunch tray, and CNA #8 yelled at CNA #9 and told her not to give RI #98 a tray. The facility observed camera footage and found this was true. CNA #8 was scheduled off at the time of the reporting and was to be suspended pending further investigation. RI #98 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include Dementia and Diabetes Mellitus. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's investigative file contained a typed statement signed by the DON #2 and ADM #5 that documented: . It was reported to me (DON) on 7/10/23 at 2:00 pm, that (CNA #8) had withheld the lunch tray from resident (RI #98) in the Dining Room on 7/9/23 until all other lunch trays were passed out. (RI #98) had asked for (his/her) tray prior to the other residents receiving their trays. (CNA #9) attempted to place the tray in front of . (RI #98) and (CNA #8) yelled at her from across the room and told her not to. Another resident was seated at the table with . (RI #98) and had received (his/her) tray and was eating during this occurrence. After observing camera footage from the Dining Room camera, this was in fact the case. This occurrence was found to be substantiated. The facility's investigative file also contained a Disciplinary Action form dated 07/13/2023 for CNA #8 that documented CNA #8's termination: . Date of Violation: 7/9/23 . Employee spoke to resident in the dining Room in a loud and hateful manner . Employee purposefully withheld tray from resident making (him/her) wait until last to be served with another resident eating at the same table. Employee is terminated due to facility and State policy (and) regulation that residents are to be free from any form of abuse. On 11/24/2024 at 4:54 PM an interview was conducted with Dietary Manager (DM) #15 who was no longer employed at the facility. DM #15 said she witnessed CNA #8 withhold RI #98's meal tray. DM #15 said she reported the incident to ADM #5 because she was supposed to report to him. The investigative file did not contain a witness statement from DM #15 or any information about her reporting abuse. On 11/26/2024 at 10:15 AM an interview was conducted with CNA #26 who also witnessed CNA #8 withhold RI #98's meal tray. CNA #26 said she reported the incident to a nurse but was unable to recall who. The investigative file did not contain a witness statement from CNA #26 or any information about her reporting abuse. The facility investigative file did not contain any information about the failure of the three staff members who witnessed the abuse, to stop the abuse, protect RI #98 from the abuse, and report the abuse immediately. The ADM at the time of the incident on 07/09/2023 was ADM #5, who is no longer employed by the facility. On 11/07/2024 at 12:00 PM a phone call was made to ADM #5, and he was asked about the incident that occurred on 07/09/2023. ADM #5 said, either him or the DON was responsible for the investigation and the process of investigation involved talking to the staff, CNAs, and any witnesses involved. ADM #5 said, the video was watched for the incident with RI #98 and CNA #9 was going to give a tray to RI #98 and CNA #8 told her not to touch that tray. ADM #5 said, it was not reported to them until 07/10/2023, they watched the video footage and CNA #8 was then suspended. ADM #5 said, it was substantiated, and CNA #8 was terminated. ADM #5 said, RI #98 was neglected. ADM #5 said, he thought he became aware of the incident with RI #98 from the Director of Nursing (DON) or DM #15. ADM #5 said, he did not recall CNA #9 being a part of the incident, even though he previously told the surveyor based on video footage CNA #8 told CNA #9 not to touch the tray. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/07/2024 at 3:01 PM DON #2 was asked what staff were to do if they witnessed abuse. The DON said, they should stop it and separate the residents and if it was an employee, they should pull them out of the room and intervene immediately. The DON said, CNA #9 should have given the food tray to RI #98 when CNA #8 yelled out to her not to give it. The DON said, the abuse RI #98 was emotional and verbal. The DON said, The DON said, it would make her feel like you did not like her if you did not give her a meal tray and she would feel fearful. On 11/26/2024 at 4:55 PM a phone interview was conducted with the previous administrator (ADM #5). ADM #5 stated staff were always interviewed to find witnesses and staff involved in the process of the investigations. He further stated the interviews were conducted with the DON and only some of the interviews were documented. ADM #5 stated all the training he received was in orientation and there was some confusion on who was supposed to be investigating the Facility Reported Incidents (FRIs), the DON or the ADM #5. He further stated he did not know if the facility had a specific policy directing employees what to do for an allegation of abuse. ADM #5 stated DON #2 trained him on FRIs but was not his supervisor. ADM #5 stated that his training was deficient in abuse training and training on FRIs was very limited. ADM #5 stated that the DON kept up with the FRIs and investigations. On 09/07/2023 the State Agency received an Online Incident Report (FRI) from the facility alleging physical abuse occurred on 09/06/2023 at 4:30 PM when CNA #22 witnessed CNA #9 being verbally and physically abusive to RI #99, being rough and smacking RI #99 with a package of wipes, and grabbing RI #99's arm, placing it down as far as it would go, between her knees, and CNA #9 told RI #99 she would break his/her arm. The report included local law enforcement was notified, CNA #9 was immediately removed from the facility pending investigation, and RI #99 was assessed with no injuries and was calm. RI #99 was admitted to the facility on [DATE] and had diagnoses to include: Heart Failure, Respiratory Failure, Convulsions, Encephalopathy, Muscle Weakness, Aphasia, and Contracture of the Right Hand. The facility investigative file contained an undated hand written statement signed by CNA #22 that documented: On September 6th (09/06/2023) around dinner me . and (CNA #9) went to change (RI #99) (CNA #9) was being rough . (RI #99) went to grab (CNA #9) and she started smacking (RI #99) with wipes after that when I rolled (RI #99) she took (RI #99's) arm and pushed it down as far as it would go and put it between her knees and told (RI #99) if (he/she) kept on she would break (RI #99's) arm. The facility investigative file contained a typed statement that documented CNA #9 had been terminated on 09/07/2023. RI #99's nurses notes contained an entry dated 09/08/2023 that documented RI #99 had a purplish bruise on the left outer wrist area, did not appear to be in pain but was a little restless. On 11/25/2024 at 2:44 PM an interview was conducted with CNA #22 who said she thought she reported the incident to DON #2 when the incident occurred. The facility investigative file did not contain a witness statement from CNA #22 or any information about her reporting abuse. The facility investigative file did not contain any information about the failure of CNA #22 to stop the abuse, protect RI #98 from the abuse, and report the abuse immediately. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/27/2024 at 12:35 PM CNA #9 was interviewed via phone. CNA #9 stated she was no longer employed at the facility because they said she beat RI #99 with baby wipes and terminated her. CNA #9 said that the facility allowed her work, having access to residents, the remainder of her shift on 09/06/2023 and half the shift on 09/07/2023 until 1:00 PM. On 11/07/2024 at 11:42 AM the ADM #5 was asked about the incident on 09/06/2023 involving RI #99. ADM #5 said, the incident was reported to the State Agency on 09/07/2023 because that was when he was made aware RI #99 had been abused by CNA #9. ADM #5 said, he expected staff who witnessed abuse to report abuse immediately. ADM #5 said, it should have been reported within two hours on 09/06/2023 to the State Agency. On 11/07/2024 at 2:59 PM the current DON #2 was asked about abuse training and procedures. DON #2 said, if staff suspected abuse they were to report it immediately. The DON said, staff should make sure the resident was safe, separate the resident, or if it was a staff on resident situation they should step in and intervene. The DON said, CNA #22 should have stopped CNA #9 from being abusive to RI #99 and pulled her out of the room and reported immediately to the supervisor. The DON stated, if staff see abuse they should intervene immediately for protection of the resident. The DON said, CNA #22 did not report the incident until the next day. The DON said, at the time of the incident she had been the corporate infection prevention and DON #17 and she investigated after they were made aware around 11:00 AM on 09/07/2023. When asked about the five day summary in the investigative file, DON #2 said, she did not see it in the file. The DON said, from what she could remember it was substantiated but there was no documentation of that since there was not a five day summary. The DON said, the abuse to RI #99 was physical and mental because it could make a resident fearful. On 11/27/2024 at 9:30 AM a follow-up interview was conducted with DON #2. She stated, the administrators have always been the abuse coordinator at the facility. She further stated for the incidents involving RI #98 and RI #99 the previous administrator ADM #5 was the acting abuse coordinator. DON #2 stated she was trained on FRIs by watching the previous DON when she was the facility Assistant Director of Nursing (ADON). DON #2 stated that she assisted with the facility reported incidents, but she had not been trained. DON #2 stated the facility reported incidents were stored in the administrator's office and FRIs were never stored in the DON's office. DON #2 stated it was the administrator's responsibility to provide a thorough investigation for the FRIs. On 11/26/2024 at 4:55 PM, a telephone interview was conducted with ADM #5. ADM #5 was asked what the reason was for the facility to have a culture of staff abusing residents, not intervening, not protecting the residents and not reporting physical, verbal, or mental abuse. ADM #5 said that the staff needed more training and better training on abuse. ADM #5 further stated that the facility should have done better training on abuse for the staff that was more in-depth and not just the definitions of abuse. ********** On 11/30/2024 the facility submitted an acceptable Removal Plan for F607 which documented: 1. Verbal abuse was submitted to the state on 7/10/2023. C.N.A #8 was placed on administrative leave and terminated on 7/13/2023. No documentation of any assessment or notifications. