STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015440	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntsville Health & Rehabilitation, LLC	4010 Chris Drive Huntsville, AL 35802

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, review of Facility Reported Incidents (FRIs), review of the facility's investigative file, review of facility's policies titled Elopement and Wandering Residents, Supervised Smoker & Other Tobacco Products, Supervised Smokers, and Incidents & Accidents the facility failed to ensure Resident Identifiers (RI) #106 and RI #121 received supervision in a manner to ensure their whereabouts were known to the facility and the residents were in an environment free of accident hazards.The facility further failed to ensure RI #33 and RI #109 complied with established smoking safety policies and procedures. The facility failed to monitor and enforce safe smoking practices, which resulted in unsafe smoking behaviors. Specifically: 1) On 04/14/2026 around 4:30 AM the facility's staff identified that RI #106, a resident at risk for elopement, was not in his/her room. The staff failed to take action to determine RI #106's whereabouts. When facility staff delivered breakfast to RI #106's it was determined the window was raised and RI #106 was not in the building. It was determined that RI #106 left the facility without staff knowledge on 04/14/2026. On the night of 04/16/2026 prior to midnight, RI #106 was almost run over by the local police patrol four miles from the facility. RI #106 was lying in the middle of the road, near an intersection adjacent to Interstate and U.S. Highway. RI #106 began having seizures and the police called Emergency Medical Services (EMS) who transported to the hospital. RI #106 was transferred to an acute care psychiatric facility after hospitalization. 2) On 04/11/2026 RI #121 was observed walking toward a busy parkway and was nearly struck by employees arriving for work. It was determined that RI #121 left the facility without staff knowledge on 04/11/2026. 3) On 03/30/2024 RI #33 was observed burning an orange juice container outside in the facility smoking area. The facility failed to monitor RI #33, a resident with a known history of starting fires and multiple documented episodes of noncompliance of the facility's smoking policy, who continued to be observed with lighters and cigarettes.4) On 09/15/2025 the State Agency received an anonymous complaint that RI #109 smoked in his/her room with a blind roommate. It was determined during the investigation that RI #109 was non-compliant with the facility smoking policy and procedures. It was determined the facility's noncompliance with one or more requirement 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 483.25 Quality of Care.On 04/22/2026 at 6:20 PM, the Regional Administrator was provided a copy of the Immediate Jeopardy template and notified of the findings of immediate jeopardy and substandard quality of care in the area of Quality of Care at F689-Free from Accident Hazards/Supervision/Devices. This template included RI #106.On 04/29/2026 at 9:39 AM, the Regional Administrator, the Director of Nursing (DON), the [NAME] President (VP) of Nursing Services, the Regional Nursing Consultant, and the Senior [NAME] President were provided a copy of the Immediate Jeopardy (IJ) template and notified of the findings of immediate jeopardy and substandard quality of care in the area of Quality of Care at F689- Free From Accident Hazards/Supervision/Devices. This template included RI #33 and RI #109.On 04/30/2026 at 11: 48 AM, the Regional Administrator, the VP of Nursing Services, the Senior VP of Operations, and the Assistant Administrator were provided a copy of the Immediate Jeopardy (IJ) (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of RI #106's initial Elopement Evaluation dated 06/17/2025 at 5:54 PM revealed documentation stating, No Elopement risk factors identified or verbalized and Elopement Care Plan not needed at this time. A review of RI #106's Elopement Evaluation dated 06/27/2025 at 10:49 AM revealed documentation stating, Resident is cognitively impaired, poor decision-making skills, and/or pertinent diagnosis (Example, dementia, Organic Bran Syndrome, Alzheimer's, delusions, hallucinations, anxiety disorder, depression, manic depression, and schizophrenia). Displays behavior(s) that may indicate an attempt to leave, body language etc., indicating an elopement may be forthcoming. Elopement Care Plan initiated. RI #106's Care Plan review revealed a care plan for RI #106's exhibited behaviors related to schizophrenia and expressive aphasia, including yelling out, resisting redirection, and emotional outbursts. Interventions had the start date of 06/17/2025 and included administering behavioral medications as ordered, approaching the wandering resident in a calm and accepting manner, and placing the resident in an area where frequent observation was possible. RI #106's Care Plan review also identified that RI #106's had a potential for elopement related to exit-seeking behavior. The interventions with start date of 06/27/2025 included observing for signs of elopement and securing an alarm bracelet with placement and function checks every shift. A review of RI #106's Physician Order Report dated 03/17/2026 through 04/17/2026 documented physician orders for adverse effect monitoring every shift and medications, including Levetiracetam, Depakote ER (divalproex), and Risperidone for mood disorder and psychiatric conditions. The orders also included an order with start date of 02/10/2026 to secure alarm bracelet to the ankle and to check for proper placement and functioning every shift. A review of RI #106's Integrated Behavioral Health (IBH) visit notes dated 04/08/2026 revealed the resident was seen for a follow-up visit related to schizoaffective disorder. The examination documented disorganized speech with tangential and circumstantial thought patterns, frequent repetition, and perseveration. The resident's thought process was documented as disorganized with loose associations. The IBH note stated staff were unable to adequately assess suicidal or homicidal ideation due to disorganized communication. RI #106's cognition was assessed as confused and aphasic, with impaired concentration and attention. The resident's language skills were significantly impaired, with disorganized output; executive functioning was impaired, memory could not be adequately assessed, and judgment and insight were poor. On 04/14/2026 at 11:01 AM, the State Agency received an Online Incident Reporting System Report (FRI) from the facility's Administrator (ADM), stating that Resident Identifier (RI) #106 was not present in the facility for breakfast on 04/14/2026 at 08:32 AM. A review of the facility's VERIFICATION OF INVESTIGATION documented: . DETAILED DESCRIPTION OF INCIDENT. On the morning of 4/14/2026, staff took breakfast to (RI #106). When they got to the room, they noticed the window was raised, and (he/she) was not in there. After doing an immediate resident count and searching the perimeter of the building, they confirmed the resident was not in the facility. CLINICAL ASSESSMENT OF RESIDENT. BIMS SCORE: 11. PROVIDE SUMMARY AND OUTCOME OF INVESTIGATION: On 04/14/26 (CNA #47) . noticed that (RI #106) was not in (RI #106's) bed. CNA #47 looked for RI #106 in the courtyard, and RI #106 was not there. (CNA #47) notified the charge nurse. who notified Administration. The investigation included that RI #106's roommate stated (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	assessment should have been completed. The RNC also stated she could not explain why RI #121 was permitted to sign himself/herself out of the facility unsupervised on 04/05/2026 and 04/10/2026, whether the resident's mother was notified, or whether the resident's care provider was informed. The RNC further stated she did not believe the 04/11/2026 elopement incident was reported to the State Agency, although it should have been reported. 3. RI #33 Facility's policy titled Supervised Smokers & Other Tobacco Products with an effective date of 12/02/2025, documented PURPOSE: The resident/guest has the right to smoke, if desired, unless facility is a smoke free property. However, smoking is supervised to protect the resident/guest(s) and staff from fire hazards, and only designated smoking areas are permitted during scheduled smoking times. This includes cigarettes, electronic cigarettes, and vapes/and any nicotine device containing E-liquids. These products should be kept at the nursing station in a safe secured place that no residents have access to and safety precautions should be followed by staff and residents. Smoking or partaking by any method or form will not be allowed on the facility premises of the following. Marijuana, THC, Hemp, and or CBD products, hallucinogenic/psychoactive drugs not prescribed or approved by the facility MD, any illegal substance in any form. STANDARD: . Resident/ Guest(s) should not be permitted to smoke or vape inside the facility/their rooms. PROCESS; Upon admission, the resident/guest(s) smoking desires should be determined, along with their ability to manage ashes safely and the smoking policy should be explained to resident/guest and representative. Use of any other tobacco products such as chewing tobacco/snuff should be determined and the policy should be explained also. Smoking materials and chewing tobacco/ snuff should be kept at the nurse's station, and staff should be informed to include electronic cigarettes and vaping materials as well as charging equipment. Staff should assist resident with recharging devices when needed and ensure safety. No fire igniting materials (matches/lighters) should be kept in resident/guest(s) possession. Smokers should obtain lighting materials from staff. Smokers should only smoke in a designated area, at designated times, with a staff member present, including electronic cigarettes and vaping. 6. Smoking Areas: Smoking areas should be designated as such. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RI #33 was re admitted to the facility on [DATE] with Diagnosed to include Dementia with Mood Disorder, Paranoid Schizophrenia and Insomnia due to Mental Disorders RI #33's quarterly MDS assessment with an ARD of 03/04/2024 documented a BIMS score of 13 of 15 indicating intact cognition. RI #33's behavior management care plan included being non-compliant with smoking and setting fires. Start date was 02/27/2024. Interventions include: . Resident Placed on 1:1.Resident re-educated on smoking policy. Observed and Document target Behaviors. Provide Diversional Activities. Administer behavior medications as ordered by physician. allow opportunity to make choices and participate in care. RI #33's progress notes documented, in January 2024, RI #33 was found twice unsupervised smoking once with a lighter on person. On 02/07/2024, RI #33 was observed outside smoking unassisted. On 03/06/2024, resident was observed on courtyard smoking a cigarette. On 3/26/2024, resident was observed in courtyard with cigarettes, no lighter, he/she stated someone else lit it for him/her. On 03/30/2024, RI #33 set an orange juice container on fire. On 02/27/2024, Integrated Behavioral Health (IBH) Notes, documented RI #33 had a history of arson 03/14/2024, IBH notes documented resident had attempted to start a fire. An Online Incident Reporting System Report, dated 04/01/2024, documented, . 03/30/2024 Time: 06:43 PM . Resident was seen by staff in courtyard setting orange juice container on fire . The facility investigative file contained a form titled, VERIFCATION OF INVESTIGATION documented . On March 30, 2024 at 643 pm facility dietary staff (cook) was notified by (a resident) to look what (RI #33) was doing in the northside courtyard, staff member (cook) opened the door to the courtyard, smell of smoke noted by (CNA #57), when observed an orange juice container was noted to have burns along with a burnt soap bottle in the flower bed. (CNA #57) notified charge and DON of incident. DON instructed staff to place resident on 1:1 observation with staff. *No injury noted to skin upon nurse assessment on 3/30/24. Facility does verify the incident occurred. Resident was discharged to hospital on 4/2/24 for psych eval. NAME OF WITNESS: POSITION / TITLE: Cook SUMMARY OF TESTIMONY: On March 30, 2024 I witnessed (RI #33) setting fire to something in the North side courtyard. When I confronted (him/her) about it (he/she) acted as if (he/she) didn't do it. (he/she) admitted to having a lighter. When I asked (him/her) where (he/she) got the lighter from (he/she) wouldn't tell me. So I told (CNA #57) to let the Nurse know what (he/she) was doing . NAME OF WITNESS: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	(CNA #57) POSITION / TITLE: Certified Nursing Asst SUMMARY OF TESTIMONY: On Saturday March 30, 2024. I was sitting in the dining room around 6 pm or so. When one of the residents had told (cook) to look what (RI #33) was doing on the north courtyard. When he got to the door and opened it I could smell something burning. I looked out the door and noticed (RI #33) was going in the building. I went to north courtyard and noticed that the orange juice container was burnt and the soap bottle in the flowerbed was burnt too. I went to the station and told the nurse (LPN #52) what was going on. That when (RI #33) was coming down the hall and (LPN #52) ask (him/her) for t

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident record review, and review of a facility policy titled Behavioral Health Care Services, The facility failed to ensure a behavior management process was implemented to ensure staff identified, evaluated, and implemented interventions to manage and address known resident behaviors that affected residents' safety. The facility failed to manage unsafe behaviors related to noncompliance with the facility's Smoking Policy and failed to manage unsafe wandering behaviors related to noncompliance with the facility elopement and wandering policy. The facility failed to recognize the need for adequate supervision and monitoring of residents with unsafe behaviors creating the risk for harming themselves and others in the facility. The facility further failed to provide the necessary behavioral health services to manage RI #116's behavioral symptoms and prevent physical aggression toward other residents. This failure placed residents at risk for physical harm. 1) Resident Identifier (RI) #33 exhibited unsafe smoking behaviors from January 2024 through April 2026, including starting fires, smoking in undesignated areas, smoking in the building, and violent behavior when redirection was attempted. 2) RI #109 exhibited unsafe smoking behaviors from 08/02/2025 through 01/26/2026, including smoking in the building. 3) RI #106, a resident with a history of being at risk for elopement, wandering the facility unsupervised during the day and at night, eloped on 04/14/2026 without the facility being aware. 