

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 11/20/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER St Martin's IN the Pines		STREET ADDRESS, CITY, STATE, ZIP CODE 4941 Montevallo Road Irondale, AL 35210	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)		

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

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

TITLE

(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents were provided baths/showers for 2 (Resident #70 and Resident #77) of 11 residents reviewed for activities of daily living (ADLs). Findings included: During an interview on 06/29/2025 at 5:53 PM, Director of Clinical Services (DCS) #12 stated they did not have a policy for ADL care; they only had a procedure. An undated form titled, CNA [Certified Nurse Aide] Bath & Shower Report, revealed, The following assessment is to be completed on all residents receiving a bath. The Charge Nurse will sign and verify each assessment for accuracy and completion. All wound and findings are to be addressed immediately by the Charge Nurse and forwarded to the Unit Manager and Treatment Nurse with follow up of a physician or Nurse Practitioner if needed. The bottom of the form included a place for the resident's name, the date, the name of the CNA who provided the bath or shower, and the name of licensed nurse who received the form. 1. The admission Record revealed the facility admitted Resident #70 on 02/28/2025. According to the admission Record, the resident had a medical history that included diagnoses of unspecified dementia, limitation of activities due to disability, muscle weakness, cognitive communication deficit, the need for assistance with personal care, and hemiplegia and hemiparesis (weakness or partial paralysis on one side of the body) following a cerebral infarction (stroke). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/24/2025, revealed Resident #70 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident exhibited verbal behaviors that occurred four to six days during the assessment's lookback period. The MDS revealed the resident did not reject care during the assessment's lookback period. The MDS revealed the resident was dependent on staff for showering and/or bathing. Resident #70's Care Plan Report, revealed a focus area initiated on 03/04/2024 and revised on 04/14/2025, that indicated the resident had a self-care deficit related to decreased abilities due to right hemiplegia and dementia. The focus area revealed the goal was that the resident's ADL needs would be met in a comfortable and caring manner. Interventions directed staff to assist with bathing as needed; provide cueing, supervision, and assistance with ADLs as needed; and provide partial/moderate assistance with showering/bathing. An undated Cottage A Shower Schedule revealed that Resident #70 was scheduled to have showers provided on the 3:00 PM to 11:00 PM shift on Tuesdays, Thursdays, and Saturdays. The schedule indicated that all bath sheets must be turned in to charge nurse for review by 12noon on 7-3 [shift] and 7PM on 3-11 [shift]. During an interview on 06/28/2025 at 3:07 PM, DCS #12 stated she was not able to locate any of the shower sheets for Resident #70. She stated that she would not necessarily assume that the resident had not had showers by not having the actual bath sheets. An observation on 06/23/2025 at 11:00 AM revealed Resident #70 was sitting up in bed. The resident's hair appeared oily to the point of looking wet, and there was an odor in the room. During a concurrent interview, Resident #70 stated that staff did not provide showers, and it had been a month since their last shower. An observation on 06/24/2025 at 3:25 PM revealed Resident #70 was in bed. The resident's hair still appeared greasy. There was an odor in the room. During a concurrent interview, Resident #70 stated that staff had not provided a bath or shower. An observation on 06/25/2025 at 12:35 PM revealed Resident #70's hair still appeared to be extremely greasy, to the point of looking wet. There was an odor in the room. During a concurrent interview, the resident reported that staff had still not provided a shower. An observation on 06/26/2025 at 12:21 PM revealed Resident #70 was sitting in bed. The resident's hair still appeared to be greasy, to the point where it almost looked wet. There was an odor in the room. During a concurrent interview, Resident #70 stated staff had not provided any bathing or a shower. During an interview on 06/26/2025 at 12:52 PM, CNA #47 stated staff were supposed to be providing showers three times a week. CNA #47 stated Resident #70 did not refuse showers. During an interview on 06/27/2025 at 8:18 AM, Licensed Practical Nurse (LPN) #51 stated she worked strictly in Cottage A. She stated that she did not track the showers staff provided. She stated staff were not turning in the shower sheets to her. LPN #51 stated she noticed Resident #70 was fairly malodorous, but the resident's showers were not on her shift, so she did not track them. During an interview on 06/27/2025 at 12:15 PM, DCS #12 stated that staff were supposed to be completing shower sheets when they provided showers or bathing as well as documenting in the electronic medical record (EMR). During an interview on 06/27/2025 at 