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A. Physical and mental abused submitted to state on 9/7/2023. C.N.A#9 was terminated on 9/7/2023 Skin evaluation performed on 9/7/2023, DON entered a progress note concerning the event on 9/7/2023. The Medical Director was notified. All residents have the potential to be affected by deficit practice. All abuse investigations since 07/10/2023 were reviewed by the Administrator to ensure all allegations were identified by staff, residents were immediately protected, allegation reports per policy, investigations were completed appropriately, had appropriate witness statements collected, all causal factors were identified, and appropriate corrective action was taken. This review was completed on 11/8/2024. There were 4 staff to resident abuse allegations reviewed. No other concerns of abuse were identified at this time. The Administrator was in-serviced on 11/8/2024 conducting a thorough investigation. Director of Clinical Services trained the Director of Operations on 11/8/2024 on the abuse policy and how to conduct a thorough investigation, how to identify contributing factors, and take corrective action to prevent further abuse. Director of Operations trained the Administrator and DON on 11/8/2024 3. Director of Operations trained the Administrator, DON and RN Supervisor on 11-8-2024 ensuring facility's abuse policies are implemented on how to conduct a thorough investigation, identifying contributing factors and take corrective action to prevent further abuse. Ensure during investigations all witness statements are collected, and the Administrator is the abuse coordinator and is responsible for all reporting of allegations and ensuring completion of the investigation. Abuse in-services were held on 11/8/2024 by the DON, 11/15/2024 by the DON, 11/22/2024 by DON, 11/26/2024 by the Administrator, 11/27/2024 by the DON and 11/29/2024 by RN Supervisor. All staff in all departments including nursing, therapy department, dietary, environmental services, management. 75 employees were in-serviced. Staff were educated on what constituted abuse including depriving goods/services for disciplinary reasons, when abuse is witnessed or suspected you are to PROTECT THE RESIDENT!!!, what should be reported (ANY suspected abuse), when to report, and to whom to report. Also, training included how to safely provide care for residents who may be agitated or resistive to care and that the facility has zero tolerance for abuse. Director of Clinical Services trained the Director of Operations on 11/8/2024 the abuse policy and how to conduct a thorough investigation, how to identify contributing factors and take corrective action to prevent further abuse. If any staff do not attend the in-service for whatever reason, the Administrator and DON will train department heads to complete the in-service with the employees prior to returning to their next scheduled shift. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Ad hoc QAPI meeting was attended by the RN Supervisor, Medical Records, Director of Rehab, Director of Nursing, Financial Coordinator, Infection Control/Restorative, Housekeeping Supervisor, HR Corporate Director, Director of Operations, Administrator, Medical Director was held on 11/29/2024 to discuss abuse recognition, reporting, and prevention. Also to ensure the Administrator understands responsibility to ensure all facility policies are implemented. Corporate will sign off on facility reportable for compliance, and on facility abuse policy/QAPI policy are implemented/conducted according to the policy on abuse. The abuse policy was updated on 11/29/2024 to include the use of root cause analysis, to identify, evaluate, monitor, and improve facility systems and processes that support the delivery of caring services. The updated policy was approved by the governing body. ********** 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 11/29/2024.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walker Rehabilitation Center, Inc	350 Northeast 4th Street Carbon Hill, AL 35549

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48195 39580 37292 Based on resident record review, interviews, review of Facility Reported Incidents (FRIs), and review of a facility policy titled ABUSE PREVENTION, the facility failed to ensure facility staff reported abuse immediately to the Administrator for allegations of abuse to be reported to the State Agency within two hours after abuse occurred when: 1. Resident Identifier (RI) #98 was verbally and mentally abused on 07/09/2023 by Certified Nursing Assistant (CNA) #8. This was witnessed by CNA #9, CNA #26, and previous Dietary Manager (DM) #15. This was not reported to Administrator until 07/10/2023. 2. RI #99 was verbally and physically abused by CNA #9 on 09/06/2023. CNA #22 witnessed the abuse and failed to report the abuse to anyone in the facility until the next day on 09/07/2023. Serious harm is likely to result when the facility's staff fail to report the incidents to the Administrator so corrective actions can be taken, including protecting residents from further potential abuse. It was determined the facility's noncompliance with one or more requirements of participation had 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 at F 609-Reporting of Alleged Violations. On 11/27/2024 at 5:12 PM, the Administrator and the Director of Nursing (DON) were provided a copy of the immediate jeopardy template and notified of the immediate jeopardy finding in the area of F 609-Reporting of Alleged Violations. The IJ began on 07/09/2023 and continued until 11/29/2024 when the facility implemented corrective action. On 11/30/2024, the immediate jeopardy was removed, F 609 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 was cited as a result of the investigation of complaint/report number AL00044741 and AL00045507 and affected RI #98 and RI #99, two of eight residents sampled for abuse. Findings include: Cross reference F 600, F 607, F 610, F 835, F 837, and F 867. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A facility policy titled ABUSE PREVENTION dated 01/06/2023 documented: . Reporting/Response: . 1. Immediately notify the facility administrator or designee . of any allegation or suspicion of abuse. 3. Complete the abuse reporting via the online reporting system as required by ADPH (Alabama Department of Public Health) within 2 hours after forming the suspicion, . On 07/10/2023 at 4:25 PM the State Agency received a FRI from the facility alleging verbal, mental and emotional abuse occurred on 07/09/2023 during lunch meal service when CNA #8 withheld a lunch tray from RI #98 until all other lunch trays had been passed out to other residents. The facility observed camera footage and found this was true. RI #98 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include Dementia and Diabetes Mellitus. The facility's investigative file contained a typed statement signed by the DON #2 and the former Administrator (ADM) #5 that documented: . It was reported to me (DON) on 7/10/23 at 2:00 pm, that (CNA #8) had withheld the lunch tray from resident (RI #98) in the Dining Room on 7/9/23 until all other lunch trays were passed out. (RI #98) had asked for (his/her) tray prior to the other residents receiving their trays. (CNA #9) attempted to place the tray in front of . (RI #98) and (CNA #8) yelled at her from across the room and told her not to. Another resident was seated at the table with . (RI #98) and had received (his/her) tray and was eating during this occurrence. After observing camera footage from the Dining Room camera, this was in fact the case. This occurrence was found to be substantiated. (CNA #8) was scheduled off work on 7/10/23 and 7/11/23. On 7/11/23, (CNA #8) was called and informed that she had complaints filed against her and was suspended pending further investigation. After . reviewing video footage from the Dining Room camera, . found to be substantiated. On 11/24/2024 at 4:54 PM an interview was conducted with Dietary Manager (DM) #15 who was no longer employed at the facility. DM #15 said she witnessed CNA #8 withhold RI #98's meal tray. DM #15 said she reported the incident to ADM #5 because she was supposed to report to him. On 11/26/2024 at 10:15 AM an interview was conducted with CNA #26 who also witnessed CNA #8 withhold RI #98's meal tray. CNA #26 said she reported the incident to a nurse but was unable to recall who. On 11/07/2024 at 12:00 PM a phone call was made to ADM #5, who was the Administrator at the time of the incident. ADM #5 was asked about the incident that occurred on 07/09/2023. ADM #5 said, it was not reported to him until 07/10/2023. ADM #5 said, it was substantiated, and CNA #8 was terminated. ADM #5 said it was not clear from the facility investigation who reported the abuse to management. 2.) On 09/07/2023 at 11:49 AM the State Agency received an Online Incident Report from the facility alleging physical abuse had occurred on 09/06/2023 at 4:30 PM. The report indicated that CNA #22 witnessed CNA #9 being verbally and physically abusive to RI #99 by being rough and smacking RI #99 with a package of wipes, grabbing RI #99's arm and placing it down as far as it would go between his/her knees, and CNA #9 told RI #99 she would break his/her arm. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #99 was admitted to the facility on [DATE] and had diagnoses to include: Heart Failure, Respiratory Failure, Convulsions, Encephalopathy, Muscle Weakness, Aphasia, and Contracture of the Right Hand. On 11/25/2024 at 2:44 PM an interview was conducted with CNA #22 who said she thought she reported the incident to DON #2 when the incident occurred. On 11/27/2024 at 12:35 PM CNA #9 was interviewed via phone. CNA #9 stated she was not longer employed at the facility because they said she beat RI #99 with baby wipes and terminated her. CNA #9 said that the facility allowed let her work all that shift and half the shift the next day until 1:00 PM. On 11/07/2024 at 2:59 PM DON #2 was interviewed. DON #2 said if abuse was witnessed, staff should have protected the resident and reported immediately to the supervisor. The DON said, she expected staff who witnessed abuse to intervene immediately for protection of the resident. The DON stated, CNA #22 did not report the abuse against RI #99 until the next day and CNA #9 was removed from providing resident care and terminated. On 11/07/2024 at 11:42 AM the ADM #5 was asked about the incident on 09/06/2023 involving RI #99. ADM #5 said, the incident was reported to the State Agency on 09/07/2023 because that was when he was made aware RI #99 had been abused by CNA #9. ADM #5 said, he expected staff who witnessed abuse to report abuse immediately. ADM #5 said, it should have been reported within two hours on 09/06/2023 to the State Agency. ********** On 11/30/2024 at 1:07 PM, the facility submitted an acceptable removal plan, which documented: ********** 1. A. Verbal abuse that occurred on 07/09/2023 that involved CNA #8 as perpetrator was submitted to the state on 7/10/2023. CNA #8 was placed on administrative leave and terminated on 7/13/2023. B. Physical and mental abuse submitted to the state on 09/07/2023 that occurred on 9/6/2023 that involved CNA #9 as perpetrator. CNA #9 was terminated on 9/7/2023. 2. All residents have the potential to be affected by deficit practice. On 11/29/2024 an audit performed by asking every resident with a BIMS of 8 or higher if they had been a victim of abuse or witnessed suspected abuse that has not been reported and/or investigated on 11/29/2024 to ensure no other residents were affected by the deficient practice. Forty-three residents reviewed. Zero was found to be affected. No action was taken because no issues were found. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Director of Clinical Services trained the Director of Operations on 11/8/2024 the abuse policy and how to conduct a thorough investigation, how to identify contributing factors and take corrective action to prevent further abuse. Abuse in-services were held on 11/9/2024 training done by DON, 11/15/2024 training done by DON, 11/22/2024 training done by DON, and 11/26/2024 training done by Administrator, 11/27/2024 training done by DON, and 11/29/2024 training done by RN Supervisor. In-service is for all staff in all departments including nursing, therapy department, dietary, environmental services, and management. 75 employees were in-serviced. The in-service were conducted on what constitutes abuse and reporting any suspected or witnessed abuse to the administrator immediately on 11/9/2024 by the DON, 11/15/2024 by the DON, 11/22/2024 by the DON, 11/26/2024 by the Administrator, 11/27/2024 by the DON, and 11/29/2024 by the RN Supervisor. All employees in all departments including nursing, therapy, dietary, environmental services, management, 75 employees were in-serviced. 5. Licensed nurses and CNAs will document any unusual observations in the 24-hour report book located at the nurse's desk and call the Administrator immediately if abuse is suspected or witnessed. Actions taken by the QAPI committee include the 24-hour report book and 24-hour report being discussed in detail each morning during the morning meeting. B. QAPI meeting QAPI meeting was held on 11/29/2024 to discuss the abuse prevention policy and above-mentioned cases. The following personnel attended the QAPI meeting: RN Supervisor, Medical Records, Director of Rehab, Director of Nursing, Financial Coordinator, Infection Control/Restorative, Housekeeping Supervisor, HR Corporate Director, Director of Operations, Administrator, Medical Director was held on 11/29/2024 to discuss the abuse prevention policy and above-mentioned cases. ********** 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 11/29/2024. 44165

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39580 48195 47408 37292 Based on interviews, resident record review, review of a facility policy titled ABUSE PREVENTION, review of Facility Reported Incidents (FRIs) received by the State Agency, and review of the facility's investigative files, the facility failed to thoroughly investigate the occurrence of abuse of residents perpetrated by employees of the facility to include when the incident occurred, and failed to obtain statements from all those present to identify contributing factors to be able to determine appropriate interventions and actions to prevent further abuse. 1.) the facility failed to ensure a thorough investigation was conducted on 07/10/2023 after receiving reports that Certified Nursing Assistant (CNA) #8 verbally and mentally abused Resident Identifier (RI) #5 on 07/08/2023 when she yelled and cursed Damn you . at RI #5, slammed the bathroom door with RI #5 in the bathroom, and RI #5 cried when explaining to staff what happened; also, RI #98 was verbally and mentally abused by CNA #8 the next day, on 07/09/2023, when CNA #8 withheld and refused to give RI #98 a lunch tray and RI #98 was served last while others around RI #98 were eating already. The facility's investigation failed to identify and implement corrective action to address the staff members, Dietary Manager (DM) #15, CNA #9, and CNA #26, who witnessed the abuse against RI #98 and failed to intervene to protect the resident, stop the abuse, and report the abuse immediately. The facility failed to obtain witness statements from all staff and residents who witnessed the incident and had information about the incident. 2.) the facility failed to ensure a thorough investigation was conducted on 09/07/2023 after receiving a report that CNA #9 physically and mentally abused RI #99 on 09/06/2023 when CNA #9 hit RI #99 with a package of wipes and held RI #99's arm down between his/her legs and threatened to break RI #99's arm. The facility further failed to identify and implement corrective action to address CNA #22 who witnessed the abuse against RI #99, but failed to intervene to protect the resident, stop the abuse, and report the abuse immediately. 3.) the facility failed to ensure a thorough investigation was conducted on 05/10/2024 after receiving a report that CNA #24 physically and mentally abused RI #20 by jerking and pushing RI #20 in the wheelchair roughly and aggressively causing RI #20 to be tearful and visibly upset as witnessed by Dietary Aid (DA) #23. The facility failed to ensure other residents were asked questions about abuse to ensure no other abuse had occurred. It was determined the facility's noncompliance with one or more requirements of participation had 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 at F 610-Investigate/Prevent/Correct Alleged Violations. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/27/2024 at 5:12 PM, the Administrator (ADM) and Director of Nursing (DON) 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 Freedom from Abuse, Neglect, and Exploitation at F 610-Investigate/Prevent/Correct Alleged Violations. The IJ began on 07/09/2023 and continued until 11/29/2024 when the survey team verified onsite that corrective actions had been implemented. On 11/30/2024 the immediate jeopardy was removed, F 610 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 was cited as a result of the investigation of complaint/report numbers AL00044741, AL00045507, and AL00047853, and affected RI #5, RI #98, RI #99, and RI #20, four of eight residents sampled for abuse. Findings Include: Cross reference F 600, F 607, F 609, F 835, F 837, and F 867. A facility policy titled ABUSE PREVENTION dated 01/06/2023 documented: . I. PURPOSE To identify actual or potential abuse and process reports to thoroughly investigate, resolve, follow-up and prevent abuse in our facility. II. POLICY Each resident, . has the right to be free from abuse by anyone, in any form . III. PROCEDURE . Investigation: 1. Require investigations on every incident to determine cause to the extent possible and plan corrective actions. Reporting/Response: 1. Immediately notify the facility administrator or designee . of any allegation or suspicion of abuse. 4. Interview the resident for statements regarding any information about the alleged incident. a. Interview the resident upon report of allegation. The interview is conducted by either the Director of Nursing, Social Services, or facility Administrator. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	b. Interviewers must document all questions asked, the individuals' responses and then read the documentation back to the person interviewed for verification or corrections. 5. Interview roommate/s and other residents in the immediate area. 6. Interview any family members or visitors that were present during the alleged incident. 7. Interview all employees who were on duty during the time of the alleged incident. 8. Schedule an appointment with any suspected employee and obtain a written statement. 10. Within 5 days, the investigation must be completed and a summary submitted via the online reporting system . 11. Write a general statement of the circumstances, investigative findings, and corporate decisions . IV. RESPONSIBILITY 1. Every employee is to recognize and report abuse. 