4) RI #121, a resident who had a history of being at risk for elopement, noncompliance with care/treatment, and confusion left the building unsupervised on 04/05/2026 and 04/10/2026. The facility was aware of these instances as RI#121 was allowed to leave the facility unsupervised. RI #121 eloped on 04/11/2026 and was nearly struck by a employee's vehicle. It was determined the facility's noncompliance with one or more requirements of participation had cause, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 443.40 Behavioral Health Services. On 05/14/2026 at 11:28 AM, the Corporate Administrator, RN, DON, VP of Nursing Services, Regional Nursing Consultant, and Senior [NAME] President were provided a copy of the Immediate Jeopardy Template and notified of the findings in the area of Behavioral Health at F740-Behavioral Health Services. The immediate jeopardy began 03/30/2024 and was removed on 05/16/2026. The facility failed to manage RI #116's pattern of abusive behaviors towards other residents. When RI #116 and other residents bumped into each other with their wheelchairs RI #116 responded by swinging at residents, hitting residents, and pulling them to the floor. The facility investigative files documented RI #116's physically abusive behaviors toward RI #115 on 12/24/2024, RI #81 on 08/09/2025, RI #115 on 10/08/2025, and RI #21 on 10/27/2025. These deficient practices were cited as a result of the investigations of facility reported incident/complaint/report numbers 447450, 2983895, 447474, 2587752, 2644312, and 2654261. This deficient practice affected RI #33, RI #109, RI #106, RI #121, and RI #116, five of five residents sampled for behaviors Findings include: Cross-reference F689 A facility policy titled Distressed Behavior Management Program with an effective date of 03/12/2018 documented: PURPOSE: Identifying resident/guest(s) who currently exhibit some type of distressed behavior symptoms for (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	which additional or new treatment programs may be considered. Not all behaviors need extensive intervention. STANDARD: Resident/Guest(s) who display mental or psychosocial adjustment difficulty should receive appropriate services, in an attempt to correct the problem. PROCESS: 1. Assessment Behaviors should be identified through the RAI process and through staff interaction. Identified behaviors should be evaluated for frequency, duration and intensity for a pattern. The plan of care should be developed by the interdisciplinary team The Care Plan Team should decide which resident/guest(s) need a behavior management program vs. resident/guest(s) that are care planned with appropriate interventions. The plan of care should be reviewed at least quarterly for continued need of behavior management and appropriate interventions. Further assessments to identify and manage behaviors may be conducted. The Interact Behavior Care Path may be used to assist in identifying causes of distressed behavior symptoms and to determine interventions. See Interact Behavior Care Path Form. Psychosocial Comprehensive Review should be completed upon admission/readmission for any distressed behaviors present, when new behaviors are identified, and with OBRA MDS. A facility policy titled Behavior Management Program with an effective date of 03/01/2010 documented: . PURPOSE: Mental and psychosocial adjustment difficulties may be experienced by a resident, due to problems adapting to changes in life's circumstances. A resident with a mental adjustment disorder may have a sad or anxious mood, or a behavioral symptom such as aggression. STANDARD: Residents who display mental or psychosocial adjustment difficulty should receive appropriate services, in an attempt to correct the problem. The social service department may assist with arrangements for outside professional consultation services, such as psychologists or psychiatrists, when ordered by the attending physician. PROCESS: .The Charge Nurse should be notified when a resident displays inappropriate physical or sexual behavior. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and Last Reviewed/Revised 01/16/2026. A review of RI #109's Resident Progress Notes revealed the following entries were made by LPN #16, the LPN providing care for RI #109 on 08/02/2025, 09/20/2025, 09/30/2025, and 01/11/2026 during the 10 PM to 6 AM shift: . 08/02/2025 7:32 AM Nurse smelled marijuana in residents room multiple occasions. Resident appeared to be very much under the influence of said substance. Several times during the shift staff would smell marijuana and go to check in (on) the residents in the room. Resident would deny having anything slurring words, and getting angry that (he/she) was asked if (he/she) was smoking in (his/her) room . 09/20/2025 1:29 AM Nurse observed the very strong smell of cigarette smoking coming from residents room, and into the surrounding residents rooms. Resident was lying in bed almost asleep. Nurse asked resident if (he/she) had been smoking in the room, resident denied . Resident was educated on smoke break times along with safety of not smoking in the facility. Resident states (he/she) understands and that (he/she) won't smoke in the room . 09/30/2025 1:56 AM . Resident was observed smoking in room. Resident gave remaining portion of (his/her) cigarette to nurse to dispose of. DON made aware . 01/11/2026 12:03 AM . DON called nurse to give instructions regarding marijuana found next to resident. Nurse was instructed to call the police to destruct the medication and file report. Police arrived at 11:30PM . confiscated drugs . DON was made aware that report was made and drugs were taken by officer . Resident woke up in a frenzy looking for drugs . On 04/23/2026 at 11:00 AM an interview was conducted with LPN #16. The LPN said RI #109 had behaviors of trying to smoke outside of the designated smoke times, smoking cigarettes and marijuana in his/her room, and vaping in his/her room. LPN #16 said she could smell the fruity smell of a vape when she went in RI #109's room. LPN #16 said the residents should smoke in the designated area on the outside of the facility. LPN #16 said she documented in RI #109's progress notes on 08/02/2025 that she smelled marijuana in RI #109's room several times, because she could smell marijuana down the hallway. LPN #16 said when she went into RI #109's room she told RI #109 she could smell marijuana, and she could see smoke in the room. LPN #16 said when she asked RI #109 about smoking in the room, RI #109 said no he/she had not been smoking. LPN #16 said she texted the DON and informed her what she had observed. LPN #16 said she documented in RI #109's progress notes on 09/20/2025 that there was a strong cigarette smell coming from RI #109's room, because she was as at the nurses station and could smell cigarette smoke in the hallway. LPN #16 said as she going to RI #109's room the smell got stronger and stronger. LPN #16 said when she entered RI #109's room RI #109 was lying in his/her bed and denied he/she had been smoking in the room. LPN #16 said she again texted the DON and informed her what she had observed. LPN #16 said she documented in RI #109's note on 09/30/2025 that she observed RI #109 smoking in his/her room, and RI #109 gave her the remaining portion of his/her cigarette butt. LPN #16 said she left the DON a message and made her aware RI #109 had given her a portion of the cigarette. LPN #16 said the progress note she made on 01/11/2026 that she observed marijuana in RI #109's room was because of what a CNA informed her of and what she observed. LPN #16 said when she entered RI #109's room RI #109 was in bed laying asleep. LPN #16 said there was an orange pill like bottle with marijuana in it lying next to RI #109. LPN #16 said she and another nurse confiscated the bottle and contacted the DON. LPN #16 said the intervention staff was to follow when RI #109 was caught (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	smoking outside of the designated smoking area was to re-educate on the smoking policy. On 04/29/2026 at 2:11 PM a follow-up interview was conducted with LPN #16. When asked what new approaches were put in place after each incident of RI #109 continuing to smoke in his/her room, LPN #16 said nothing new was put in place, staff continued to educate RI #109 on the smoking policy. LPN #16 said RI #109 probably would not have been able to smoke in the room if the facility increased the level of supervision for RI #109 while he/she was in his/her room. LPN #16 said there could have potentially been an explosion if the resident in the adjoining room used oxygen, since RI #109 smoked in the bathroom at times and had to use a lighter to light the cigarette. When asked what the potential harm was when a resident had a cigarette lighter in their possession, LPN #16 said catching something on fire or giving it to another resident who could do the same thing. A review of RI #109's Resident Progress Notes revealed the following entries were made by LPN #17, the LPN providing care for RI #109 on 08/18/2025 and 09/04/2025 during the 6 PM to 6 AM shift: . 08/18/2025 2:17 AM CNA . came to nurses station and asked if this nurse could come to resident room . Approaching resident room, there was a strong odor of cigarette smoke. This nurse asked resident if (he/she) was smoking in the room . Resident stated that (he/she) was not, upon returning to resident room for a second time, resident admitted that when I approached (his/her) room the first time (he/she) was in the bathroom smoking and that (he/she) put the cigarette out when I knocked on the bathroom (door) . 09/04/2025 7:39 AM CNA . called this nurse to resident room, on the way to resident room, the strong odor of cigarette smoke in the hallway and the odor started at (the room next to RI #109's room) and got stronger upon arriving to (RI #109's room). This nurse asked resident if (he/she) had been smoking in the room, resident denied that this nurse was smelling the smoke from (his/her) room and was possibly smelling it from another room. The smoke was stronger in (RI #109's room) than any other room. Resident was counseled on the dangers of smoking in the room, resident continued to deny smoking inside of room . On 04/24/2026 at 9:23 AM a telephone interview was conducted with LPN #17. The LPN said she documented in RI #109's progress notes on 08/18/2025 that there was a strong odor of cigarette smoke in RI #109's room. LPN #17 said a CNA made her aware of this and when she went to RI #109's room RI #109 was in his/her bathroom with the door locked. LPN #17 said she asked RI #109 to open the door and RI #109 said he/she was in the bathroom right then. LPN #17 said she turned and left the room and smoke could be smelled from the bathroom coming into the room. LPN #17 said she documented the incident in the nurses' notes, reported it to the next shift, and put it on the 24-hour report sheet. LPN #17 said she documented in RI #109's progress notes on 09/04/2025 that there was a strong odor of cigarette smoke in the hallway that led to RI #109's room. LPN #17 said a CNA notified her of this. LPN #17 said when she went to RI #109's room RI #109 was sitting in his/her WC and you could smell the smoke. LPN #17 said when she asked RI #109 if he/she had been smoking RI #109 denied it and said she was probably smelling the smoke in another room. LPN #17 said she educated RI #109 on the facility's smoking policy and RI #109 kept denying he/she had been smoking. LPN #17 said on the two occasions she smelled smoke in RI #109's room, to her knowledge, RI #109 was not on 1:1 supervision. LPN #109 said 1:1 means someone would have to be watching RI #109 and RI #109 was the only one besides his/her roommate in the room at those times. A review of RI #109's Resident Progress Notes revealed the following entry was made by LPN #18, the LPN providing care for RI #109 on 09/19/2025: (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	. 09/19/2025 9:16 PM Resident noted with behaviors this shift. (He/She) was caught smoking a cigarette in (his/her) room. Alerted by CNA she noted the smell of smoke in (his/her) room. Upon this nurse entering room I smelled cigarette smoke; asked resident where (he/she) put the cigarette. (He/She) stated (he/she) put it out in a juice container. This nurse educated resident on the dangers of smoking inside the facility. Also re-educated resident of residents supervised smoke times/breaks . This nurse took juice container and disposed of it appropriately. DON was alerted who then alerted administrator . On 04/23/2026 at 3:02 PM an interview was conducted with LPN #18. The LPN said she documented in RI 109's progress notes on 09/19/2025 that RI #109 was caught smoking in his/her room. LPN #18 said a CNA came to her and informed her of this. LPN #18 said when she was notified of this, she immediately went to RI #109's room, knocked on door asked RI #109 if he/she was smoking and RI #109 said no. LPN #18 said she informed RI #109 she smelled the smoke and asked RI #109 where did he/she put the cigarette out. LPN #18 said RI #109 said he/she put the cigarette out in a juice container. LPN #18 said she observed a cigarette butt in a juice container on RI #109's bedside table. LPN #18 said she got the container and educated RI #109 on the smoking policy, where the smoking area was and the times to smoke. LPN #18 said she took the container out of the room and called the DON. LPN #18 said the DON told her to make sure she took the container out of RI #109's room and to educate RI #109 on the smoking policy. LPN #18 said to her knowledge RI #109 was not on 1:1 supervision at that time. A review of RI #109's Resident Progress Notes revealed the following entries were made by LPN #19, the LPN providing care for RI #109 on 09/25/2025 and 11/04/2025 on the 2 PM – 10 PM shift: . 09/25/2025 6:09 PM 4:00PM RESIDENT NOTED IN ROOM, EXTREMELY STRONG CIGARETTE ODOR AND SLIGHT SMOKE NOTED IN ROOM, RESIDENT DENIES SMOKING IN ROOM, HOWEVER IT'S PASS THE 3 PM CIGARETTE BREAK RESIDENT DID NOT JUST GO IN ROOM, WAS IN ROOM WHEN THE SMELL WAS PRESENT. ADON MADE AWARE . 11/04/2025 10:52PM 9:26PM CNA REPORTD IT SMELLS LIKE SMOKE IN RESIDENT'S ROOM, UPON ENTERING THE ROOM THIS NURSE ALSO SMELLED CIGARETTE SMOKE, BOTH DOORS LEADING TO THE BATHROOM WERE LOCKED, STAFF KNOCKED ON BATHROOM DOOR AND ASKED RESIDENT WAS (HE/SHE) SMOKING? BECAUSE WE CAN SMELL IT, RESIDENT STATES,I'M GETTING READY TO PUT IT OUT MA'AM, RESIDENT FINALLY CAME OUT THE BATHROOM, A STRONG CIGARETTE ODOR WAS PRESENT, THIS NURSE CALLED D.O.N AND MADE HER AWARE OF THIS BEHAVIOR . On 05/07/2026 at 4:13 PM a telephone interview was conducted with LPN #19. The LPN said RI #109 did have the behavior of smoking in the room and was caught a couple of times with cigarette lighters. LPN #19 said when she documented in RI #109's progress notes on 09/25/2025 that there was an extremely strong cigarette odor and slight smoke noted in RI #109's room, she could not remember if someone told her this or if she was on the hall doing a med pass and smelled the smoke. LPN #19 said she never saw RI #109 smoking, but RI #109 did admit to her that he/she was smoking in his/her room. LPN #19 said the progress note she made on 11/04/2025, that it smelled like smoke in RI #109's room she probably found out the same way, someone told her or she smelled smoke in the hallway. LPN #19 said the times she smelled smoke in RI #109's room RI #109 was not on 1:1 supervision. When asked what new approaches were done after each incident of RI #109 continuing to smoke in his/her room, LPN #19 said RI #109 was educated on not smoking and what could occur. When asked what would increased supervision while RI #109 was in his/her room have done, since RI #109 was noticed often to be noncompliant when it came to smoking in his/her room, LPN #19 said RI (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	#109 would not have been able to smoke in front of staff. When asked what could have potentially occurred if RI #109 continued to smoke in his/her room, LPN #19 said RI #109 could have caught the facility on fire and it could have been a danger to the facility and RI #109's roommate. LPN #19 said the potential harm when a resident has a cigarette lighter in their possession is they could start a fire and if there was anyone with oxygen the oxygen could have exploded. A review of RI #109's Resident Progress Notes revealed the following entries were made by RN #20, the RN providing care for RI #109 on 10/22/2025 and on 11/27/2025: . 10/22/2025 11:25PM Resident smoking in room. Stated (he/she) had a little butt that's all of cigar. Pt educated on no smoking policy . 11/27/2025 4:22AM Smoking in room, using bedside table to extinguish cigarettes. Resident educated again on policy . Unsuccessful telephone attempts were made to contact RN #20 on 04/27/2026 at 2:05 PM and on 04/29/2026 at 2:45 PM. A review of RI #109's Resident Progress Notes revealed the following entry was made by RN #22 on 01/10/2026: . 01/10/2025 10:21PM CNA found resident in bed with eyes closed . CNA then noticed a bottle with marijuana in it. 2nd and 3rd shift nurse confiscated the bottle and locked it in the med room . On 04/27/2026 at 2:16 PM a telephone interview was conducted with RN #22. The RN said she documented in the progress note on 01/10/2026 that RI #109 was sleeping in bed and a bottle of marijuana was observed. RN #22 said she walked in the room with another nurse (LPN #16) coming on to work the night shift, and she and the nurse saw the pill bottle with marijuana in it at the end of the bed near RI #109's feet. RN #22 said the other nurse followed through from there. RN #22 said they were told to call the police and she left before the police came. RN #22 said she had heard the CNAs talk about RI #109 smoking in the room and finding a lighter on RI #109. When asked what potential harm could occur when a resident has a cigarette lighter in their possession, RN #22 said the resident could light the room or themselves on fire. A review of RI #109's Resident Progress Notes revealed the following entry was made by LPN #23, the LPN providing care for RI #109 on 01/15/2026 on the 2 PM – 10 PM shift: . 01/15/2026 10:43 PM . Resident continued smoking in the facility . On 04/26/2026 at 2:24 PM an interview was conducted with LPN #23. The LPN said she documented the progress note on RI #109 on 01/15/2026 because someone told her RI #109 was smoking on the inside of the facility. When asked what potential harm there was when a resident has a lighter in their possession, LPN #23 said it could cause fire in the entire facility and in the resident's room if the resident lite the lighter, and it could harm both the roommate and the resident if something caught fire. LPN #23 said if there was oxygen in use, the oxygen could easily explode. A review of RI #109's Resident Progress Notes revealed the following entry was made by the Social Service Director (SSD) on 01/13/2026: (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	. 01/13/2026 2:37PM Discovered paraphernalia in pt (patient) room during CPM (Care Plan Meeting). Educated pt that it cannot be kept in room or on (him/her) due it being a smoking material. Pt began to yell You can't take my stuff from me, SW (Social worker) began to step backwards to exit the room. Pt then yelled to get out of (his/her) room . On 04/28/2026 at 4:47 PM an interview was conducted with the SSD. The SSD said RI #109 was noncompliant with the facility's smoking policy. The SSD said she was in RI #109's room having a care plan meeting and RI #109 had blunt spray, something to mask the smell of smoke, in his/her room. The SSD said she told RI #109 he/she could not have that and RI #109 cursed at her and told her to get out of his/her room. The surveyor shared with the SSD that there was documentation in RI #109's progress notes that on numerous occasions cigarette smoke had been smelled, cigarette butts had been seen, and the smell of marijuana and marijuana had been observed in RI #109's room. Whe