1:33 PM, LPN #48 stated she normally worked in Cottage A where Resident #70 resided. She noted she was familiar with Resident #70, but did not know the resident's scheduled shower days. She stated the resident did not refuse care. LPN #48		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility document and policy review, the facility failed to prevent a fire in a kitchen near residents. Specifically, kitchen staff placed plastic and foam containers in an oven on the second and third floor kitchens of Cottage B, causing the containers to melt and excessive smoke to [NAME] out of the oven into an area near residents. It was determined the facility's non-compliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to 483.25(d)(1) (Accidents). The IJ began on 06/23/2025 at 11:46 AM when Food Service Worker (FSW) #24 placed five plastic containers and one foam to-go container holding food for a lunch meal into an oven set to the warm setting on the second floor of Cottage B. FSW #24 then proceeded to deliver the lunch meal to the third floor of Cottage B. There was then a strong smell of burnt plastic in the living area on the second floor of Cottage B. Certified Nurse Aide (CNA) #33 opened the oven, and smoke billowed out into the kitchen and common area where residents were sitting. CNA #33 then turned the oven off and opened the door to the outdoor balcony to air out the living area of the second floor. An observation on 06/23/2025 at 12:05 PM revealed two burnt and melted foam to-go containers sitting on a countertop in the kitchen on the third floor of Cottage B. The Administrator (ADM) and Community Executive Director (ED) were notified of the IJ and provided the IJ template on 06/23/2025 at 5:49 PM. A Removal Plan was requested. The Removal Plan was accepted by the state survey agency on 06/27/2025 at 11:01 PM. The IJ was determined to be removed on 06/29/2025 at 7:00 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Noncompliance remained at the lower scope and severity of E that was not immediate jeopardy for F689. Additional findings were identified related to Residents #36, #92, #77, and #53. Specifically, Resident #36 suffered a right femur fracture when staff provided care and a thorough investigation was not conducted, Resident #92 suffered a fall and the facility did not investigate for the root cause of the fall, Resident #77 was assessed to need a sit-to-stand lift for transfers when one was not available for staff to use, and Resident #53 was found outside of the facility, gone for an unknown period of time. Findings included: 1. A facility policy titled, Fire Safety, dated 08/01/2012, indicated, It is the policy of this facility to insure [sic] that equipment is in compliance with applicable state and local regulations regarding fire safety. An owner's manual provided by the facility staff titled, Direct Air Convection Built-In Electric Wall Oven, revised in May 2024, indicated Do not store or use flammable materials in or near an oven, including paper, plastic, pot holders, linens, wall coverings, curtains, drapes and gasoline or other flammable vapors and liquids. Product specifications provided by facility staff, dated 06/23/2025, indicated the foam to-go containers should be stored at temperatures from 55 to 90 degrees Fahrenheit (F) and the plastic deli containers maximum storage temperature was 212 degrees F. An observation on 06/23/2025 at 11:46 AM revealed double ovens in the kitchen on the second floor of Cottage B. The observation revealed both ovens were dirty with crusty black lumps on the bottom of the ovens and inside the doors. Further observation revealed FSW #24 placed five small plastic containers and one foam to-go container holding food for the lunch meal directly on metal racks in an oven. During an interview at that time, FSW #24 stated that foam and plastic containers could go in the oven to keep the food warm. An observation on 06/23/2025 at 11:55 AM, revealed a strong smell of burnt plastic in the kitchen second floor. The observation revealed CNA #33 opened the oven, and smoke billowed out into the kitchen and common area where residents were sitting. The observation revealed CNA #33 pulled the food out of the oven and opened the door to the outdoor balcony to air out the living area of the second floor. An observation on 06/23/2025 at 12:05 PM revealed two burnt and melted foam to-go containers sitting on a countertop in the kitchen on the third floor of Cottage B. During an interview on 06/29/2025 at 11:04 AM, CNA #27, who was on the third floor on 06/23/2025, stated she witnessed FSW #24 place the plastic and foam to-go containers into the oven, she knew they should not have been in the oven, but by the time she removed them from the oven they had already started melting. During an interview on 06/23/2025 at 4:05 PM, the Executive Chef stated the kitchen staff prepared food in the main kitchen located in the main building and then sent it to Cottage A and Cottage B in metal steam table pans, plastic deli containers, and individual meals in foam to-go containers. The Executive Chef further stated if the plastic containers holding the food for the residents in the cottages melted, then the ovens must have been on the wrong setting because they could withstand being reheated to 200 to 