2. Administrator is responsible to ensure that all aspects of this program are effectively implemented. 1.) On 07/10/2023 the State Agency received an Online Incident Report from the facility alleging that RI #98 was verbally, mentally, and emotionally abused on 07/09/2023 when CNA #8 withheld a lunch tray from RI #98 until all other lunch trays had been passed out to other residents. RI #98 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include Dementia and Diabetes Mellitus. The Dietary Manager at the time of the incident on 07/09/2023 involving RI #98 was DM #15. On 11/06/2024 at 10:00 AM DM #15 was asked about the incident involving RI #98 and CNA #8. DM #15 said she witnessed it from the kitchen, CNA #8 and CNA #9 were in the dining room and were saying RI #98 could not have his/her lunch tray even though RI #98 kept asking for it. DM #15 said, she went to the dining room and RI #98's tray was still not given to RI #98. DM #15 said RI #98 was very upset. DM #15 stated, CNA #9 also had every opportunity to grab the tray and give it to RI #98. The investigative file did not contain a witness statement from DM #15. The facility's investigative file also did not contain witness statements from RI #98, CNA #8, CNA #9, or CNA #26. The investigative file did not contain any information about CNA #9's involvement in the abuse against RI #98. The investigative file summary did not have documentation to specify who reported the incident or why it was not reported until 2:00 PM on 07/10/2024. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/07/2024 at 12:00 PM the former Administrator, (ADM) #5, was asked about the incident involving CNA #8. ADM #5 said, he or the DON was responsible for the investigation. ADM #5 said, the process of investigation involved talking to the staff, CNAs, and any witnesses involved, report to the state agency, and local law enforcement. ADM #5 said, the incident with RI #98 was not reported to them until 07/10/2023. ADM #5 said, the video was watched for the incident with RI #98 and CNA #9 was going to give a tray to RI #98 and CNA #8 told her not to touch that tray. ADM #5 said, it was substantiated, and CNA #8 was terminated. ADM #5 said, RI #98 was neglected. ADM #5 said, he thought he became aware of the incident with RI #98 from the DON #2 or DM #15. ADM #5 said, he did not recall CNA #9 being a part of the incident, even though he told the surveyor based on video footage CNA #8 told CNA #9 not to touch the tray. ADM #5 said, he did not recall obtaining statements or interviews from other staff or residents during the investigations. ADM #5 did not recall getting a statement from DM #15 but said he should have. When asked about the video, ADM #5 said, he sent the video to someone, but he was not sure who. On 11/07/2024 at 3:01 PM DON #2 was asked what staff were to do if they witnessed abuse. The DON said, they should stop it and separate the residents and if it is an employee, they should pull them out of the room and intervene immediately. The DON said, witness statements were missing from the investigation, CNA #9 did not report timely what had happened to RI #98, and other residents in the dining room were not interviewed to see if they were abused as well. DON #2 said it was not a thorough investigation. 2.) On 09/07/2023 the State Agency received an Online Incident Report from the facility alleging physical abuse occurred on 09/06/2023 at 4:30 PM when CNA #22 witnessed CNA #9 being verbally and physically abusive to RI #99 The facility investigative file was reviewed, and it did not contain a five-day investigative summary of the abuse against RI #99, it did not contain interviews with other residents who might have had knowledge of other incidents of unreported abuse that involved CNA #9. On 11/07/2024 at 2:59 PM the current DON #2 said at the time of the incident, she had been the corporate infection preventionist, and the DON was DON #17. DON #2 said she investigated after they were made aware around 11:00 AM on 09/07/2023. When asked about the five-day summary in the investigative file, DON #2 said, she did not see it in the file. The DON said, from what she could remember it was substantiated but she agreed that it was not documented whether it was substantiated or not. DON #2 said, she did not see any interviews with other residents in the investigative file. 3.) On 05/10/2024 the State Agency received an Online Incident Report from the facility alleging physical abuse occurred when DA #23 witnessed CNA #24 aggressively pull RI #20 into the chair and threaten to put RI #20 back to bed. The incident occurred in the hallway beside a dining room. The facility investigative file was reviewed and there were no interviews with other residents to determine if they had knowledge of any other instances of unreported abuse that involved CNA #24. On 11/07/2024 at 3:34 PM DON #2 was asked about the investigation of the abuse against RI #20. The DON said, other residents were not interviewed to see if they had experienced any abuse. DON #2 said it was not a thorough investigation. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/26/2024 at 4:55 PM, a telephone interview was conducted with ADM #5. When asked what the process was for abuse investigations, ADM #5 stated that if there were any witnesses, they would ask them to write a statement, they would review video footage as soon as allegations were reported, then they would report them on the website to the State Agency, report some of them to the police, and then they did a five-day investigation. ADM #5 stated that he did not recall ever interviewing a resident or staff member about an incident, but he did tell anyone that reported an allegation to him to handwrite their own statement. ADM #5 was asked should other residents and staff be interviewed to identify unreported concerns regarding a resident's behavior or staff concerns, and he said that he would think that they should be. ADM #5 said DON #2 trained him to investigate abuse allegations, but that the Director of Operations (DO), was his immediate supervisor. When asked what the facility's process was for documenting what was reviewed on the videos, ADM #5 said that he did not know, and he said that he did not document what was reviewed. On 11/27/2024 at 9:30 AM an interview was conducted with DON #2. She stated the abuse coordinator was the Administrator and at the time of the incidents it was ADM #5. DON #2 stated that she was not trained on the abuse investigation and that she only watched the previous DON complete a couple of incident reports when she was the Assistant Director of Nursing. According to DON #2 there were no five-day reports in the files for RI #98, RI #20, and RI #99. She further stated the five-day reports should have been completed and filed with their incident reports. DON #2 stated that ADM #5 was responsible for investigating and turning in the five-day reports to the State Agency for RI #98, RI #20, and RI #99. ********** On 11/30/2024 at 1:07 PM, the facility submitted an acceptable removal plan, which documented: 1. A. Verbal abuse was submitted to the state on 7/10/2023. CNA #8 was placed on administrative leave and terminated on 7/13/2023. No assessments, no statements, no incident report, no documentation for notification of responsible party and medical director, no updated care plan, abuse not reported in timely manner, no in-services, and MDS not updated. Employees and residents involved are no longer here. Spoke with sponsor of RI #5 regarding an event that occurred on 7/8/23 with a CNA. Sponsor states that she does remember being notified. Asked if she felt he had any lasting effects from this event and she stated, not that I can tell. B. Physical and mental abused submitted to state on 9/6/2023. C.N.A#9 was terminated on 9/7/2023. No statements, no incident report, no updated care plan or MDS. No residents or employees involved are at the facility. C. Physical and mental abuse submitted to the state on 5/10/2024. No incident reports, no statements, and no updated care plans or MDS. Residents and employees involved are not at the facility. CNA #24 was terminated on 5/16/2024. All residents have the potential to be affected by deficit practice. Director of Clinical Services reviewed all abuse investigations on 11/8/2024. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administrator #5 resigned on 10/28/2024 and the new administrator hired on 10/28/2024. Director of Operations provided an in-service to new administrator and DON regarding abuse policy implemented and including conducting thorough investigations, collecting and retaining witness statements to determine a clear time of occurrence of events to ensure all staff respond appropriately per the policy 11/6/2024 and 11/29/2024, preserving evidence such as videos of the incidents as applicable, identifying all causal factors, and implementing the appropriate corrective action(s). 2. On 11/29/2024 the Administrator reviewed all incidents of abuse, neglect, and misappropriation reported to the state agency from 7/8/2023 to 11/29/2024. Concerns identified include: no statements, no incident reports, no notification to the party responsible and medical director and no updated care plans and MDS. 3. QAPI meeting was attended by: RN Supervisor, Medical Records, Director of Rehab, Director of Nursing, Financial Coordinator, Infection Control/Restorative, Housekeeping Supervisor, HR Director, Director of Operations, Administrator and Medical Director was held on 11/29/2024 to discuss the abuse prevention policy. The Director of Operations completed QAPI meeting with the Administrator on understanding administrator's responsibility regarding policy being implemented and followed and expectations for conducting a thorough investigation including identification of all causal factors and implementing corrective action(s). The Director of Operations will sign off on reportable investigations to ensure compliance with abuse/ and QAPI policy. The Administrator will email the DO the allegation when reported and email the completed investigation summary. The administrator, DON and DO and Director of Clinical Services will do a conference call before submitting the five-day summary to state. ********** 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 11/29/2024. 44165