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, the facility investigation, and a policy titled titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation the facility failed to ensure Resident Identifier (RI) #48 was free from physical restraint when staff forcibly restrained him/her after he/she refused care. The facility further failed to ensure staff utilized non-forceful, resident centered approaches during care interactions. Specifically On 08/04/2025 RI #48 refused care on multiple occasions. Despite the refusal Registered Nurse (RN) #63 and Certified Nursing Assistant (CNA) #64 proceeded to forcibly hold RI #48 down and provide incontinent care. RI #48 said that RN #63 and CNA #64 came in the room held him/her down, grabbed his/her arms, ripped his/her clothes off, and washed him/her with a cold rag. A clinical assessment revealed bilateral bruising and redness to the wrist area, discoloration to both hands, soreness to touch, emotional distress and tearfulness when recalling the event. A police report confirmed visible, fresh bruising to RI #48's wrists and hands. It was determined the facility's noncompliance with one or more requirements of participation had cause, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect, and Exploitation.On 05/21/2026 at 1:38 PM, the Regional Administrator, [NAME] President of Nursing Services, Senior [NAME] President of Operations and the Director of Quality Assurance Corporate Compliance were provided a copy of the Immediate Jeopardy Template and notified of the findings of substandard quality of care at the immediate jeopardy level in the area of Freedom from Abuse, Neglect, and Exploitation at F604-Physical Restraints. The immediate jeopardy began on 08/04/2025 and continued until 08/07/2025 when the facility implemented corrective actions to remove the immediacy; thus, immediate jeopardy past noncompliance was cited.F604 was cited as a result of the investigation of complaint/report number 2581004.Findings Include: On 08/04/2025 at approximately 12:30 PM the State Agency received a Facility Reported Incident (FRI) that documented RI #48's daughter reported to the facility that staff admitted to holding RI #48 down to provide care. A policy titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation with an effective date of October 15, 2022, revealed the following: PURPOSE:This policy . is concerned with all incidents and accidents involving resident/guest(s). All of our residents/guests have the right to be free from abuse, neglect, exploitation, and misappropriation of resident/guest property. This includes, but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's/guest's medical symptoms. A. Abuse. The definition of abuse encompasses. the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. In addition, abuse includes depriving the resident/guest of goods and/or services that are necessary to obtain or maintain physical, mental, and psychological well-being. E. Exploitation. Corporal Punishment- physical punishment used as a means to correct or control behavior. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Physical Restraint . as any manual method, physical or mechanical equipment, or material that is attached or adjacent to the resident/guest(s) body, cannot be removed easily by the resident/guest, and restricts the resident/guest(s) freedom of movement or normal access to his or her body.RI #48 was admitted to the facility on [DATE] with diagnoses to include Myopathy and Essential Hypertension. A Minimum Data Set (MDS) for RI #48 dated 06/12/2025 documented RI #48 had a Brief Interview of Mental Status (BIMS) of 11 out of 15 which indicated moderate cognitive impairment. Review of RI #48's care plan dated 02/18/2024 revealed the resident exhibited behavioral symptoms including cursing at other residents, becoming aggressive and combative with staff during care, refusing care, attempting to hit housekeeping staff, yelling and screaming at staff, name-calling, refusing diagnostic and physician orders, noncompliance with mechanically altered diet recommendations, making accusations, and frequently refusing vital signs and weights. Interventions included allowing the resident the opportunity to make choices, not arguing with the resident, identifying causes for the behaviors, talking to the resident in a calm voice when a behavior was disruptive, if the resident became combative staff should leave and approach later, ask a different employee to approach if refusals persisted and to provide pericare as resident would allow. Further review of the care plan dated 06/24/2024 revealed RI #48 experienced episodes of bladder and bowel incontinence and frequently refused incontinent care and daily hygiene care. Interventions included providing peri-care after each incontinent episode as the resident would allow. On 04/30/2026 at 7:51 AM during a phone interview CNA #64 recalled her initial visit to RI #48's room. CNA #64 stated she attempted to provide care by asking to check RI #48's brief, but the resident refused. CNA #64 returned to the room twice more, only to encounter the same refusal from RI #48. Following these attempts, she informed RN #63 about the situation. RN #63 then directed CNA #64 to gather supplies for washing RI #48 and insisted she return to assist with the care. During their attempt to provide care, RI #48 began scratching and punching RN #63 with a closed fist. CNA #64 could not recall what RI #48 was saying during the incident. A review of a witness statement from the investigative file revealed that CNA #64 participated in a demonstration of the care provided to RI #48. CNA #64 explained that during care, RI #48 grabbed RN #63's shirt, was rolled toward CNA #64, and then punched CNA #64 in the face. CNA #64 stated that RN #63 then held or guarded RI #48's arms, preventing him/her from striking CNA #64 again. CNA #64 reported that she performed the RI #48's care while RN #63 removed the brief. CNA #64 stated that RN #63 told her RI #48 could no longer refuse care, and CNA #64 followed RN #63's instructions. CNA #64 stated that she did not initially believe continuing care was wrong because RN #63 told her RI #48 could no longer refuse care and often instructed CNAs that residents could not continue refusing care. CNA #64 acknowledged that she understood abuse included physical and emotional harm to residents and, after the incident was explained to her, recognized concerns with the actions taken. CNA #64 stated she felt intimidated and feared disciplinary action or accusations of insubordination if she did not comply with RN #63's instructions. On 04/29/2026 at 11:00 AM during an interview CNA #65 said she witnessed CNA #64 inform RN #63 that RI #48 had refused to be changed. She recalled hearing RN #63 say they needed to go back to the room because RI #48 had to be changed. She said CNA #64 did not want to go back, but she complied with RN #63's directive. CNA #65 expressed that the situation could have been avoided had they not re-entered RI #48's room. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a witness statement from the investigative file revealed CNA #65 stated that CNA #64 informed RN #63 that RI #48 did not want to be changed. CNA #65 recalled RN #34 telling staff to leave RI #48 alone and not force care. CNA #65 further stated that RN #63 later directed CNA #64 to assist with changing RI #48. After returning from the RI #48's room, RN #63 reportedly stated RI #48 had to be held down to be changed. RN #63 also stated that RI #48 scratched her, while CNA #64 reported that RI #48 punched her in the mouth. CNA #65 reported that RN #34, was present in the hallway when these statements were made. On 04/29/2026 at 11:48 AM during an interview RN #34 said she told RN #63 that if RI #48 did not want to be changed, he/she had the right not to be changed, and if he/she did not want to be changed staff should call the daughter. On 04/29/2026 at 4:28 PM during an interview, the daughter of RI #48 reported that a nurse had informed her that RI #48 was refusing care, prompting her to come to the facility. She learned that a CNA held RI #48 down while another staff member provided care. The daughter said that the two staff members who held RI #48 down, resulting in bruises, attempted to apologize. She indicated that RI #48 was aware of the mistreatment and had expressed his/her refusal to the staff, yet they continued with the care. RI #48's daughter said RI #48 felt frightened during the restraint and that the incident could have been avoided had the staff chosen to leave RI #48 alone. On 04/29/2026 at 3:00 PM during an interview the Regional Administrator (RADM) stated that as the abuse coordinator, it was his responsibility to ensure residents were protected from abuse. The RADM said that the incident involving RI #48 was substantiated as physical abuse and could have been prevented. A review of a witness statement from the investigative file revealed that RN #63 stated that residents have the right to refuse care; however, she believed intervention was necessary when a resident remained incontinent and soaked with urine. RN #63 reported that CNA #64 informed her RI #48 had refused multiple attempts at care and requested assistance. RN #63 stated she spoke with RI #48, advised him/her that he/she was soaked with urine and needed to be changed, and referenced previous discussions with family regarding care refusals. According to RN #63, RI #48 did not respond verbally at first but began yelling when staff attempted care. RN #63 reported that the resident's bed and clothing were heavily saturated with urine. RN #63 stated that when staff began removing clothing and providing care, RI #48 became physically aggressive by hitting, scratching, swinging, and attempting to bite staff. RN #63 stated that she raised her arms to protect CNA #64 from being struck and denied holding the resident down. RN #63 reported that after she stopped guarding herself, RI #48 punched CNA #64 in the mouth. RN #63 contacted the resident's daughter, who asked whether staff had held the resident down. RN #63 reported that she denied holding RI #48 down but stated she had guarded against the resident's aggressive actions. RN #63 acknowledged that residents have the right to refuse care to a point and referenced previous workplace practices where care was provided after multiple refusals. RN #63 denied grabbing or restraining RI #48 and admitted I only raised my hands defensively to protect CNA #64. A review of a police report dated 08/04/2025, located in the investigative file indicated that an officer made contact with RI #48, who was alert and oriented. RI #48 informed the officer that nurses stripped him/her and washed his/her body with a cold rag. RI #48 also told the officer that his/her hands and wrists were hurt, and the officer noted apparent bruising. On 04/30/2026 at 12:27 PM, during an interview, the Interim Director of Nursing said that mental and (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	physical injuries, including bruises, skin tears, fractures, lacerations, and post-traumatic stress, could occur if a resident was held down to facilitate care. _____ The facility took immediate action to correct the noncompliance including: ********** Employees involved were immediately suspended on 8/4/2025. Psychosocial assessment completed with results day 1 with score 3, and day 2 with score 3. 8/5/2025 – 8/7/2025. Consult placed for IBH to speak with the resident 8/5/2025 Reeducated residents about resident rights and the right to be free from abuse by the Director of Nursing (DON) 8/5/2025 – 8/5/2025 Medical Director notified 8/5/2025 Law enforcement notified and in the facility for report 8/5/2025 Ombudsman notified 8/6/2025 Reeducated residents and employees about resident rights initiated 8/5/2025 and completed Skin assessment noted and conducted. Noted with discoloration to top of the hand and redness to wrist. Completed 8/5/2025. Facility wide resident interviews conducted and completed 96/96 (Residents) Completed 8/5/25 Body audits conducted for cognitively impaired residents 12/96. Completed 8/5/25 Reeducated residents about resident rights by treatment nurse and ADON. Completed 8/5/25. All staff reeducated on abuse and proper care for residents initiated 8/5/2025. Completed 8/5/25. All staff reeducated on resident rights and their right to be free from restraints and their right to refuse. 8/5/2025. Hand in hand education and abuse module reassigned to all active staff. 8/5/25 - Completed 8/8/2025 Reeducation to nurses to phone representative response and resident care follow up treatment nurse and ADON. 8/5/25 – Completed 8/5/25 Identified resident to be assessed for behavioral changes and conduct a psychosocial assessment x three days. 8/5/25 – Completed 8/7/25 (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN and CNA trained on abuse and right to refuse on hire and quarterly and last in-services prior to event. Training completed prior to incident. Three alert and oriented residents and three staff members will be interviewed on resident rights and abuse three times a week for four weeks. 8/5/25 – 9/2/25 Three cognitively impaired residents will have a body audit completed three times a week for four weeks. 8/5/25 – Completed 9/2/25 Three cognitively impaired residents will have a body audit completed weekly for four weeks. 8/5/25 – Completed 9/2/25. Three alert and oriented residents and three staff members will be interviewed on resident rights and abuse monthly for one month. 8/5/25 – Completed 9/2/25. Three cognitively impaired residents will have a body audit completed monthly for one month. 8/5/25 – Completed 9/2/25 _____ After review of documentation supporting the above corrective actions, including the facility's investigation file, in-service/education records, QAPI documentation, and staff interviews, the survey team verified the facility implemented corrective actions including ongoing monitoring from 08/04/2025 to 08/07/2025, and past non-compliance was cited.