250 degrees F. Per the Executive Chef, the foam to-go containers were not designed to		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, interview, and facility policy review, the facility failed to have an effective pain management program for 1 (Resident #98) of 1 resident reviewed for pain management. Findings included: On 07/18/2025 at 6:03 PM, Corporate Director of Clinical Services (DCS) #12 stated the facility did not have a policy for pain management, but it was the resident's right to be free of pain. An admission Record indicated the facility admitted Resident #98 on 09/05/2024. According to the admission Record, the resident had a medical history that included orthopedic aftercare following surgical amputation of the right leg below the knee, peripheral vascular disease, chronic pain, and anxiety disorder. The admission record indicated the resident was discharged home with home health services on 09/25/2024. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/09/2024, revealed Resident #98 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident frequently experienced pain that occasionally made it hard to sleep but rarely limited participation in therapy or day-to-day activities. The MDS indicated the resident rated their worst pain at an 8 (on a scale of 0 to 10, with 10 being the worst pain possible) in the last five days during the assessment period. Resident #98's Care Plan Report, included a focus area initiated 09/17/2024, that indicated the resident needed pain management and monitoring related to a surgical procedure, wound disruption, neuropathy, and peripheral vascular disease. Interventions directed staff to administer pain medication as ordered; evaluate and establish a level of pain on a numeric scale or using a pain evaluation tool; evaluate characteristics, frequency, and pattern of pain; evaluate need for routinely scheduled medications rather than as-needed pain medication administration; evaluate the need to provide medications prior to treatment or therapy; evaluate what made the resident's pain worse; provide dim lighting and quiet environment; reposition as needed; provide rest; and consults with the pharmacy as needed. Resident #98's hospital Discharge Summaries, dated 09/05/2024, indicated the resident's hospital course was complicated by difficulty controlling the resident's pain, and in-patient pain services were consulted. The summaries indicated that the resident was stable to transfer to a skilled nursing facility on a medication regimen. Resident #98's facility Order Recap [Recapitulation] Report, for the timeframe from 09/01/2024 through 06/24/2025, included an order dated 09/05/2024 for oxycodone 10 milligrams (mg) with instructions to give 10 mg orally every four hours as need for pain. Further review revealed there were no orders to monitor the resident's pain level on a routine basis or orders for non-pharmacological interventions. Resident #98's September 2024 Medication Administration Record [MAR], revealed Registered Nurse (RN) #79 documented that oxycodone 10 mg was administered on 09/19/2024 at 5:24 AM, for pain level that was rated 6 and documented as being ineffective with no follow-up. Further review revealed no non-pharmacological interventions were documented prior to the administration of the oxycodone. Resident #98's Progress Notes, revealed no evidence of non-pharmacological interventions implemented on 09/19/2024 prior to the administration of the oxycodone. Resident #98's Progress Notes revealed Daily Skilled Nurses Notes dated 09/15/2024, 09/16/2024, 09/18/2024, and 09/19/2024 that indicated the resident required frequent pain medication. During a phone interview on 07/18/2025 at 9:21 AM, RN #79 stated they should ask the resident what their pain level was every shift and when administering an as-needed pain medication. He stated if the medication was not effective, then he would give something else if it were available and if not, he would contact the physician to get something. He stated non-pharmacological interventions were not used often because the residents just wanted medication. RN #79 stated they did not remember Resident #98. During an interview on 07/18/2025 at 11:00 AM, former Director of Nursing Services (DNS) #53 stated that when a resident was in pain, it was up to the nurse to treat that resident's pain with something and get ahold of the physician for orders. During an interview on 07/18/2025 at 1:05 PM, Licensed Practical Nurse (LPN) #22, a Unit Manager, stated residents' pain should be monitored every shift and documented on the MAR. She stated they should try non-pharmacological interventions first and document them, but she was not sure where. She stated they should always reassess a resident's pain after as-needed pain medication was given, and if it was not effective, they should try something else if available or contact the physician. During an interview on 07/18/2025 at 3:10 PM, the DNS stated pain should be monitored every shift and documented on the MAR. She stated non-pharmacological interventions should be tried and documented on the MAR. She stated if an as needed pain medication was given, the nurse should follow up, and if it was not effective, the nurse should give something else or contact the physician. During an interview		