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Walker Rehabilitation Center, Inc	350 Northeast 4th Street Carbon Hill, AL 35549

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 33738 Based on interviews, record review, and review of the job responsibilities of the Certified Medication Aide (CMA), the facility failed to ensure subcutaneous insulin injections were not administered to residents by CMA/MAC (Medication Assistant, Certified) #10, #11, #12 and #13 from May 2023 through October 2023. This affected RI #6, #10, #18, #28, #31, #32 and #98 seven of 16 sampled residents receiving medications in the facility. This deficient practice affected four of five Med Techs who administered insulin to residents. This deficient practice was cited as a result of investigation of complaint/report number AL00046139. Findings include: Review of the facility's CMA, Job Title, with an effective date of 04/15/2021, revealed the following: PURPOSE OF THE JOB: . The CMA will adhere to the scope of practice with regard to the Medication Aide Act and facility rules, regulations, policies and procedures applicable in the performance of duties to enhance and safeguard resident(s). ACCOUNTABILITY . A MAC may perform limited medication administration tasks delegated to the MAC by the licensed nurse in a licensed health care facility. Limitations for MAC workers . 2. No injectable medications, with the exception of premeasured auto injectable mediations for anaphylaxis, vaccines, and opioid-related drug overdose. 6. MAC medication administration is limited to include eye, ear, nose, oral, topical, inhalant, rectal, or vaginal. RI #6's Medication Administration Record (MAR) for May 2023- October 2023 documented insulin was administered 208 times by MAC #10, #11, #12 and #13. RI #10's MAR for May 2023-October 2023 documented insulin was administered 39 times by MAC #10, #11, #12 and #13. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RI #18's MAR for May 2023- October 2023 documented insulin was administered 94 times by MAC #10, #11 and #13. RI #28's MAR for May 2023-October 2023 documented insulin was administered 50 times by MAC #10, and #13. RI #31's MAR for May 2023-October 2023 documented insulin was administered 78 times by MAC #10, #11, #12 and #13. RI #32's MAR for May 2023-October 2023 documented insulin was administered 36 time by MAC #10 and #12. RI #98's MAR for May 2023-October 2023 documented insulin was administered 116 times by MAC #10, #11, #12 and #13. On 11/06/2024 at 11:15 AM an interview was conducted with MAC #13 and he was asked had he ever administered insulin via pen from May October 2023. MAC #13 stated yes he did and it was signed off on the MAR. MAC #13 stated, he stopped administering insulin per pen in October 2023. An interview was conducted on 11/06/2024 at 12:54 PM with MAC #18. She stated when she started working at the facility in September of 2023, she was instructed to administer insulin, but refused to do it. MAC #18 further stated that other MACs had administered insulin to residents and she told the DON. MAC #18 was asked what was the concern of a MAC administering insulin. She stated they could give the wrong dose, give too much or wrong insulin and if the resident was borderline, if blood sugars were not monitored they could drop. On 11/08/2024 at 11:03 AM an interview was conducted with MAC #10 and MAC #10 stated she had administered insulin to residents to help out. MAC #10 stated she had administered insulin for about six months. MAC #10 stated the Alabama Board of Nursing said, MACs can not administer insulin. MAC #10 was asked what was the potential harm of administering insulin to residents and she stated you may give a resident too much that could kill them. On 11/08/2024 at 3:36 PM an interview was conducted with MAC #12. MAC #12 stated he had administered insulin to residents in 2023. MAC #12 said he did not follow the company policy regarding administering insulin to residents. On 11/07/2024 at 11:37 AM an interview was conducted with Registered Nurse (RN) Supervisor. RN #16 was asked about the concern of MACs administering insulin. RN #16 stated they would not know the sign and symptoms of hypoglycemia or hyperglycemia and they were not trained to administer insulin and it was not in their scope of practice. On 11/07/2024 at 11:53 AM an interview was conducted with the current DON #2. DON #2 stated the med techs were administering insulin until she became the DON again. She was asked what was the concern of MACs administering insulin. DON #2 stated they have not been trained well enough to know the side effects if they gave too much insulin, blood sugar could bottom out and cause coma, delirium, hypoglycemia and hyperglycemia. DON #2 further stated administration of insulin was not in their scope of practice. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/08/2024 at 1:36 PM an interview was conducted with the Former DON #17. DON #17 was asked if she instructed MACs to administer insulin. DON #17 stated, when she was hired as the DON, the MACs were administering insulin. She further stated that the DON who was the corporate nurse at the time instructed the MACs to administer insulin. DON #17 stated, administering insulin was not in the med techs scope of practice and they did not follow the facility's policy. A follow up interview was conducted on 11/08/2024 at 3:51 PM with DON #2. DON #2 stated when she found out the MACs were administering insulin she immediately called the Alabama Board of Nursing. DON #2 stated she was told by the Alabama Board of Nursing that MACs were not allowed to administer insulin, so they were informed to stop the administration of insulin. DON #2 stated all MACs and nurses were in-serviced about insulin administration.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 39580 Based on observations, interview, and review of a facility policy titled Posting Direct Care Daily Staffing Numbers, the facility failed to ensure the required data was on the staff posting form, to include census and the number of staff working and actual hours worked for all nursing staff on four of five days of the survey. This deficient practice had the potential to affect all 46 residents residing in the facility. Findings include: A facility policy titled, Posting Direct Care Daily Staffing Numbers, with a revised date of July 2016 documented: . Policy Interpretation and Implementation 1. Within two (2) hours of the beginning of each shift, the number of licensed nurses . and the number of unlicensed nursing personnel (CNA's) directly responsible for resident care will be posted . 3. Shift staffing information shall be recorded on the Nursing Staff Directly Responsible for Resident Care form for each shift. The information recorded on the form shall include the following: a. The name of the facility. b. The date for which the information is posted. c. The resident census at the beginning of the shift for which the information is posted. d. Twenty-four (24)-hour shift schedule operated by the facility. e. The shift for which the information is posted. g. The actual time worked during that shift for each category and type of nursing staff. h. Total number of licensed and non-licensed nursing staff working for the posted shift. On 11/04/2024 at 3:03 PM the surveyor observed the Staffing Sheet posted on the bulletin board at the nurses station. There was no census documented and no total hours actually worked for the staff on the first shift (6:00 AM-2:00 PM) and the second shift (2:00 PM-10:00 PM). On 11/05/2024 at 4:11 PM the surveyor observed the Staffing Sheet posted on the bulletin board at the nurses station. There was no total number of Licensed Staff or total actual hours worked for the second shift. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	On 11/06/2024 at 4:28 PM the surveyor observed the Staffing Sheet posted on the bulletin board at the nurses station. There was no documentation of the total actual hours worked for all nursing staff for the second shift. On 11/07/2024 at 2:56 PM the surveyor received a copy of the Staffing Sheet. There was no documentation of the number of nursing staff working and the total actual hours worked for all nursing staff for the second shift. On 11/08/2024 at 12:46 PM an interview was conducted with the DON (Director of Nurses) #2. DON #2 was asked what information should be included in the staffing sheet. DON #2 stated the staff present in the building and the census. The Surveyor asked DON #2 to look at the staffing sheets for 11/04/2024 through 11/07/2024 and identify what information was missing. DON #2 stated, the census, total hours, night shift hours for nurses and the CNA hours from 6 p-6A were missing. DON #2 was asked what was the concern of not posting the accurate staff count of RN's LPN's MAC's and CNA's in the facility. DON #2 stated you need to know the total of staff in the building in the case of an emergency. DON #2 said the facility's policy regarding posting the date on the staffing form included the census and the total number of licensed and non-licensed nursing staff working the shift, when should it be done. DON #2 stated it should be posted within 2 hours of shift start, the staffing sheet should be posted, but it was not done. DON #2 was asked what was the concern of the staffing sheet not being posted two hours prior to the start of shift. DON #2 stated the facility did not have an accurate count of staff and the policy was not followed.