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of residents' medical records, and review of the facility policy titled Pressure Injury , the facility failed to provide ongoing skin assessments to ensure pressure injuries or pressure ulcers were identified at an early stage which resulted in pressure injuries being identified at advanced stages of unstageable wounds. Specifically:1. On [DATE], Resident Identifier (RI) #108 was noted to have excoriation and redness to his/her buttocks/sacral area. The facility did not perform a detailed assessment of the area such as measurements, drainage, or odor. An order was obtained on [DATE] to clean and cover the area three times a week. The facility failed to reassess the area or make any treatment alterations for the excoriation until the area was assessed as an unstageable wound on [DATE]. On [DATE] the area to RI #108's right buttocks measured 5 centimeters (cm) x 4.5 cm with a depth of 1 cm, had seropurulent drainage with a foul odor, and necrotic tissue. RI #108 expired on [DATE].2. On [DATE], RI #51 was noted to have two open abrasions to his/her lower right buttocks. The areas were not assessed by the treatment nurse and appropriate preventive treatments were not initiated. The areas were not reassessed until [DATE] when the wound to RI #51's right buttocks was identified as an unstageable wound with slough and serosanguineous drainage present. The wound measured 5 cm x 4 cm and; on [DATE] the area was assessed as stage IV. Further, on [DATE] RI #51 was noted to have several open wounds on his/her coccyx. The area was not assessed by the treatment nurse and appropriate preventive treatments were not initiated until [DATE]. On [DATE] the opened areas to RI #51's sacrum were identified as a pressure ulcer. On [DATE] the area was staged as unstageable, and on [DATE] the wound was assessed as a stage III pressure injury.It was determined the facility's noncompliance with one or more requirement 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 483.25 Quality of Care.On [DATE], the Regional Administrator was provided a copy of the Immediate Jeopardy template and notified of the findings of immediate jeopardy and substandard quality of care in the area of Quality of Care at F686-Treatment /Services to Prevent/Heal Pressure Ulcers.The IJ began on [DATE] and continued until [DATE] when the survey team verified that onsite corrective actions had been implemented. The immediate jeopardy was removed on [DATE].This was cited as a result of the investigation of complaint number 2621001 and 2744696.This affected RI #108 and RI #51, two of three residents sampled for pressure injury. Findings Include: On [DATE] at 4:05 PM, the State Agency received an anonymous complaint via the Alabama Department of Public Health Online Incident Reporting System. The report alleged neglect and indicated RI #108 had expired due to neglect of pressure injuries and RI #51 had a wound that had worsened. A review of the facility policy titled Pressure Injury with a revision date of [DATE] revealed the following: .Pressure Injury will be assessed at least every 7 Days by a trained Registered Nurse as part of the Interdisciplinary Team review.Process:II. Documentationa) The physician should be informed of the pressure injury, or the failure of an ulcer to respond to treatment; physicians' orders for care should be recorded. b) The physician should be encouraged to document the diagnosis or clinical conditions that may be contributing to the development of pressure ulcers. c) The status of ulcers should be recorded on the Wound Flow Record weekly.e) Observations pertinent to the resident's skin status should be recorded in the nurses' notes, as appropriate. f) The interdisciplinary plan of care communicates care instructions to staff. The interdisciplinary team consists of (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DON/designated RN, Wound Care Nurse. Restorative Nurser designee, and Dietary Manager. Other disciplines as needed. The facility Protocol for CNA and Licensed Nurse titled Skin Inspections, with a revision date of [DATE] included the following:Guidelines Intent:To identify any skin concerns in residents immediately and implement early intervention. Frequency:CNA's will conduct body inspections of residents at risk for pressure sores on a daily basis.Licensed Nurse will conduct body inspections of residents at risk for pressure sores on a weekly basis. Procedure for CNA Daily Inspections:CNA's will conduct a body inspection on all assigned residents.Results of inspections will be documented in Smart Charting beside appropriate resident's name. Any skin concerns identified by CNA will be reported to assigned Licensed Nurse immediately. CNA will document the nurse it was reported to or report changes recorded in Smart Charting. All body audits sheets will be shared with the assigned Licensed Nurse and Licensed Nurse will submit to the DON/designee.The body audit sheets will be reviewed by the Treatment Nurse/designee for new skin concerns and findings will be presented at the QA Skin Sub-committee. Treatment Nurse/designee will review for appropriate measures taken and report at morning meetings. Procedure for Licensed Nurse Weekly Inspections:Designated Licensed Nurse will conduct body inspections on all residents on a weekly basis, per schedule. (DON will ensure that a weekly schedule is developed and implemented.)Licensed Nurse will document findings of inspection on MAR which is individualized for each resident. Any skin concerns identified by licensed nurse will be reported to designated Treatment Nurse immediately for evaluation and treatment orders. If Treatment Nurse is not available, nurse identifying concern should evaluate wound and notify MD for initial treatment orders. Any skin concerns identified will be presented at the morning meeting.Weekly results will be reviewed at the QA Skin Sub-committee meeting. Retention of Records:CNA body audit records will be maintained in the DON office for 90- days in a QA binder if manual sheets and reviewed by DON if electronic. 1.)RI #108 was admitted to the facility on [DATE] with diagnoses to include: Parkinsonism, Contracture right elbow, Autistic Disorder, Unspecified Mycosis, Muscle Weakness, and Aphasia. A review of RI #108 Braden Scale dated [DATE] revealed RI #108 was at high risk of developing pressure ulcers/injuries. RI #108's Quarterly MDS assessment with an ARD of [DATE] revealed RI #108 scored a 12 of 15 on the BIMS indicating identified moderate impaired cognition. The MDS review include that RI #108 was identified as being at risk for developing pressure ulcers. A review of a hospice provider's note dated [DATE] revealed that RI #108 had a Braden Scale score of 13 and was moderate risk to develop pressure injury. RI #108's medical record included a Wound Management Detail Report which documented that on [DATE] RI #108 had an unstageable pressure ulcer to right buttock with measurements of 2 centimeters (cm) Length by 1 (cm) Width with slough and /or Eschar with no measurable depth. No odor or exudate was documented. The medical record included a Progress Note dated [DATE] (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	documenting that the area was healed and resolved. A progress note in RI #108's medical record dated [DATE] revealed the Former Wound Care Nurse (FWCN) documented that RI #108 had an alteration in skin integrity. The note documented that upon observation, the resident's buttocks/sacral area was noted to be excoriated/irritated. The note include that the Nurse Practitioner (NP) was notified and new orders were documented for a protective dressing. RI #108's [DATE] Treatments Administration History revealed that RI #108 had excoriation to his/her Sacral area and orders were to change the dressing every Monday, Wednesday, and Friday. RI# 108's [DATE] Licensed Nurse Administration History revealed the charge nurse was to observe the resident's sacrum to ensure dressing is clean/dry intact every shift. RI # 108's [DATE], [DATE], and [DATE] General Administration History revealed weekly skin audits were performed, and no new skin problems were noted. A review of RI #108's Wound Management Report dated [DATE] revealed RI # 108 had an unstageable pressure ulcer to right buttock with slough and/or eschar with measurements of 5 (cm) length by 4.5 (cm) width and depth of 1 (cm). The report documented that the wound had moderate seropurulent exudate with odor present; necrotic tissue with irregular edges/margins; and the skin surrounding wound was noted to have erythema(redness)/blanchable. A progress note dated [DATE] documented that RI #108 had a wound to center of buttocks. The wound had a foul-smelling odor and some drainage noted. A progress note dated [DATE] documented by the Former Wound Care Nurse (FWCN) revealed RI #108 had an unstageable wound to buttocks with slough/necrotic tissue to wound bed with notable decline to peri-wound; the area was red and irritated with some inflammation noted. The note documented that the Nurse Practitioner was aware and new order for oral antibiotics was entered and the treatment order frequency was increased to daily. On [DATE] at 4:54 PM an interview was conducted with the RN Clinical Care Consultant (RNCCC). The surveyor showed the RNCCC a copy of RI #108's wound report. The RNCCC said the pressure ulcer was on RI #108's right buttocks was identified on [DATE]. The RNCCC said RI #108's pressure ulcer never resolved. The RNCCC said the documentation of the wound was discontinued on [DATE] when RI #108 expired. On [DATE] at 2:39 PM a follow up interview was conducted with Certified Registered Nurse Practitioner (CRNP) #25. When the surveyor went over the order for RI #108's review of records, the surveyor found on [DATE] an order was placed stating excoriation to sacral area. A new order was placed for dressing to be changed every Monday, Wednesday, Friday, and as needed. Cleanse with normal saline and gauze. Apply skin prep to peri wound. Cover with foam dressing. The surveyor asked the CRNP #25 did she order this. The CRNP #25 replied it was probably a protocol for a standing order, but if it's Monday, Wednesday and Friday there should have been a Wound Report, that was care for a wound not an excoriation. CRNP #25 said she was not sure what it was that was being treated because she was never told and there was no documentation on a wound at that time. The surveyor then asked CRNP #25 in her professional opinion could a pressure ulcer develop and be unstageable at 5 cm x 4.5 cm with foul odor and necrotic tissue as first documented on the wound (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	detail report on [DATE] when there was no documentation of any wound before that date. The CRNP #25 replied no, it could not have. On [DATE] at 2:49 PM a telephone interview was conducted with the Licensed Practical Nurse (LPN) #16, who was a night shift nurse that had been assigned to RI #108. When asked if she ever cared for RI #108, she replied yes, she did. The surveyor asked LPN #16 if she ever performed body audits on RI #108 and LPN #16 replied yes. The surveyor asked if RI #108 had pressure ulcers and the LPN #16 replied yes, RI #108's skin issues started as a skin shear. LPN #16 said the skin shearing resolved then RI #108 had skin shearing again on his/her bottom and this was reported to the treatment nurse. LPN # 16 said this wound was what turned into the giant wound on RI# 108's buttocks. LPN #16 said it went from a skin shear to getting deeper and progressed over three weeks and started dipping down. LPN #16 said they started covering the wound and within six weeks it was a hole. LPN #16 said the wound was as big as half a dollar, the skin was black and had a horrible odor. The LPN #16 said RI #108 wound was not being treated by the wound care nurse at the time. On [DATE] at 9:48 AM a telephone interview was conducted with the FWCN. When the surveyor asks why no wound measurements were being documented from [DATE] until [DATE], the FWCN replied, there was not a wound if she did not document on it. The surveyor then told the FWCN according to the Wound Management Report the first wound report was on [DATE] and was measured at 5 cm Length x 4.5 cm Width x 1 centimeters depth, with foul new odor. The FWCN replied there had to be documentation before that, RI #108's wound could not have been that big without her documenting it before that unless she was not made aware of it. The FWCN said that only could have occurred if staff let it get that bad before they let her know about it. On [DATE] at 2:40 PM a follow up interview was conducted with LPN #16. The surveyor referred to the Physician Order Report for RI #108 and ask if LPN #16 if she changed the sacral dressing on [DATE], [DATE], and [DATE]. The surveyor asked LPN #16 could she tell the surveyor the description of the area on the sacral when she changed the dressings, LPN #16 stated each time she changed the bandage it was gradually getting worse. LPN #16 said at first, it was not that big, but it just kept getting bigger. LPN #16 said in the beginning the wound was not covered with bandages. LPN # 16 said it was a little later when the wound was covered. LPN #16 said after the initial skin shear about 2-3 weeks was when it started getting bigger and she felt like the wound was getting worse before they started covering. LPN #16 said she felt like the wound should have been covered sooner and the wound got so bad and deep really fast and the tissue was changing colors. LPN #16 said she felt like RI #108 needed to go into a wound clinic and have the wound debrided. The surveyor then asked what the harm was when wounds are not treated appropriate and LPN # 16 replied so many things like risk of infection, risk of wound getting deeper, sepsis, growth of the wound and skin breakdown. The surveyor asked LPN #16 if she reported the change in skin conditions to anyone and LPN #16 said she reported it to the FWCN. The LPN #16 said she reported it to CRNP #25 and was told to report it to the treatment nurse. LPN #16 said the CRNP said she did not handle wounds the Treatment Nurse did that. On [DATE] at 4:42 PM a follow up telephone interview was conducted with the FWCN. The surveyor shared with the FWCN that after reviewing the treatment record for the month of June the FWCN changed RI #108's sacral dressing on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE] this indicates you were doing the dressing changes three time a week for excoriation to sacral area in June. The surveyor asked the FWCN could she explain how this area was excoriation during the month of June and then on [DATE] the Wound Management Report revealed a pressure ulcer to RI #108's right buttock that measured 5 centimeters (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	length by 4.5 centimeters Width with a depth of 1 centimeter, the FWCN replied, she did not recall RI #108's wound getting that bad that fast .The FWCN said if she documented that, it just went from excoriation to a wound that fast. The surveyor informed the FWCN that she put her initials on the Treatment Administration Record that she did the dressing changes in June, so did she make observation of the area. The FWCN said that correct. The surveyor asked why the same treatment was done for almost two months (7 weeks) for excoriation to sacral area with no change in treatment from [DATE] to 07/ 04/2025. The FWCN replied it was probably working good at the time and at the end if it wasn't working then it was changed. The surveyor then asked the FWCN, according to RI #108's care plan it states to reassess treatment if no healing within 2-4 weeks. The surveyor asked the FWCN where there would be evidence the pressure ulcer had been reassessed, and a different treatment plan was put in place. The FWCN replied the orders would have changed. On [DATE] at 4:31 PM a telephone interview was conducted with the Certified Nursing Assistant (CNA) #27. The surveyor asked CNA #27 if she recalled RI #108 having a wound to his/her buttocks. CNA #27 replied yes, and the wound was pretty bad. The surveyor asked why she documented on [DATE] and [DATE] in the Matrix Care Report that there was an open area to RI #108's buttocks. CNA #27 stated she really did not remember why she documented that, and stated RI #108's wound was pretty bad and it smelled rotten and was open. The surveyor asked CNA #27 if she could tell what was being covered on RI #108 and CNA #27 stated, it was a big sore on RI #108's bottom, it was very big, the size of your fist. CNA #27 stated it was black looking, you could see the bone. CNA #27 said it smelled rotten and you could smell it in the hallway. 2) RI #51's Right Buttock Wound On [DATE] at 4:05 PM, the State Agency received an anonymous complaint via the Alabama Department of Public Health Online Incident Reporting System. The report alleged neglect and indicated RI #51 had a wound that had worsened. RI #51 was admitted to the facility on [DATE] and had a latest return date of [DATE], with diagnoses to include Osteomyelitis, Type 2 Diabetes with Diabetic Neuropathy and Pressure Ulcer of Unspecified Buttocks, Unspecified Stage. RI #51's Quarterly MDS assessment with an ARD of [DATE] revealed RI #51 scored a 15 of 15 on the BIMS indicating no impaired cognition and RI #51 was identified as being at risk for developing pressures ulcers. RI #51's Progress Note dated [DATE], revealed the following: . 2-10PM REPORTED BY CNA RESIDENT HAS FLUID FILLED AREA ON BACK OF UPPER LEG, ASSESSMENT DONE RESIDENT NOTED WITH BLISTER TO BACK OF LEFT UPPER LEG, WITH TWO (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	SMALL OPEN ABRASIONS AND SEVERAL RED AREAS NOTED ON BUTTOCKS, BARRIER CREAM APPLIED, TREATMENT NURSE WILL BE NOTIFIED FOR EVAL (evaluation) IN AM . This Progress note was completed by LPN #19. On [DATE] at 4:28 PM a telephone interview was conducted with LPN #19. The surveyor shared with LPN #19 that the surveyor saw where LPN #19 documented on RI #51's progress notes on [DATE] that RI #51 was observed with two small open abrasions and several red areas on his/her buttocks and the treatment nurse was to be notified in the AM. When asked who the treatment nurse at that time was, LPN #19 said LPN #24, the FWCN. LPN #19 said she left a note under the FWCN's office door and verified with the FWCN that she had received the note. LPN #19 said the nurses normally documented their observations of skin concerns in the progress notes. LPN #19 said it would be important to document their wound observations to make sure the resident gets the care needed, and the treatment nurse is aware and keeps the wound from getting worse. RI #51's progress note dated [DATE] revealed when RI #51 was readmitted back to the facility, RI #51 had areas to his/her buttocks, which were not new and were present before going to the hospital. The progress note revealed staff were to continue to use barrier cream until further assessment by the wound care nurse. Review of RI #51's June, July and [DATE] Progress Notes revealed there was no evidence the opened areas to RI #51's right buttocks were ever assessed by the wound care nurse until [DATE] when it was documented Resident noted to have worsened area to right lower buttocks with slough present. Sacral area MASD (Moisture Associated Dermatitis) not improving with moisture barrier . Review of RI #51's Wound Management Detail Report dated [DATE] revealed, at this time, a pressure ulcer was identified to RI #51's right lower buttocks and measured 5 cm (centimeters) x 4 cm, had light exudate, and was unstageable with slough present. In the comment section it was documented: . MASD worsened, resident non-complaint with turning/repositioning . Review of RI #51's Physician Orders ([DATE]) revealed on [DATE] an order was written to cleanse RI #51's unstageable wound to right lower buttocks with normal saline, apply skin prep to peri wound, cover with foam dressing every Monday, Wednesday and Friday and PRN if soiled or removed. On [DATE] a6 10:01 AM a telephone interview was conducted with the FWCN. When asked how often she as the wound care nurse was completing the Wound Management Detail Report forms, the FWCN said weekly. The surveyor informed the FWCN that looking at RI #51's Wound Management Reports, on [DATE] the area to RI #51's right buttocks was identified as a pressure ulcer measuring 5 cm x 4 cm with slough identified. When asked should a pressure ulcer be identified before it reached that stage, the FWCN said yes. The FWCN said it would be important to ensure pressure ulcers are identified and treated in a timely manner to keep them from turning into something else, like one stage developing into a higher stage. [DATE] at 4:45 PM a follow-up telephone interview was conducted with the FWCN. The surveyor shared with the FWCN that it was documented in RI #51's progress notes on [DATE] that she was to be notified about RI #51 having two open areas and redness to his/her buttock. When asked if she was notified of this, the FWCN said the nurses would put a lot of things under her door all the time and she could not remember if she received information about RI #51 or not. The FWCN said if she had been informed of this, she would have assessed the wound and started the treatment as needed. The FWCN said the evidence she had done this would be she would have written an order and started (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	treatment for the open areas. Review of RI #51's [DATE] Physician Orders did not reveal a treatment order had been written for the opened areas to RI #51's buttocks. Review of RI #51's [DATE] Treatment Administration History also did not reveal a treatment had been initiated for the opened areas to RI #51's buttocks. On [DATE] at 2:43 PM an interview was conducted with the CRNP. When asked, was she notified of the two open areas on RI #51's right buttocks on [DATE], the CRNP said she could not recall if she was notified or not. The CRNP was asked why it would be important to assess and measure newly identified open areas on a resident. The CRNP said for one you would need to monitor for improvement and be sure the appropriate treatment is in place. The CRNP said if a wound is not improving, then you would want to change the treatment. The CRNP said she should have been notified of the open areas on RI #51 buttocks, and it should have been put on the wound sheets (Wound Management Detail Report). The CRNP said if she had been notified, she would have made sure treatment orders were put in place and the wound would have been monitored. According to RI #51's July, June and [DATE] Progress Notes, Physician Orders, and Treatment Administration History, there was no evidence the opened areas to RI #51's right buttocks had been assessed and a treatment initiated until [DATE], when the areas were identified as unstageable. RI #51's Wound Management Detail Report documented that RI #51's wound to right lower buttocks was assessed as a stage III pressure ulcer on [DATE] and [DATE]. The report documented that the wound was assessed as stage IV pressure ulcer on [DATE]. RI #51's Sacral Wound RI #51's Progress Note dated [DATE], revealed the following: . Patient readmitted back from hospital . Patient has several open areas on coccyx (sacrum) . This note was made by RN #81. An unsuccessful attempt was made to contact RN #81 on [DATE] at 3:21 PM. On [DATE] at 3:03 PM a telephone interview was conducted with the FWCN. When asked when she was informed that RI #51 had a sacral wound, the FWCN said she did not recall but RI #51 was admitted from the hospital with the wound and whoever admitted RI #51 from the hospital would have informed her. When asked what she did, the FWCN said she was sure she assessed RI #51's wound and put a treatment in place. The FWCN said she would have documented what she did in the Progress Notes. The FWCN said she would have initially documented the measurements of the wound in the wound assessment manager (Wound Management Detail Report). Review of RI #51's [DATE] Progress Notes from [DATE], after RI #51 was readmitted to the facility, through [DATE] revealed there was no documented evidence that the FWCN assessed the wound or documented initial measurements of the open areas. Review of RI #51's [DATE] Physician Orders revealed a treatment order to clean MASD to RI #51's sacrum with normal saline, apply Triad past every shift and leave open to air was written on [DATE]. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of RI #51's [DATE] Treatment Administration History also revealed treatments were not initiated to the opened areas to RI #51's coccyx/sacrum area, until [DATE]. A review of RI #51's Wound Management Detail Report revealed that on [DATE] the opened areas to RI #51's sacrum were identified as a pressure ulcer and measured 8.5 cm x 6 cm with slough present. The report included that on [DATE] the wound was assessed and staged as an unstageable pressure injury. On [DATE] at 8:22 AM an interview was conducted with the RN TXN. When asked who should be notified when a resident is identified with new skin concerns such as opened areas or returns to the facility with a pressure ulcer or any new skin concerns, the RN TXN said the treatment nurse, Director of Nursing, and the Assistant Director of Nursing. The RN TXN said this information would be communicated to the treatment nurse in the progress notes and the treatment nurse should evaluate the skin concerns within 72 hours as well. The surveyor shared with the RN TXN that RI #51's progress note dated [DATE] revealed open areas were noted to RI #51's buttocks. The surveyor asked the RN TXN to look at RI #51's June - [DATE] Licensed Nurse Administration History (MAR) and show the surveyor the evidence the opened areas to RI #51's right buttocks were being treated. The RN TXN said the only treatment she saw for the right buttocks was the Medi honey treatment and that treatment started on [DATE]. The surveyor shared with the RN TXN nurse that RI #51's progress notes dated [DATE] revealed RI #51 was readmitted to the facility with several open areas on his/her coccyx. The surveyor asked the RN TXN where there would be evidence of an assessment and treatment being initiated for the identified areas. The RN TXN said the treatment nurse should have at least had documentation in the progress notes by [DATE] of her assessment. The RN TXN said there was nothing documented in the progress notes by the treatment nurse for the opened areas identified on [DATE] nor the opened areas identified on [DATE]. The RN TXN said a progress note should have been made by the treatment nurse about what she was going to do, what orders were written and the type of treatments that were being put in place. When asked why it would have been important to ensure treatments were started to RI #51's right buttocks and sacral/coccyx area when the areas were identified, the RN TXN said to promote healing and prevent infection or any further infection and to ensure proper treatments were in place. During the interview on [DATE] at 8:22 AM, the RN TXN said according to RI #51's Wound Management Detail Reports, the pressure ulcer to RI #51's right buttocks was first identified on [DATE] and measured 5 cm x 4 cm and was unstageable. The RN TXN said a pressure ulcer should never first be identified as unstageable at the measurements of 5 cm x 4 cm. The RN TXN said according to RI #51's Wound Management Detail Report, the sacrum pressure ulcer was first identified on [DATE] and measured 8.5 cm x 6 cm. The RN TXN said the sacral wound was not staged until [DATE] when it was assessed as an unstageable pressure wound. The RN TXN said a pressure ulcer should never first be identified as unstageable. The RN TXN said the pressure ulcers should have been identified before they got to the point they were. The RN TXN said it would be important to assess and treat pressure ulcers in a timely manner to prevent them from getting worse and to initiate the proper treatment. A review of RI #51's Wound Management Detail Report revealed that on [DATE] the wound to RI #51's sacrum was assessed as a stage III pressure ulcer. The facility submitted an acceptable removal plan which documented: ********** (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	********** F-686 Treatment/Services to Prevent/Heal Pressure Ulcer Immediate Actions Taken to Remove Jeopardy. The immediate jeopardy was identified on [DATE], for wound care for RI #108: On [DATE] at 10:13am charge nurse identified excoriated/irritated skin at buttocks/sacral area. Nurse practitioner was notified and new orders were given for protective dressing. TAR shows order was transcribed by charge nurse to the TAR. Treatment was documented as completed for May and [DATE] beginning [DATE] following initial dressings on identification [DATE]. Excoriation/irritation is not routinely measured or staged or entered in the wound care module. All skin audits were documented in [DATE] as ordered with no new issues identified. The excoriation orders were documented as administered for the month of [DATE]. On [DATE] a nurse identified area on right buttock as wound unable to determine stage 5cm x 4.5cm with 1cm depth. Nurse practitioner was notified and new orders were obtained, transcribed and administered on [DATE] at 2:44 pm. Resident later expired on [DATE]. He had autism, Parkinson disease, progressive intake declines and placed on hospice and hospice completed the death certificate. RI #51 was readmitted to the facility with several open areas noted on the coccyx and right heel [DATE]. On [DATE] the wound care nurse documented worsened area to right lower buttock with slough present and sacral area not improving with moisture barrier due to RI#51refusing to turn to either side. On the same date [DATE] orders were obtained and implemented for right lower buttock with Medi-honey covered with foam dressing and sacrum triad paste and leave open to air for sacrum. These treatments were documented as ordered beginning [DATE]. On [DATE] at 2:00 pm area to sacrum was measured at 8.5 cm 6.1cm with serosanguinous drainage and slough present, on [DATE] measurement of 8.0 cm x 5.0cm noted improvement, on [DATE] measured stage III and remained a stage III until healed, on [DATE] sacrum area documented as healed. The Area on right buttocks was stage III on [DATE]. The area on right buttocks is stage IV as of [DATE] and currently is stage IV with undermining and wound care consult orders being followed. Wound care nurse will assess wounds weekly and notify the provider if worsening for additional orders. RI#51 wounds will be reviewed by wound committee weekly to ensure appropriate assessment and treatments are in place. Wound care nurse was suspended on [DATE] that was responsible for wound care for RI#108 and RI#51 at the time of the alleged failure to treat, assess and prevent pressure ulcers and was terminated on [DATE]. Current wound care nurses have been trained in their responsibilities outlined by NHS wound care specialists including p

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, interviews, the Resident Council Minutes, the Grievance Log, the facility's Beef Stroganoff recipe, the facility's Spring/Summer 2026 Week 3 Menu and Diet Guides, the facility's chart of Scoop Sizes, and the facility's policies for Cycle Menus, Food Preparation Guidelines, and Puree Foods; the facility failed to ensure the portion sizes specified on the facility's menu for Wednesday, 04/22/2026 were provided for Puree Beef Stroganoff and Sliced Strawberries. In addition, Puree Noodles (Bow Tie Pasta) were not part of the Puree Beef Stroganoff entree as included in the facility's Beef Stroganoff recipe. This affected residents receiving Puree Beef Stroganoff and those receiving Sliced Strawberries. This had the potential to affect four of four Puree Diets and 75 of 75 Regular Texture diets. This deficiency was cited as a result of complaint/report #2973530. Findings include: The facility's policy for Cycle Menus, dated 10/01/2005, included the following: . PURPOSE:To meet the nutritional needs of resident/guest(s), in accordance with the recommended dietary allowances (RDA) of the Food and Nutrition Board of the National Research Council, standard menus are utilized.PROCESS: .c. Menus should have portions stated in ounces, and/or measurements. The facility's policy for Puree Foods, dated 08/23/2017, included the following: . PURPOSE: Food should be served in a form designed to meet individual resident/ guest needs .PROCESS:I. General Pureed Food Principles:Pureed food items should be the same as those served on the regular menu . The facility's policy for Food Preparation Guidelines, dated 08/10/2018, included the following: . PROCESS:a. The cook, or designee, should prepare menu items following the written menus and recipes. The facility's Beef Stroganoff recipe, undated, included the following direction: . Serve . 4 ounce . over rice or noodles. The facility's Spring/Summer 2026 Diet Guide Sheet for Wednesday (Day 18) Lunch (provided by the Clinical Certified Dietary Manager) specified 6 oz (ounces) of Pureed Beef Stroganoff on the Pureed menu and 1/2 cup of Sliced Strawberries on the Regular menu. An undated chart titled SCOOP SIZES posted on the wall in the facility's kitchen identified the scoops by number (#) and included the following information:Scoop #5 measured 3/4 cup or 6 ozScoop #8 measured 1/2 cup or 4 ozScoop #12 measured 1/3 cup or 2 2/3 ozScoop #16 measured 1/4 cup or 2 oz The facility's Resident Council Minutes included the following:July 17, 2025 - . Food Portions: Concerns were voiced regarding inadequate portion sizes, leaving residents feeling hungry.October 2025 - . Food . portion control is not consistent. The facility's Grievance Log included the following:August 21, 2025 - . some residents get little food . and they are not receiving double portions . On Wednesday, 04/22/2026 at 11:50 AM, the residents' Lunch trayline was observed. The Dietary Manager (DM) was performing the duties of the AM [NAME] for the day. As the DM checked the food temperatures on the trayline, the scoop being used for portioning the Puree Beef Stroganoff was observed to be a #12 scoop (2 2/3 oz). The Regular consistency diets were to receive Beef Stroganoff portioned with a 4-ounce spoodle and served over Bowtie Noodles. At 12:22 PM, a 4-ounce perforated spoodle was used to portion the Bowtie Noodles used for the Regular diets. During the Lunch trayline on 04/22/2026 at 12:28 PM, a double portion Puree plate was observed being prepared. Two dips of a #12 scoop of Puree Beef Stroganoff were placed on the resident's plate. A #12 scoop used twice would yield a serving of 5 1/3 oz. During the Lunch trayline on 04/22/2026 at 12:34 PM, a normal Puree plate was observed being prepared. According to the DM, this was a standard Puree: one #12 scoop (2 2/3 oz) Puree Beef Stroganoff, one #8 scoop (4 oz) Puree [NAME] Beans, one #12 scoop (2 2/3 oz) Puree Bread. During the Lunch trayline on 04/22/2026 at 12:57 PM, Sliced Strawberries were observed being dipped up into serving containers and placed onto trays as the trayline was running. A #16 scoop (2 oz) was being used to portion the strawberries. The #16 scoop size was verified by the AM Dietary Aide, who was serving the strawberries. One #16 scoop was used per serving of Sliced Strawberries. On 04/22/2026 at 1:42 PM, the AM Dietary Aide was interviewed. The AM Dietary Aide said she used the Diet Guide to know how much to serve for a portion of Sliced (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Strawberries. When the AM Dietary Aide was shown the Diet Guide for Wednesday (Day 18) Lunch, she said a half cup for a serving of strawberries. The AM Dietary Aide further said today was her first time needing to use a scoop, so she asked the DM and was shown what size to use. The AM Dietary Aide also said there is a chart to the right of the stove near the seasonings that tells you about the colors and sizes of the scoops. The AM Dietary Aide said she had not referred to this chart today. Upon being asked how she would know the portion provided by a #16 scoop, the AM Dietary Aide said she would look at the chart. The AM Dietary Aide said she did not know the size of the scoop she was using until the number on the scoop was pointed out to her today. On 04/22/2026 at 1:59 PM, the DM, who was acting as the AM [NAME] for today, was interviewed. The DM said the Puree Beef Stroganoff was just the beef and the gravy and it did not include the noodles. When asked how do you know how much to serve for a portion of Puree Beef Stroganoff, the DM said the portion sizes are on the Production Sheet and that is what I am supposed to go by. When asked if she knew the amount provided by a #12 scoop, the DM said I don't. Upon going to the kitchen to view the Scoop Sizes chart and the Production Sheet, it was discovered that the Production Sheet did not include Puree diet portion information. The Production sheet for Wednesday (Day 18) Lunch was headed as, Spring/Summer 2026 Diet Guide Sheet and included the subheadings for the following diets: Regular, NAS (No Added Salt), Consistent Carb (Carbohydrate), CCD (Consistent Carbohydrate Diet)/NAS, TF (Tube Feeding) only, and CCD/NAS. On 04/22/2026 at 2:13 PM, the AM Dietary Aide was asked if the Production Sheet (as identified by the DM) was what she used. The AM Dietary Aide said the Production Sheet was the Diet Guide she used. On 04/22/2026 at 6:05 PM, the Regional Dietary Consultant, a Registered Dietitian, was interviewed. The Regional Dietary Consultant said four residents were receiving a Puree diet and 75 residents would have been eligible to receive Sliced Strawberries for lunch today. The Regional Dietary Consultant said the correct serving size for the Puree Beef Stroganoff should have been a 6-ounce serving of the meat and gravy mixed with pasta. She said a #5 scoop should have been used to provide that amount. The Regional Dietary Consultant said the #12 scoop used to provide Puree Beef Stroganoff was incorrect. The Regional Dietary Consultant also said the #16 scoop used to portion the Sliced Strawberries was incorrect and that a #8 scoop should have been used to provide a 1/2 cup serving. She further said the #16 scoop only gave half of what should have been served. The Regional Dietary Consultant said the dietary recommendations were not being met, the residents were being underfed, and weight loss would be a concern. The Regional Dietary Consultant said the Spring/Summer 2026, Wednesday, Day 18 Menu was not being followed. This deficiency was cited as a result of complaint/report #2973530.