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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. 34019 Based on observations, interviews and facility policies titled Cleaning Dishes/Dish Machine and Resource: Taking Accurate Temperatures, the facility failed to ensure: 1) Plate domes/covers and trays were not wet nesting and; 2) The temperatures on the tray line were taken and recorded. This had the potential to affect 40 residents who received meals from the kitchen. Findings include: 1.) A facility policy titled Cleaning Dishes/Dish Machine dated 2017 documented the following: . Procedure . 9. Dishes should be air dried on the dish racks. Do not dry with towels. 11. Dishes should not be nested unless they are completely dry. On 11/06/2024 at 09:28 AM during an observation of dishwashing, clean trays and domes were staked on top of each other as they came out of the dishwasher. Kitchen staff were observed transporting the trays and domes out of the dish room onto a cart and they were stacked on top of each other. On 11/06/2024 at 11:18 AM the surveyor observed seven trays with water in them, four domes with a small amount of water in the top of the dome, and one dome with a large amount of water. On 11/06/2024 at 12:39 PM Dietary Aide (DA) #19 stated she saw water on the trays and domes. DA #19 stated, there were about ten domes and five trays with water in them. When asked what she had done after the surveyor had asked what was on the trays and domes, DA #19 stated, she did nothing. DA #19 stated, she did not know the facility policy regarding wet nesting and she had not had an in-service on wet nesting. On 11/07/2024 at 9:30 AM Dietary Manager (DM) #4 stated, staff have not had a lot of training on wet nesting. The DM stated, it was important that domes and trays are not wet because it could grow bacteria. DM #4 stated, domes and trays were stacked on top of each other in the dish room. DM #4 stated, domes and trays taken from the dish room do not have time to air dry. 2.) A facility policy titled Resource: Taking Accurate Temperatures dated 2010, documented: . Taking Accurate Temperature using Metal Stem Thermometers . 2. Wait for the thermometer to rise . read and record the temperature . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a facility temperature log document dated 11/06/2024 for the lunch meal service revealed no temperatures were documented by Cook/Dietary Aide #20 after taking the temperatures for the lunch meal for 11/06/2024. On 11/06/2024 at 10:36 AM the Cook/Dietary Aide #20 took the temperature of the vegetables and they were 192 degrees, however she did not record the temperatures. The first pan of chicken and rice temperature was 173 degrees and it was placed on the tray line with no temperature written down. The second pan of rice was 180 degrees and the temperature was not written down. On 11/06/2024 11:18 AM the Cook/Dietary Aid #20 did not take the temperature of the puree chicken and and she did not write the temperature down. She also did not take the temperatures of any of the pureed foods. On 11/06/2024 at 12:29 PM an interview was conducted with Cook/Dietary Aide #20. DA #20 stated, she did not remember the temperature of the first pan of chicken and rice. She was given the temperature log and she stated that she did not remember what the temperature of the second pan of rice was and she did not know who wrote down the temperature of 188. DA #20 stated it was not her handwriting. DA #20 stated, she did not write down the food temperatures immediately. DA #20 stated, she did not know the facility's policy on writing down food items on the tray line. DA #20 stated, all food on the tray line should be written down. DA #20 stated, it was important to write down food temperature on the tray line so you would know it had been done and would have what the temperatures were. On 11/07/2024 at 9:30 AM an interview was conducted with the DM #4. DM #4 stated, all food items on the tray line should be written down immediately and all food items on the tray line temperature should be taken.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 37292 Based on interviews, record review, review of the Administrator Job Description, and review of the facility's Abuse Policy, the facility's former Administrator, ADM #5, failed to provide oversight to ensure the facility's abuse policies were implemented and failed to conduct thorough investigations of abuse allegations to identify contributing factors and take corrective action to prevent further abuse. The Administrator's failure to ensure that the facility's abuse policies were implemented, and that allegations of abuse were thoroughly investigated to ensure the appropriate corrective actions were taken, was likely to result in further abuse and serious harm, serious injury, impairment, or death. 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 serious psychosocial harm to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.70 Administration at F 835-Administration. On 11/27/2024 at 5:12 PM, the Administrator (ADM) and Director of Nursing (DON) were provided a copy of the IJ template and notified of the finding of immediate jeopardy at F 835-Administration. The IJ began on 07/09/2023 and continued until 11/29/2024 when the survey team verified onsite that corrective actions had been implemented. On 11/30/2024 the immediate jeopardy was removed, F 835 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. These failures of the Administrator had the potential to affect all residents residing in the facility. This deficiency was cited as the result of the investigation of complaint/report numbers AL00044741, AL00045507, and AL00047853. Findings include: Cross-Reference F 600, F 607, F 609, F 610, F 837, and F 867. Review of the Administrator Job Description, with no date, revealed the following: . Administrator Job Description . General Purpose: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	To direct the day-to-day functions of the facility in accordance with current federal, state, and local standards governing long-term care facilities to ensure that the highest degree of quality care can be provided to the residents at all times . Essential Job Functions: A. Administrative Functions Duties: . ensure that each resident receives the necessary nursing, medical and psychological service to attain and maintain the highest possible mental and physical function status . ensure compliance with all facility policies and procedures . A facility policy titled ABUSE PREVENTION, Revised 01/06/2023, documented: . I. PURPOSE To identify actual or potential abuse and process reports to thoroughly investigate, resolve, follow-up and prevent abuse in our facility. . II. POLICY Each resident, . has the right to be free from abuse by anyone, in any form . IV. RESPONSIBILITY 1. Every employee is responsible to recognize and report abuse. 2. Administrator is responsible to ensure that all aspects of this program are effectively implemented. On 11/27/2024 at 09:30 AM an interview was conducted with DON #2. She stated the abuse coordinator was the Administrator. DON #2 stated that she was not trained on the abuse investigation and that she only watched the previous DON complete a couple of incident reports when she was the Assistant Director of Nursing (ADON). According to DON #2 there were no five-day reports in the files for RI #98, RI #20, and RI #99. She further stated the five-day reports should have been done and filed with their incident reports. DON #2 stated that ADM #5 was responsible for investigating and turning in the five-day reports to the State Agency for RI #98, RI #20, and RI #99. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/26/2024 at 4:55 PM, a telephone interview was conducted with ADM #5 who stated that there was some confusion about who the abuse coordinator was because the Director of Operations (DO) initially told him that it was the Director of Nursing (DON), but then later told him that it was him. When asked if he ever interviewed other residents or staff when he was doing his abuse investigations, ADM #5 stated not that he recalled. ADM #5 was asked should other residents and staff be interviewed to identify unreported concerns regarding a resident's behavior or staff concerns, and he said that they should be. When asked who trained him on investigating abuse or Facility Reported Incidents, ADM #5 said DON #2, but that the DO, was his immediate supervisor. He said that he received very limited training from his supervisor. On 11/27/2024 at 2:41 PM, a telephone interview was conducted with the DO. When asked who did the ADM report to, the DO said that the ADM reported to her. When asked how ADM #5 was trained, the DO said that she went to the facility for one day on his second day there. The DO said that there a checklist that she went over with ADM #5 on the second day, but that she was always available by phone for any questions. When asked if ADM #5 should have had a completed checklist in his folder, she said that he should, but she had been told that his folder was missing. The DO was asked who the abuse coordinator was in the facility, and she said that the ADM was always the designated abuse coordinator, but the ADM and DON worked together on the reports. When asked who was responsible for the five-day report to ADPH, the DO said it was the ADM. ********** On 11/30/2024 at 1:13 PM, the facility submitted an acceptable removal plan, which documented: F 835 Removal Plan 11/29/2024 1. Immediate action(s) taken for the resident(s) found to have been potentially affected include: A. The facility's Administrator resigned on 10/28/2024, and the new Administrator was hired on 10/28/2024. B. The Director of Operations trained the new administrator on the abuse policy on 11/8/2024. C. The Director of Operations provided one on one in-service education on 11/08/2024 and 11/29/2024 to the Administrator regarding the abuse policy being implemented and including conducting thorough investigations, collecting and retaining witness statements to determine a clear time of occurrence of events to ensure all staff respond appropriately and preserve all evidence such as videos of the incidents as applicable. 