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F 0600 Level of Harm - Minimal harm or potential for actual harm 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** Based on interviews, review of resident medical records, review of a facility policy titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation, 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 physical abuse perpetrated by Resident Identifier (RI) #116, a resident with unmanaged behaviors who had pattern of abusing residents when their wheelchairs bumped together. The facility failed to implement appropriate interventions and supervision of RI #116 to prevent further physical abuse of residents. On 12/24/2024 during an activity in the dining room, RI #115 was at the soda vending machine and accidentally bumped his/her wheelchair into RI #116's wheelchair. RI #116 responded by yelling and cursing at RI #115. RI #116 and RI #115 began physically abusing each other, hitting each other in the face resulting in pink discoloration to RI #115's left cheek and a small cut to the bridge of RI #116's nose. On 08/09/2025 RI #81 accidentally bumped RI #116's wheelchair near the dining room entrance. RI #116 began to swing and hit RI #81 and grabbed RI #81's shirt. RI #81 then hit back at RI #116. The physical abuse resulted in RI #81 having a small discoloration under his/her right eye and redness to the left side of his/her neck.On 10/08/2025 RI #115 was in his/her wheelchair attempting to pass by RI #116 and accidentally bumped RI #116's wheelchair. RI #116 then grabbed RI #115's hair, pulled RI #115 out of the wheelchair, RI #116 would not let go, and both residents fell to the floor hitting each other while on the floor. The physical abuse resulted in RI #115 having a red scratch on the left middle finger and three small scratches on the right forehead. RI #116 had a red eye with surrounding discolor and a discolored raised area to the right forehead. On 10/27/2025 RI #21 was sitting in his/her wheelchair and RI #116 bumped his/her wheelchair into RI #21's wheelchair. RI #116 tried to grab RI #21's hair, RI #21 put his/her arms up in self-defense, and RI #116 with his/her fist hit RI #21 in the side of the head. These deficient practices were cited as a result of the investigations of facility reported incident/complaint/report numbers 447474, 2644312, 2587752, and 2654261 and affected four of 26 residents reviewed for abuse concerns during the survey. Findings Include: A policy titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation with an effective date of May 1, 2023 documented: PURPOSE:This Policy . is concerned with all incidents and accidents involving resident/guest(s). The facility will investigate and document all incidents and accidents involving resident/guest(s). The facility's Policy strictly prohibits the abuse, neglect, exploitation and involuntary seclusion of resident/guest(s).This Policy against abuse, neglect, exploitation and misappropriation of resident/guest property includes abuse by any other person, including, but not limited to: .other resident/guest(s) . A. Abuse. The definition of abuse encompasses a broad scope of behavior. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Physical- Physical abuse includes, hitting, slapping, pinching and kicking. RI #115 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include: Acquired Absence of Left leg, Mood Disorder Due to Known Physiological Condition with Depressive features, and Post-Traumatic Stress Disorder. RI #116 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include: Peripheral Vascular Disease, Mood Disorder, and Intellectual Disabilities. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RI #116's Quarterly MDS assessment with an ARD of 10/08/2024 documented a BIMS score of 15 which indicated intact cognition. RI #116's care plan with a Problem Start date of 11/27/2023 documented: . Category: Psychosocial Well-Being Requires Behavior Management, . Resident is noted to be aggressive . Resident is aggressive with other residents, hitting others resident, fighting. RI #116's care plan did not include approaches that would guide staff to supervise RI #116 or deescalate behaviors to prevent RI #116 from abusing other residents. On 12/24/2024 the SA received a FRI alleging physical abuse occurred after RI #115 rolled into RI #116's wheelchair. The two hit each other and then were separated and sent to the hospital for evaluation. The facility investigative file contained a typed witness statement dated 12/24/2024 at 3:06 PM, taken from RI #37, that documented the following: . (RI #37) said she witnessed (RI #115) come into the . (dining) room for a coke when (RI #116) entered the dining room and sat in (his/her) usual space. (RI #37) said (RI #115) started to back out with (his/her) wheelchair and (RI #116) became upset and started hitting (RI #115). (RI #37) explained that (RI #115) was hit in the face as (RI #116) was swing (ing) at (him/her). 'They were going at it face to face', she explained, hitting each other. The male entertainer (activity performer) . intervene (d) and separated the two residents. Review of the facility investigative file revealed there were not any staff members who witnessed how the physical abuse started during the activity in the dining room. Review of the facility investigative file revealed a summary of the abuse that documented the following: . 12/24/2024 . 2:00 PM . (RI #115) observed with slight pinkness area to left cheek, . (RI #116) observed with a small shallow laceration to bridge of (his/her) nose. Both residents were interviewed . (RI #116) reports he was sitting at the table in the dining area when (RI #115) bumped into (his/her) wheelchair. (He/she) confirms yelling at (RI #115). (He/she) then reports resident (RI #115) began hitting (him/her). (RI #115) reports he went into the dining room to obtain a coke from the vending machine. He reports he backed up (his/her) wheelchair trying to exit the dining room when he bumped his wheelchair into (RI #116's) wheelchair. (RI #115) reports (RI #116) began cussing at (him/her) and then they 'got into an altercation.' . After completing a thorough investigation, this investigator feels physical abuse (resident to resident altercation) is confirmed. On 08/09/2025 the SA received a FRI alleging physical abuse occurred after RI #81 accidentally bumped RI #116's wheelchair, then RI #116 started swinging at RI #81.RI #81 was admitted to the facility on [DATE] and readmitted [DATE] and had diagnoses to include, Atherosclerotic Heart Disease of Native Coronary Artery, Major Depressive Disorder and Mood Disturbance. RI #81's Quarterly MDS assessment with an ARD of 06/30/2025 documented a BIMS score of 15 which indicated intact cognition. Review of the facility investigative summary revealed a summary of the abuse as follows: . Resident (RI #116) was sitting in (his/her) wheelchair in the hallway in front of the dining room when (RI #81) came out of the dining room . in (his/her) wheelchair and accidently bumped into (RI #116's) wheelchair. (RI #116) did not like that and swung at (RI #81). The two residents began to swing their upper extremities toward one another. (RI #116) grabbed (RI #81's) shirt. The (residents) were separated, taken back to their respective units, skin audits were completed on both residents . (RI (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#116) had no new discolorations or injury . (RI #81) was noted to have a small discoloration under (his/her) right eye and redness to the left side of (his/her) neck. (RI #116) is noted to have combative behaviors and has previously been care planned as having altercations with other (residents) in the past. (He/she) will be seen by (Behavior Services) and Social Services will continue to assess. The facility does verify the allegation of resident on resident physical abuse. Review of the facility investigative file revealed a SUMMARY OF TESTIMONY dated 08/09/2025 for Certified Nursing Assistant (CNA) #79 who witnessed the abuse as follows: . (RI #116) was sitting in the hallway backed up in front of the dining room and (RI #81) was coming out of the dining room. (RI #81) accidentally bumped (his/her) wheelchair and (RI #116) told (him/her) to leave (him/her) alone. They started swinging at each other and (RI #116) grabbed (RI #81) by (his/her) shirt and (RI #81) knocked off (his/her) glasses. On 10/08/2025 the SA received a FRI alleging physical abuse occurred after RI #115 was attempting to pass RI #116 and accidentally bumped RI #116's wheelchair. RI #116 grabbed RI #115 by the hair, pulled RI #115 out of the wheelchair and hit RI #115. RI #115 had a scratch on one finger and RI #116 had a bruise to the right eye and a raised area to his/her forehead.The facility investigative file contained a handwritten witness statement dated 10/08/2025, signed by Registered Nurse (RN) #82 that documented the following: . I had been sitting at the nurse's station charting. Resident #1 (RI #115) was sitting on the opposite side of nurse's station talking with this writer and a CNA. Resident #2 (RI #116) was sitting in (his/her) wheelchair against the wall facing the nurse's station. As I started to stand up to go to the dining room, resident #1 started rolling (his/her) wheelchair to the left in front of resident #2. Resident #1 bumped resident #2 as (he/she) was going by. It did not appear to be purposeful. Resident #2 became angry and started yelling at resident #1. Resident #2 yelled some more and started to roll (his/her) wheelchair to the right away from Resident #1. Resident #2 turned back,, started moving . and was reaching (his/her) arm out to resident #1. As I was coming out of the (nurse's) station . Resident #2 had grabbed Resident #1 by the bottom of (his/her) hair and top of (his/her) t-shirt. Resident #1 was trying to roll away and resident #2 was not letting go. Resident #1 kept rolling, pulling #2 so as resident #2 started to fall to the floor bringing resident #1 with (him/her) to the floor since he would not let go. They both landed on the floor , resident #2 was on (his/her) back while resident #1 was at the head of resident #2 punching resident 2 in the face. Employees had arrived and had started trying to pull residents apart. The facility investigative summary for the abuse dated 10/08/2025 documented the following: . The facility does verify resident on resident abuse . RI #116's medical record contained a Behavioral Health Progress Note, signed by a Family Nurse Practitioner (FNP) dated 10/22/2025 that documented the following: . Reason for Appointment1. Initial visit for psychiatric evaluation and medication managementHistory of Present Illness . presenting for initial psychiatric evaluation and medication management following a recent physical altercation with another resident where patient was the aggressor. Patient has a documented history of monthly altercations resulting in hospitalizations due to aggressive behavior. Patient exhibits significant behavioral resistance, refusing medications, food and activities of daily living. Patient demonstrates confusion . Mood Disorder: Patient has a known diagnosis of unspecified mood disorder. Current Symptom include aggressive behavior with monthly physical altercations, uncooperative and resistant behavior toward staff and care activities, and difficulty with redirection and compliance. There were not any recommendations for supervision or monitoring of RI #116's behaviors to prevent further abuse of residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/27/2025 the SA received a FRI alleging physical abuse occurred when staff observed RI #21 trying to get by in his/her wheelchair and RI #116 got mad and tried to grab RI #21's hair and RI #21 put his/her hands up and RI #116 took his/her fist and hit RI #21 in the back of the head. RI #116 said that he just felt like hitting RI #21. RI #21 was admitted to the facility on [DATE] and had diagnoses to include: Multiple Sclerosis, Hypertensive Heart Disease with Heart Failure, Obesity, and Personal History of other Venous Thrombosis and Embolism. RI #21's Quarterly MDS with an ARD of 10/13/2025 documented a BIMS score of 15 of 15 which indicated intact cognition. The facility's investigative file contained a handwritten witness statement signed by CNA #80 dated 10/28/2025 which documented the following: . (RI #116) was trying to get by (RI #21) . (his/her wheelchair) kept running into (RI #21's) . (RI #116) said something not sure what . (RI #21) said 'Oh you got the wrong one' so (RI #116) got mad . tried to grab (RI #21s) hair . then (RI #21) put (his/her) hand up. When (RI #21) put (his/her) hand up (RI #116) took (his/her) fist (and) hit (RI #21) in the side of the head. The facility's investigative file contained a summary of the abuse dated 11/03/2025 as follows: . While residents were in hallway on the station, (RI #116) attempted to get around (RI #21), but was having difficulty. (RI #116) became upset and hit (RI #21) in the head. (RI #116) was sent to hospital for (psychiatric evaluation) . Body audit completed on (RI #21) and no injuries or new marks noted. The facility does verify the allegation of physical abuse. On 04/29/2026 at 2:47 PM an interview was conducted with RI #21. RI #21 said he/she was coming out of the dining room going down the hallway near the nurse station and RI #116 begin to hit him/her. He/she did not know why the resident began to hit him/her. RI #21 stated RI #116 hit him/her with a closed fist. On 04/30/2026 at 8:15 AM, an interview was conducted with SSD. She stated that the facility assess for the level of supervision needed to protect others from being affected of abuse by RI #116 was through the nurses, practitioner and consulting Behavior Health. She stated that the process used for the assessment of supervision level required for RI #116 was through the nurse observation or the Practitioner assessment. She also stated the previous intervention has not been effective for RI #116. She stated that RI #116 behavior affecting others of abuse could have been prevented with more in-depth Assessment prior to admission. According the SSD physical abuse happened between RI #116 and RI #115, RI #116 was the aggressor. The SSD was asked how effective have RI #116's interventions been and she said not effective. On 04/30/2026 at 10:32 AM an interview was conducted with Interim DON. She stated that the facility did not protect RI #115 from physical abuse by RI #116 because his/her behavior was very unpredictable. She was asked why she said the facility did not protect RI #115 from abuse by RI #116 and she stated RI #116 had prior incidents of aggressive behaviors. According to the Interim DON, resident should be free of abuse at all time for their wellbeing. On 05/01/2026 at 9:53 AM a follow up interview was conducted with the SSD. She was asked why the facility did not protect RI #115, RI #81, and RI #21 from RI #116. She stated that the facility protected the residents with the resources they had. When asked if after RI #116 hit residents on (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/24/2024, 08/09/2025, 10/08/2025 and 10/27/2025, should the facility have known that RI #116 would hit other residents, the SSD stated they should have known because of a history of hitting residents. On 05/05/2026 at 3:06 PM an interview was conducted with Licensed Practical Nurse (LPN) #82 who witnessed RI #116 abuse RI #115. She stated RI #116 reached his/her arms out and grabbed RI #115. LPN #82 said, RI #115 had accidentally bumped into RI #116's wheelchair and RI #116 was a difficult resident.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, a test tray, interviews, the Resident Council Minutes, the Grievance Log, and the facility's policies for Food Preparation Guidelines and Food Cooking and Serving Temperatures; the facility failed to ensure hot food was served hot at Lunch on Wednesday, 04/22/2026. This affected Puree Beef Stroganoff and Puree [NAME] Beans on the test tray and had the potential to affect four of four Puree Diets. This deficiency was cited as a result of complaint/report #2621001.Findings include: The facility's policy for Food Cooking and Serving Temperatures, dated 08/23/2017, included the following: . STANDARD: . food . should be served attractively at proper temperatures. The facility's policy for Food Preparation Guidelines, dated 08/10/2018, included the following: . PURPOSE: . Food should be palatable, attractive, and at the proper temperature, as determined by the type of food, to ensure resident/ guest(s) satisfaction. The facility's Resident Council Minutes included the following:October 2025 - . Food . Still cold on the halls, .March 19, 2026 - . food cold . Also food is cold off of cart . The facility's Grievance Log included the following:March 19, 2026 - . Chilli (sic) came out cold, resident told staff and nobody heated it up. (RI #80) On Wednesday, 04/22/2026 at 11:50 AM, the residents' Lunch trayline was observed. At 12:50 PM, a Test Tray was requested for the last tray on the last cart. At 1:09 PM, the loading of the last cart (North #3) began. At 1:20 PM, the Test Tray was prepared. At 1:21 PM, the last cart left the kitchen and arrived on the North Hall. By 1:25 PM, facility staff were in the process of serving lunch trays to residents. The last tray was served at 1:29 PM. On Wednesday, 04/22/2026 at 1:31 PM, the Test Tray was evaluated with the Clinical Certified Dietary Manager. The Puree Beef Stroganoff and the Puree [NAME] Beans did not melt butter/margarine. Upon tasting, the Clinical Certified Dietary Manager agreed these two items were not hot. On 04/22/2026 at 6:05 PM, the Regional Dietary Consultant, a Registered Dietitian, was interviewed. The Regional Dietary Consultant said four residents received a Puree diet for lunch today. When asked the concern for hot food not being served to residents at an acceptably hot temperature, the Regional Dietary Consultant said they may not like it and may not eat it, therefore missing calories in their diet. This deficiency was cited as a result of complaint/report #2621001.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on interview and record review the facility failed to ensure policies and procedures were developed and implemented regarding residents independently signing themselves out of the facility and leaving without supervision. This failure had the potential to affect all residents who leave the facility independently by limiting the facility's ability to assess resident safety, supervision needs, and risk prior to departure. Findings Include: Cross Reference F689 During an interview conducted on 05/19/2026 at 5:45 PM with the Corporate Compliance Officer/ Quality Assurance Director she was questioned regarding residents who independently sign themselves out without supervision. She explained a nurse would ask about their expected return time, confirm that the resident was not a risk by consulting the elopement book, and administer or send medication if necessary. She further stated that if the resident failed to return, the nurse would follow up with a call to ascertain their return time. When asked about a policy for assessing residents' ability to sign themselves out independently or with supervision, she was unaware of a specific policy but said resident rights included the ability to sign out if capable. Regarding how the facility meets residents' needs while they are away from the facility she said if a resident could sign out independently, they would be presumed capable of managing their Activities of Daily Living (ADLs), and would be determined by the Minimum Data Set (MDS) and Elopement Assessment. When questioned whether a resident's refusal to sign out would be classified as an elopement, she said it would be deemed leaving against medical advice (AMA) if their Brief Interview of Mental Status (BIMS) score was sufficiently high. She said the facility would consult with the Medical Director (MD) and refer the case to the Department of Human Resources (DHR) if a resident departed and the facility deemed it an inappropriate placement.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interviews, record review, and a review of the facility policy titled, Quality Assurance/ Performance Improvement, the Quality Assurance Performance Improvement (QAPI) committee failed to identify all causal factors related to two elopements for Resident Identifiers (RI) #106 and RI #121 and for smoking non compliance for RI #33 and RI #109. The facility also failed to determine what corrective actions needed to be taken to prevent any further resident safety concerns. This deficient practice affected RI #106, RI #121, RI #33 and RI #109These deficient practices were cited as a result of the investigations of facility reported incident/complaint/report numbers 447450, 2983895 and 2621001.Findings Include: Cross-Reference F689 A review of a facility policy titled, Quality Assurance/Quality Assurance Performance Improvement, updated 10/15/2022 revealed: Policy Our purpose is to provide excellent quality resident/guest services. Quality is defined as meeting or exceeding the needs, expectations and requirements of the resident/guest cost effectively while maintaining good resident/guest outcomes and perceptions of resident/guest care. ScopeOur facilities have a Performance Improvement Program which systematically monitors data, analyzes and improves its performance to improve resident/guest outcomes. It recognizes that value in healthcare is the appropriate balance between good measures, excellent care, services and cost.QAPI Plan address: . b. Quality of Life - Monitor existing data available through annual licensing survey, resident/guest family satisfaction surveys, resident/guest/family concerns brought up at council meetings, concerns for care conferences and individual rounding with residents/guests and family members. Review grievances for patterns and trends.I. Governance and Leadership Administration is responsible and accountable for developing, leading and closely monitoring of QAPI Program.a. Input is obtained from facility staff on a monthly basis through the QAPI committees .c. The administrator will be the Quality Management Coordinator and responsible for the NHS QAPI process .III. QAPI Monthly Committee . c. The committee maintains a QAPI policies, minutes, project chartered PIP's, Quality metrics and data analysis .V. Guidelines for Performance improvement Project (PIP) Teams .i Potential topics for PIP's are identified through prioritization process in the QAPIii Criteria for prioritizing and selecting PIP's are based on prevalence, risk, cost, relevance, responsiveness, feasibility, and continuity. PIP's involve gathering information to clarify issue or problems, design and implement interventions, assess results, and sustain improvement utilizing a Root cause process .VI. Systematic Analysis and Systematic Action .b. The Plan-Do-Study-Act (PDSA) process or any applicable system for Root Cause Analysis (RCA) are used to identify improvement opportunities and to understand how to improve them.c. The QAPI Committee monitors progress to ensure that interventions or actions are implemented and effective in making and sustaining improvements.On 05/20/2026 at 10:50 AM, the Regional Administrator (RADM) stated that the facility's QAPI committee convenes on a monthly basis with weekly subcommittee meetings. He noted that prior to the survey team's arrival, the facility had recognized issues related to elopement, pressure injuries, and non-compliance with smoking regulations. When asked about the actions taken regarding those issues, he reported that for elopement, residents were evaluated for their risk of elopement, window securement was replaced on all windows, and staff were educated on two-hour observation protocols, wander guards, and the elopement policy. Regarding smoking concerns, all residents who smoked underwent evaluations, a policy review was conducted with each identified smoker and signed, and a locked toolbox was purchased to secure smoking materials. Concerning pressure injuries, the current wound nurse received training, skin assessments were performed on 95 residents, and any issues identified were referred to the wound care specialist for evaluation and treatment, along with ongoing audits of wound care. The RADM indicated that the root cause of elopement was a resident had accessed clippers, which allowed them to cut the screen, and the window was not properly secured. The root cause of non-compliance with smoking regulations was (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	attributed to the absence of a locked container for smoking materials, while the root cause of the pressure injury was the wound care nurse failed to adhere to the wound care protocol. When asked about the systems that were established and put into action to assess the effectiveness of corrective actions, he stated that the staff received training regarding the elopement process, the smoking policy and procedure, as well as the responsibilities of the Certified Nursing Assistant (CNA) in recognizing early skin changes and reporting those changes to the nurse. He said the facility conducted weekly monitoring for elopements, checked the wander guards, and ensured compliance with the smoking policy through daily audits. The Director of Nursing (DON) monitored the wound care nurse to ensure skin audits were performed and that any new wounds were identified and treated.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on observations, interviews, record review, a facility policy titled Resident Rights, and a Facility Reported Incident (FRI) received by the State Agency, the facility failed to protect Resident Identifier (RI) #105's right to refuse care and treatment on 02/12/2023 when Certified Nursing Assistant (CNA) #75 and CNA #76 held RI #105 on his/her side to provide care. RI #105 was combative and told the CNAs not to touch him/her, as they continue to hold RI #105 on his/her side and provide care. This affected RI #105 one of three residents reviewed for Activities of Daily Living (ADL) and was cited as a result of the investigation of Complaint/FRI report number 447447.Findings Include: A review of a policy titled Resident Rights documented: .(c) Planning and implementing care. The resident has the right to be informed of, and participate in, his or her treatment including: . (c)(6) The right to . refuse .treatment, . RI#105 was admitted to the facility 01/12/2023 with Diagnosis of Systolic Congestive Heart Failure and Essential Hypertension. RI#105's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 01/19/2023 documented a Brief Interview of Mental Status score of 14 indicting RI #105 was cognitively intact. RI #105's care plan dated 01/14/2023 indicated the resident was care planned for ADL's with a potential for bruises/tears related to fragile skin. Interventions included to use gentleness when working with the resident and to allow resident to make choices when possible. On 02/12/2023 the SA received a FRI from the facility alleging injury of unknown origin after RI #105's resident representative reported bruises and discolorations to both of RI #105's hands.On 05/01/2026 at 10:23 AM a phone interview was conducted with the RI #105's resident representative (RR) about the incident on 02/12/2023. RI #015's RR said, she went to see RI #105 and observed bruising to RI #105's hands. The facility investigative file contained a statement from RI #105's RR dated 02/12/2023 as follows: . I CAME IN TO SEE . (RI #105) THIS MORNING AT 8:40 A.M. (He/she) was upset and showed me (his/her) hands. Both were badly bruised. I had been to visit yesterday and left at 4:15 P.M. They were not bruised at that time.The facility investigative file contained an undated RESIDENT INTERVIEW SUMMARY from RI #105 that documented the following: . The other night that lady was trying to change me, . it hurt, so I slapped at them. The facility investigative file contained a witness statement from LPN #77 dated 02/12/2023 as follows: . SUMMARY OF TESTIMONY: (RI #105's RR) reported to another charge nurse she had a problem when the nurse asked what the problem was she stated (RI #105) didn't have these bruises on (him/her) when I left yesterday! The other charge nurse and I both went into the room and discoloration was noted on bilateral hands. Incident report was completed, body audit completed, Nurses note completed and (administration) made aware.On 05/01/2026 at 10:38 AM during a phone interview with Licensed Practical Nurse (LPN) #77 she said due to the length of time she did not remember the incident involving RI #105. The facility investigative file contained a statement from CNA #75 dated 02/12/2023 which documented the following: . I went to change (RI #105), . I was on the door side of the bed I needed (RI #105) to roll and (he/she) started calling me a bitch and said I will kick you. I went to the other side to help (RI #105) roll and (he/she) refused, I told (RI #105) I was getting someone to help me and went and got . (CNA #76). When (CNA #76) came into the room, (RI #105) done the same thing to her. (RI #105) called her a bitch and started kicking at (CNA #76) and hitting at her. We got (RI #105) hanged and covered . The facility investigative file contained a statement from CNA #76 dated 02/12/2023 which documented the following: . (CNA #75) asked me to help turn (RI #105) over because (he/she) was being combative and cussing. I went in the room and (RI #105) was cussing both of us. And being combative. Don't touch me, gets your hands off me bitch (RI #105) also tried to hit us numerous times. (CNA #75) asked me to help roll (RI #105) over, and that is all I did. I held (RI #105's) shoulder and leg while (he/she) (held) the rail, I put my hands up to block (RI#105) from hitting me as (he/she) hitting me numerous times. (RI #105) was then pulled up and I left the room. The facility investigative file contained a statement from Treatment Nurse/Registered (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse (TXN) #5 dated 02/12/2023 which documented the following: . (#105's) family came to the nurses station around 9:00 am . stating She had a problem. (RI #105) didn't have these bruises on (him/her) when I left yesterday and now (he/she) is covered in them. The residents nurse and I went to the room for further investigation, upon arrival noticed discoloration noted to both hands and fingers, left hand had more discoloration.On 05/04/2026 at 2:10 PM an interview was conducted with the TXN and she did not recall an incident involving RI #105 on 02/12/2023. The TXN said if a resident became agitated during care she would try to calm the resident down and if that did not work she would leave the room until they calmed down and try again.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, review of a facility policy titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Uknown Source, Exploitation and review of a Facility Reported Incident (FRI), the facility failed to ensure Resident Identifier (RI) #114 was protected from RI #19 when RI #19 was placed back in the room with RI #114 without 15-minute checks or supervision upon returning from the hospital's psychiatric unit on 08/22/2025. RI #19 was sent to the hospital's psychiatric unit on 08/21/2025 after he/she became agitated and began yelling, cursing, and slamming doors in the room shared by RI #19 and RI #114. RI #114 stated the actions of RI #19 scared him/her. This deficient practice affected RI #114, one of 24 residents reviewed for alleged abuse. This deficiency was cited as a result of the investigation by complaint/report/FRI #2610724. Findings Include:A facility policy titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation with an effective date of 05/15/2023 revealed the following: This Policy (the Policy) is concerned with all incidents .involving resident/guest(s) . V. Protection of Resident/Guest(s) during the Investigation a) The facility will take all reasonable measures to protect a resident/guest . Such measures may include separating the resident/guest from the person(s) who is (are) suspected of abusing the resident/guest .On 08/25/2025 at 11:07 AM the State Agency received a FRI alleging verbal abuse by RI #19 towards his/her roommate RI #114. RI #19 was sent out for a psych evaluation. RI #19 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include: Alzheimer's Disease with late onset (Primary) Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, Anxiety, Adjustment with disorder with depressed mood, Schizophrenia, unspecified, and bipolar disorder.A review of RI #19's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/15/2025 revealed a BIMS score of 14 which indicates intact cognition.RI #114 was admitted to the facility on [DATE] and discharged on 08/25/2025. RI #114 had diagnoses to include: Muscle Weakness, and Spina Bifida.A review of RI #114's MDS assessment with an ARD of 08/20/2025 revealed a BIMS score of 15 which indicated intact cognition.RI #19's progress notes completed by Licensed Practical Nurse (LPN) #18 revealed the following: 08/21/2025 at 10:10 RESIDENT NOTED YELLING, CURSING . NOTIFIED UNIT MANAGER TO NOTIFY ADMINISTRATOR, RESIDENT SENT OUT TO HUNTSVILLE HOSPITAL FOR PSYCH EVALUATION PER ADMIINISTRATOR. RESIDENTS FAMILY NOTIFIED OF RESIDENTS EPISODE AND WOULD BE SENDING OUT RESIDENT TO THE HOSPITAL. RESIDENT OUT OF FACILITY AT APPROXIMATELY 8:45PM.RI #19's progress notes made by Registered Nurse (RN) #49 revealed the following: 08/22/2025 8:23 AM Resident returned to facility @ (at) 0301 (3:01 AM) via (by way of) (name of transport company) . On assessment resident is alert and oriented with slight confusion. Denies any suicidal or homicidal ideation. Resident is now q15min (every 15 minutes) checks .On 05/13/2026 at 12:05 PM RI #114 was interviewed about the incident on 08/21/2025 with former roommate RI #19. RI #114 stated on 08/21/2025 he/she was lying in bed looking out the window when RI #19 came over to him/her side of the room, slammed the shade shut, slammed the bathroom door and started screaming at him/her. RI #114 stated he/she was just yelling and screaming going off towards him/her. RI #114 said, I don't remember exactly what he/she was saying he/she was just going off. RI #114 further stated RI #19 was sent off and came back later to the same room. RI #114 could not remember if staff came in and checked on RI #19 every 15 minutes. RI #114 stated when RI #19 began yelling and screaming he/she was scared to be in the room with RI #19.On 05/13/2026 at 9:32 AM during an interview RI #19 stated he/she did not remember an incident occurring back in August 2025 with his/her former roommate RI #114.On 05/01/2026 at 11:23 AM LPN #18 was interviewed regarding the incident that occurred on 08/21/2025 between roommates RI #19 and RI #114. LPN #18 stated a CNA came up to her and told her that RI #19 was yelling and cursing his/her roommate RI #114. LPN #18 (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated when she got to the room RI #19 was still yelling and cursing. LPN #18 stated that she called the unit manager who informed she was going to call the administrator. LPN #18 stated the unit manager called her back and said to send RI #19 out and then she called the hospital and gave them report and RI #19 was sent out.On 05/13/2026 at 5:18 PM RN #49 was interviewed regarding the progress note made on 08/22/2025 referencing RI #19's return to the facility from the psychiatric unit. RN #49 stated she remembered writing the progress note. RN #49 stated that once RI #19 returned to the facility she and the CNAs were responsible for conducting the q15min checks with the CNA's having the primary responsibility. RN #49 said she did not know where the q15min checks would have been documented. RN #49 said the RI #19 was placed back in the same room he/she came from.On 05/14/2026 at 2:07 PM the surveyor interviewed the Administrator (ADM) regarding the reported incident on 08/21/2025 between RI #19 and RI #114. The ADM stated she did not know why RI #19 was placed back in the room with RI #114, but when she found out she instructed them to be separated. The ADM further stated she did not think it was a good idea for RI #19 to go back in the room.A review of a signed statement dated 05/11/2026, made by the Regional Administrator, noted that after looking facility staff were currently unable to locate the q15-minute documentation for RI #19 in August 2025 showing that RI #19 was monitored and RI #114 was being protected from further outburst from RI #19.