2. Identification of other residents having the potential to be affected: A. This had the potential to affect all residents. B. No other incidents regarding not reporting timely or investigating allegations of abuse were noted through the staff and resident interviews conducted on 11/29/2024. 3. Actions taken/systems to be put into place to reduce the risk of future occurrences include: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A. The facility's abuse policy was discussed in the QAPI Committee Meeting held on 11/29/2024 with the Administrator understanding the responsibilities regarding the policy being implemented. In addition to the Administrator and Director of Operations, the following people attended the QAPI meeting on 11/29/2024: RN Supervisor, Medical Records, Director of Rehab, Director of Nursing, Financial Coordinator, Infection Preventionist/Restorative Nurse, Environmental Services, Director of Operations, Corporate Human Resources Director. The Director of Operations is to sign off on all reportables. B. Abuse in-services were held on 11/09/2024 training done by DON, 11/15/2024 training done by DON, 11/22/2024 training done by DON, 11/26/2024 training done by Administrator, 11/27/2024 training done by DON, and 11/29/2024 training done by RN Supervisor. In-service was for all staff in all departments including nursing, therapy department, dietary, environmental services, and management. 75 employees were in-serviced. Facility requests for IJ removal plan to be effective on 11/29/2024. This plan was written by Director of Operations, Administrator, and Director of Nursing. ********** 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 11/29/2024.

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 37292 Based on interviews, record review and review of the Director of Operations Job Description, the Governing Body failed to provide oversite to ensure the facility's Abuse Coordinators, including Administrator (ADM) #5, were provided training on how to conduct a thorough investigation, identify contributing factors, and take corrective action to prevent further abuse. The Governing Body further failed to ensure the facility developed its Abuse Policy to include the process for coordination with the QAPI program to ensure the Abuse Policy was fully implemented for all allegations of abuse and thoroughly investigated to ensure the appropriate corrective actions were taken to prevent further abuse. It was determined the facility's noncompliance with one or more requirements of participation had 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 at F 837- Governing Body. On 11/27/2024 at 5:12 PM, the Administrator and the Director of Nursing (DON) were provided a copy of the immediate jeopardy template and notified of the immediate jeopardy finding in the area of F 837-Governing Body. The IJ began on 07/09/2023 and continued until 11/29/2024 when the facility implemented corrective action. On 11/30/2024, the immediate jeopardy was removed, F 837 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. These failures had the potential to affect all residents who reside in the facility. This deficient practice was cited as a result of the investigation of the Facility Reported Incidents (FRIs), complaint/report numbers AL00044741, AL00045507, and AL00047853. Findings Include: Cross Reference F 600, F 607, F 609, F 610, F 835, and F 867. A review of the Director of Operations Job Description, signed by Employee Identifier (EI) #25 on 8/13/18, revealed: General Purpose: To direct the day-to-day functions of the facility in accordance with current federal, state, and local standards governing long-term care facilities to ensure that the highest degree of quality care can be provided to the residents at all times. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walker Rehabilitation Center, Inc	350 Northeast 4th Street Carbon Hill, AL 35549

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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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Essential Job Functions: A. Administrative Functions Duties: . ensure that each resident receives the necessary nursing, medical and psychological services to attain and maintain the highest possible mental, emotional and physical functional status . ensure compliance with all facility policies and procedures by all employees . On 11/26/2024 at 4:55 PM, a telephone interview was conducted with ADM #5. ADM #5 stated that there was some confusion about who the abuse coordinator was because the Director of Operations (DO) initially told him that it was the Director of Nursing (DON), but then later told him that it was him. When asked who trained him on investigating abuse, ADM #5 said DON #2, but that the DO, was his immediate supervisor. He said that he received very limited training from his supervisor, and they did not work with him to help him be a better Administrator. On 11/27/2024 at 2:41 PM, a telephone interview was conducted with the DO. The DO confirmed that she was responsible for the day-to-day operations of the facility and that the ADM or DON discussed any allegations of abuse with her on the phone, but she had not been provided with any physical proof of the investigations. The DO said the ADM was also responsible for making sure that allegations were investigated. When asked who did the ADM report to, the DO said that the ADM reported to her. When asked how ADM #5 was trained, the DO said that she went to the facility for one day on his second day there. The DO said that there a checklist that she went over with ADM #5 on the second day, but his checklist was missing. The DO said that she was always available by phone for any questions. The DO was asked how she ensured that the ADM was fully trained and understood how to investigate, and she said that they had access to the policies, they called and discussed, and they did a check off to make sure that they have what they needed in the file for the allegation. The DO was asked if she felt like ADM #5 had been provided adequate training for investigating FRIs, she said that she did not know any reason why he would not know. The DO was asked who was responsible and accountable for the Quality Assurance and Performance Improvement (QAPI) Program. She said the ADM was ultimately responsible for the QAPI Program. When asked if she participated in QAPI, she said that she had not had time to be in the meeting. During the interview with the DO, she was asked if allegations of abuse should be discussed during the QAPI meeting, she said that they should be so that the root cause analysis could be determined. When asked what oversight she provided to the facility regarding the QAPI Committee to include the reported incidents of abuse, the DO stated that she was not personally looking at it. ********** On 11/30/2024 the facility submitted an acceptable removal plan, which documented: 1. Administrator #5 resigned on 10/28/2024 and the new administrator was hired on 10/28/2024. 2. All residents have the potential to be affected by the deficient practice. The owner is a member of the governing body. The Director of Clinical Services trained the Director of Operations on 11/08/2024 on the abuse policy and how to conduct a thorough investigation, how to identify contributing factors and how to take corrective action to prevent further abuse. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. The Director of Operations trained the new administrator on the abuse policy on 11/08/2024 on how to conduct a thorough investigation, how to identify contributing factors, and how to take corrective actions to prevent further abuse. The Director of Operations updated the abuse policy on 11/08/2024 and 11/29/2024 to include the process for coordination within the QAPI program. 4. Facility abuse policy was discussed in QAPI meeting held on 11/29/2024. A. The QAPI meeting was held on 11/29/2024 to discuss the abuse prevention policy. Actions taken by the QAPI committee include the 24-hour report book and 24-hour report being discussed in detail each morning during the morning meeting. B. The following personnel attended the QAPI meeting: RN Supervisor, Medical Records, Director of Rehab, Director of Nursing, Financial Coordinator, Infection Control/Restorative, Housekeeping Supervisor, HR Corporate Director, Director of Operations, Administrator, Medical Director. Facility requests for IJ removal plan to be effective on 11/29/2024. ********** 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 11/29/2024.

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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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 44165 Based on interviews, record review, and review of facility policy titled Quality Assurance and Performance Improvement (QAPI) Program-Governance and Leadership the facility's QAPI committee, failed to thoroughly review all allegations of abuse that occurred on 07/08/2023, 07/09/2023, 09/06/2023, 05/10/2024 of incidents to identify all causal factors and to take appropriate action to prevent reoccurrences. These incidents are related to Resident Identifiers (RI) #5, RI #20, RI #98, and RI #99's Facility Reported Incidents (FRIs). The facility failed to ensure its Quality Assessment and Assurance (QAA) Program developed and implemented process to analyze and review all adverse events including substantiated allegations of abuse. The QAA committee did not review incidents of abuse that occurred to ensure the Abuse Policy was fully implemented for all allegations of abuse including staff's identifying, stopping (protecting the resident from further abuse), and reporting abuse. The QAA committee did not review the incidents to ensure the allegations were thoroughly investigated to ensure the appropriate corrective actions were taken to prevent further abuse. It was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.75 Quality Assurance and Performance Improvement at F 867-QAPI/QAA Improvement Activities. On 11/27/2024 at 5:21 PM, the Administrator (ADM) and Director of Nursing (DON) were provided a copy of the IJ template and notified of the finding of immediate jeopardy at F 867- QAPI/QAA Improvement Activities. The IJ began on 07/09/2023 and continued until 11/29/2024 when the survey team verified onsite that corrective actions had been implemented. On 11/30/2024 the immediate jeopardy was removed, F 867 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 was cited as a result of the investigation of the Facility Reported Incidents (FRIs), complaint/report numbers AL00044741, AL00045507, and AL00047853. Findings include: Cross reference F 600, F 607, F 609, F 610, F 835, and F 837. A review of a facility policy titled Quality Assurance and Performance Improvement (QAPI) Program-Governance and Leadership with a revised date of March 2020, revealed: Policy Statement (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The quality assurance and performance improvement program is overseen and implemented by the QAPI committee, which reports its findings, actions and results to the administrator and governing body. Policy Interpretation and Implementation 1. The administrator, whether a member of the QAPI committee or not, is ultimately responsible for the QAPI program, and for interpreting its results and findings to the governing body. 2. The governing body is responsible for ensuring that the QAPI program: a. Is implemented and maintained to address identified priorities; . 4. The responsibilities of the QAPI committee are to: a. Collect and analyze performance indicator data and other information; b. Identify, evaluate, monitor and improve facility systems and processes that support the delivery of care and services; c. Identify and help to resolve negative outcomes and/or care quality problems identified during the QAPI process; d. Utilize root cause analysis to help identify where identified problems point to underlying systematic problems; e. Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality of care; A review of the QAPI committee documentation revealed there was no evidence that indicated any review or discussion of the incidents of abuse that occurred on 07/08/2023, 07/09/2023, 09/06/2023, or 05/10/2024, during QAPI meeting in order to identify all causal factors necessary to take appropriate action for future prevention. On 11/27/2024 at 09:30 AM an interview was conducted with DON #2 who stated the QAPI committee consisted of all department heads and the medical director and met at least quarterly. During QAPI, clinical, pharmacy, infection control, wounds, restorative, Minimum Data Set (MDS), care plans, incidents and accidents, therapy, social services, medical records, supplies, dietary, workplace safety and employee incidents, human resources, maintenance, housekeeping, activities, business office, administrators report, and regulatory compliance were all discussed during these meetings. DON #2 further stated the incidents for Resident Identifier (RI) #98, RI #5, RI #20, and RI #99 had not been discussed in any QAPI meetings. DON #2 stated she could not answer why the incidents were not discussed in QAPI. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/26/2024 at 4:55 PM a phone interview was conducted with ADM #5. He stated there no discussion about each incident for RI #5, RI #20, RI #98 and RI #99 in the QAPI meetings. He further stated that there was just a number entered on the form for the number of abuse incidents received, but they were not reviewed or discussed during the meetings. When asked what interventions were developed to address the culture and behavior of staff abusing residents and not intervening, ADM #5 stated the facility did not address that in QAPI. On 11/27/2024 at 2:41 PM a phone interview was conducted with Director of Operations (DO). The DO stated her responsibility was the day to day operations. The DO stated she has not had time to participate in a QAPI meeting. She further stated she expected the facility to have monthly QAPI meetings. During the interview with the DO, she was asked if allegations of abuse should be discussed during the QAPI meeting, she said that they should be so that the root cause analysis could be determined. ********** QAPI committee failed to thoroughly review allegations of abuse that occurred on 7/8/2023, 7/9/2023, 9/6/2023, 5/10/2024 of incidents to identify all causal factors necessary to take appropriate action for future prevention. Request immediate jeopardy removal effective 11/29/2024 1. Administrator #5 resigned on 10/28/2024 and the new administrator hired on 10/28/2024. 2. All residents have the potential to be affected by deficit practice 3. Director of Clinical Services trained the Director of Operations on 11/8/2024 the abuse policy and how to conduct a thorough investigation, how to identify contributing factors and take corrective action to prevent further abuse. 4. The Director of Operations in-serviced the new administrator on QAPI program and all the elements the elements related to abuse include screening, training, prevention, identification, investigation, protection, reporting/response, and QAPI on 11/29/2024. The administrator trained following employees who attended QAPI committee meeting include RN supervisor, medical records, director of rehab, director of nursing, infection preventionist/restorative nurse, environmental services, director of operations, and corporate human resources director on QAPI program and all the elements the elements related to abuse include screening, training, prevention, identification, investigation, protection, reporting/response, and QAPI on 11/29/2024. 5. All abuse investigations since 07/10/2023 were reviewed by the Administrator to ensure all allegations were identified by staff, residents were immediately protected, allegation reports per policy, investigations were completed appropriately, had appropriate witness statements collected, all causal factors were identified, and appropriate corrective action was taken. This review was completed on 11/8/2024. Employees who failed to report are no longer employed with the company and the residents are not in the facility at this time. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	6. The Director of Operations provided 1-on-1 in-service to Administrator and DON regarding conducting QAPI meeting on 11/29/2024. Monthly QAPI meetings since January 2024 reviewed were reviewed on 11/29/2024 to ensure no other residents were affected. Reviewed to make sure nothing was missed in QAPI. There was no specific abuse allegations discussed in QAPI. No other incidents were identified in our review of our monthly QAPI meeting. The Ad Hoc QAPI meeting was completed on 11/29/2024 QAPI committee was informed and the plan was made that one member of the corporate team will be included in all meetings to ensure allegations of abuse and monthly QAPI meeting to ensure all causal factors are addressed. The casual factors will be identified through the root cause analysis using the five Why's method. QAPI team will need to be educated on conducting root cause analysis. 7. QAPI meeting The following employees attended QAPI committee meeting include RN supervisor, medical records, director of rehab, director of nursing, infection preventionist/restorative nurse, environmental services, director of operations, and corporate human resources director held on 11/29/2024 to develop and implement a process to ensure all substantiated allegations of abuse are reviewed and analyzed to ensure the appropriate corrective actions is taken to address all contributing factors of abuse. The administrator will be responsible for bringing all allegations of abuse to the QAPI meeting utilizing root cause analysis and the five why's method to ensure all casual factors have been addressed. Facility requests for IJ removal plan to be effective on 11/29/2024. ********** 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 11/29/2024.