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	015440	A. Building B. Wing	05/21/2026

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Huntsville Health & Rehabilitation, LLC	4010 Chris Drive Huntsville, AL 35802

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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 0609 Level of Harm - Minimal harm or potential for actual harm 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** Based on resident record review, interview, review of Facility Reported Incident (FRI), review of the facility's investigative file and review of a facility policy titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation, the facility failed to ensure an allegation of verbal abuse involving Resident Identifier (RI) #19 and RI #114 was reported to the Administrator (ADM) immediately. This deficient practice affected RI #19 and RI #114, two of 24 residents reviewed for alleged abuse. This deficiency was cited as a result of the investigation of complaint/report/FRI #2610724.Findings Include:A facility policy titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation dated 05/15/2023 documented: PURPOSE:This Policy (the Policy) is concerned with all incidents and accidents involving resident/guest(s) . Section IV. Identification of Resident/Guest(s) Incidents and Accidents: .d). Each employee has an obligation to immediately report any incident or allegation that could constitute an instance of abuse or neglect, any injury of unknown origin, exploitation or misappropriation of resident/guest property to the Administrator, Director of Nursing (DON), or the Department Supervisor.VI. Investigations and Facility Response to Incidents or Accidents .b) Investigation and Reporting StepsNotify the Administrator of any unusual situation in the facility, whether reportable or not immediately . On 08/25/2025 at 11:07 AM the State Agency received a FRI alleging verbal abuse involving RI #19 and RI #114 on 08/21/2025. The date and time staff became aware of the incident was on 08/21/2025 at 7:45 PM. RI #19 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include: Alzheimer's Disease with late onset (Primary), Dementia, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, Anxiety, Adjustment with Disorder with Depressed Mood, Schizophrenia, and Bipolar Disorder. A review of RI #19's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 07/17/2025 revealed a BIMS score of 14 which indicated intact cognition. RI #114 was admitted to the facility on [DATE] and discharged on 08/25/2025. RI #114 had diagnoses to include: Muscle Weakness and Spina Bifida.Review of the facility's investigative file contained a document titled VERIFICATION OF INVESTIGATION which revealed the following: NAME OF RESIDENT:(RI #19)(RI #114) .LOCATION OF INCIDENT: Resident's Room TIME OF INCIDENT: 7:45PMDATE OF INCIDENT: 8/21/2025DETAILED DESCRIPTION OF INCIDENT/ALLEGATION: (RI #19) was in (his/her) room with his/her roommate, (RI #114), when (RI #19) became agitated and began yelling, cursing, slamming doors .PROVIDE SUMMARY AND OUTCOME OF INVESTIGATION:On Thursday, 8/21/2025, it was reported by (LPN #18), charge nurse, to the unit manager, (Registered Nurse/Treatment Nurse (RN TXN)), (RI #19) was agitated .On Monday, 8/25/25, Director of Nursing (DON) returned from vacation and was reading the nurses notes . DON asked the Administrator if she was aware that the resident was threatening (his/her) roommate. Administrator was unaware and immediately called the unit manager, (RN TXN), to speak to her and the DON for an interview of what was told. Unit manager (RN TXN), stated that she really could not remember all that the charge nurse, (LPN #18) had said. At that time, the unit manager, (RN TXN) was sent home pending the investigation process. The DON spoke to the resident, (RI #114), .When interviewed, (RI #114) stated (he/she) was not threatened . and that (RI #114) did not say anything about hurting (him/her). (He/She) was afraid because (RI #19) was slamming doors and being ballistic. On 05/14/2026 at 2:07 PM a telephone interview was conducted with the ADM. The ADM stated she did remember the incident between RI #19 and RI #114 that occurred on 08/21/2025. The ADM said the incident was reported to her by RN TXN. ADM stated the incident should have been reported to her immediately.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, review of a facility policy titled, Pain Management and Assessment , review of a Facility Reported Incident (FRI) received by the State Agency and review of the facility's investigative file, the facility nurses failed to provide pain management for Resident Identifier (RI) #120. On 04/02/2026 around 3:35 AM RI #120 was admitted to the facility and was assessed as having a pain level of 7 on a scale of 1-10. The pain medication ordered, Oxycodone 5 milligrams (mg), was not in the facility for administration. On 04/02/2026 at 12:44 AM the pain medication was delivered to the facility, but it was not until 04/03/2026 at approximately 8 AM, when RI #120's pain level was between 8-9, that RI #120 was medicated for his/her pain. RI #120 called 911 to be taken to the hospital due to his/her pain. Further, a facility nurse failed to administer RI #120 the correct number of pain tablets for his/her pain level of 8-9 on 04/03/2026. RI #120's pain medication not being available for administration placed RI #120 at risk of having unmanaged and unrelieved pain. This deficient practice affected RI #120, one of five residents sampled for pain management. This deficiency was cited as a result of the investigation of complaint/report/FRI #2977469. Findings Include: On 04/06/2026 at 2:52 PM, the State Agency received by way of the Online Incident Reporting System an allegation of neglect indicating RI #120 left a Google review stating he/she did not receive medication for 38 hours.Review of a facility policy, titled Pain Management and Assessment, with an effective date of 12/18/2019 revealed the following: PURPOSE:The detection of the presence of pain, determining the frequency and intensity of pain, and identification of effective pain management interventions can help avoid adverse outcomes that impact the resident/guest(s) functional status and quality of life .PROCESS:I. General Informationa) Pain is any type of physical pain or discomfort in any part of the body. It may be localized to one area or may be more generalized. It may be acute or chronic, continuous or intermittent, or occur at rest or movement. Pain is subjective, pain is whatever the experiencing person says it is and exists whenever he or she says it does .f) Most residents/guest(s) with moderate to severe pain will require regularly dosed pain medication, and some will require additional PRN (as needed) pain medication for breakthrough pain.g) Some resident/guest(s) with intermittent or mild pain may have orders for PRN dosing only.II. Ongoing Pain Assessmenta) The alert resident/guest should be asked to describe their pain on a scale of 1-10; with zero being no pain and 10 being the most severe pain the resident/guest can imagine . RI #120 was admitted to the facility on [DATE] around 3:35 AM with diagnoses to include Fracture of Shaft of Right Fibula, Subsequent Encounter for Closed Fracture with Routine Healing and Discoloration of Right Ankle Joint. RI #120's April 2026 Physician Order Report revealed RI #120 had an order for Oxycodone 5 mg, two tablets, to be administered for moderate pain between the pain levels of 4-7; and four tablets to be administered for severe pain between the pain levels of 8-10. A review of RI #120's April 2026 Medication Administration Record (MAR) revealed RI #120 was administered Oxycodone 5 mg, one tablet for a pain level of 9, when the resident should have been administered four tablets for that pain level. A review of RI #120's Controlled Drug Record for the Oxycodone 5 mg also revealed only one tablet was administered. A review of RI #120's Progress Notes dated 04/03/2026 at 8:00 AM revealed the following: . Pt (patient) c/o (complained of) pain of 8 Pt given prn Pt called ambulance to pick (him/her) up because (he/she) was in pain . On 04/24/2026 at 10:49 AM a telephone interview was conducted with RI #120. When asked, RI#120 said he/she had fallen and had ankle surgery was why he/she was admitted to the facility. When asked what his/her level of pain was from 1-10 while he/she was at the facility, RI #120 said his/her pain level stayed at an 8. RI #120 said he/she called the ambulance to take him/her to the hospital due to the inability to receive proper care. When asked what care he/she did not receive, RI #120 said he/she did not receive his/her medications. Contained within the facility's investigative file was a typed, signed statement made by the Former Director of Nursing (FDON) #21, which revealed the following: . Q: Did you work (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 4-2-26?A: YesQ: Did you take care of (RI #120)?A: YesQ: Did (RI #120) complain of pain?A: YesQ: What did (RI #120) voice (his/her) pain level?A: Yes, (he/she) stated a 7.Q: Where was (RI #120's) pain located?A: (He/She) pointed to (his/her) right leg where the external fixator device was located .Q: Did you give (RI #120) anything for pain?A: No, I didn't give (him/her) any pain med .Q: Who did you tell to give (RI #120) something for pain?A: (Licensed Practical Nurse [LPN] #33) and (LPN #31) was at the nurses desk when I informed them that (RI #120) needed something for pain .Q: Why did you come in early?A: (RI #33) LPN was working 11p-7a and she notified me to come in to assist her because she had an admission .Q: Did they give (RI #120) any pain medication?A: I don't know . On 05/05/2026 at 5:20 PM a telephone interview was conducted with the FDON. The FDON said she did complete RI #120's admission assessment and RI #120 did complain of being in pain. The FDON said RI #120's pain medication was not in the facility at that time because she had just put the orders in that morning. The FDON said she did not know if RI #120's physician was informed that RI #120 was in pain and did not have pain medication at the facility. The FDON said the facility does have an emergency supply of medication, but Oxycodone was not in the stat box. The FDON said the pain medication Percocet was in the box, and someone could have called the physician and got orders for a one-time dose until RI #120's pain medication was delivered to the facility. When asked if a resident is in pain and does not get their pain medication as ordered what would this be considered, the FDON said it would be considered a delay in the resident's care. Contained within the facility's investigative file was a typed, signed statement made by LPN #31 on 04/07/2026 which revealed the following: . Q: Did you work on 4-2-26?A: YesQ: Did you take care of (RI #120)?A: YesQ: Did (he/she) ask for any pain medications?A: YesQ: Did you give (RI #120) anything for pain?A: NoQ: Did you notify the Provider?A: Yes, I asked (name of Certified Nurse Practitioner [CRNP] #83)Q: Did you ever speak back with the provider?A: I can't recall . On 05/14/2026 at 10:30 AM a telephone interview was conducted with LPN #31, the LPN assigned to care for RI #120 on 04/02/2026 on the 6 AM - 2 PM shift. The LPN said she was doing her morning med pass when RI #120 asked for something for pain. LPN #31 said she did not provide RI #120 any pain medication because what RI #120 was ordered was not in the facility's stat box. LPN #31 said it was after this incident that it was brought to her attention that the facility could use the backup pharmacy for getting medications. When asked what potential was there when a resident is in pain and does not receive pain medication as requested, LPN #31 said the blood pressure could go up, healing could be delayed and the resident could have increased pain. LPN #31 said according to a pain scale of 1-10, the pain level of 8-9 would be considered pretty high. On 05/14/2026 at 4:03 PM and on 05/15/2026 at 11:10 AM unsuccessful attempts were made to contact CRNP #83. Contained within the facility's investigative file was a typed, signed statement made by Registered Nurse (RN) #34 on 04/07/2026 which revealed the following: . Q: Did you work on 4-3-26?A: YesQ: Did you take care of (RI #120)?A: Yes, I gave (him/her) pain medication around 7:57 am before (he/she) left for the hospital.Q: Why did (he/she) go to the hospital?A: (He/She) called (name of transportation company) to come pick (him/her) up because (he/she) was in pain . On 05/15/2026 at 12:24 PM a telephone interview was conducted with RN #34, the RN providing care for RI #120 on 04/03/2026 on the 6 AM - 2 PM shift. RN #34 said from what she recalled RI #120 was admitted to the facility because he/she had surgery on one of his/her legs. RN #34 said she made the statement she did because the Administrator came to her and asked her had RI #120 had his/her pain medication. RN #34 said she was passing medications that morning and had not gotten to RI #120 when the administrator came to her and asked her about RI #120 getting his/her pain medication. RN #34 said she told the administrator she had not given RI #120 any medications and stopped to give RI #120 his/her pain medication. RN #34 said RI #120's medications were on the med cart at that time. When asked what was the potential when a resident was in pain and did not receive pain medication as requested, RN #34 said increased pain. RN #34 said according to a pain scale of 1-10, a level of pain at 8-9 would be considered severe. When asked why RI #120 went to the hospital on the morning of 04/03/2026, RN #34 said because RI #120 said he/she had not (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had his/her pain medication. 05/15/2026 at 11:25 AM an interview was conducted with the Interim Director of Nursing (IDON). The IDON said she became aware of a Google review left by RI #120 on the 3rd (04/03/2026), after RI #120 discharged from the facility. The IDON said the facility started conducting interviews and looking at things that took place during that time. When asked what the nurse should do when a resident's pain medications were not available at the facility or in the stat box, the IDON said nurses are expected to call the doctor and get an order for something that was in the stat box until the narcotic medication arrived. The IDON said the facility had a backup pharmacy and that would be an alternative for getting pain medication that the facility did not have in the Stat emergency box. When asked should a resident ever not have pain medication available for administration if it was ordered, the IDON said the resident should always have pain medication available or an alternative measure should be attempted to get the pain medication. The IDON said the potential when a person does not get their pain medication when they requested to receive it would be unrelieved pain. The IDON said according to a pain scale from 1-10, the pain level of an 8-9 would be considered more severe pain. The IDON said according to RI #120's Progress Notes his/her pain level was at an 8 on 04/03/2026. When asked, according to RI #120's Physicians Orders how many Oxycodone 5 mg tablets should RI #120 have received for a pain level between 8-10, the IDON said four. The IDON said that according to RI #120's Controlled Drug Substance Sheet, RI #120 only received one tablet. When asked, did RI #120 receive the right amount of pain medication for his severe pain, the IDON said no. **********The facility took immediate action to correct the noncompliance including:********** PAIN QAPI ACTIONS Section 1: Corrections for identified resident 4/2/2026, DON entered orders for identified resident at 7:52 am. Pain level=7/10 per DON, resident was laughing and joking, no pain med requested.4/2/2026, Nurses evaluated pain level each shift after this. Pain was not described as higher than 2/10 until pain medication was administered 4/3/26.4/2/2026 at 12:49 pm, pain medication received from pharmacy and Identified resident received pain medication on 4/3/26 at 7:57 am.4/3/2026. Identified resident went to hospital by ambulance at (his/her) request due to complaint of pain at 8:12 am. Pain level at this time = 8/10 Section 2: How did the facility determine other residents who may be affected. Residents admitted with-in previous 30 days were reviewed to ensure necessary medications were received and available. Any identified will have medications obtained at that time by nurses.4/7/2026, resident interviews were conducted with alert and oriented residents regarding abuse/neglect. No concerns were identified. Section 3: Corrective actions/systemic changes 4/6/2026, Administrator/DON educated nurses on narcotic substitution, med availability/pharmacy policy and pain evaluations4/7/2026, Admissions uploads new admits into a document folder, Medical records nurse began emailing confirmation replies back to admissions group that orders were entered into MatrixCare.4/8/2026, Administrator/DON educated nurses on the admission process for after hours including order entry. Section 4: Monitoring process-Administrator/DON or other designee 5 new admits will be reviewed weekly x 4 to ensure mediation availability. Any concerns with medication will be addressed at that time and corrected immediately.Then once 4 weeks are complete, 10 new admits will be reviewed the next month, then quarterly. Results will be reported to the QAPI committee to guide actions and ensure compliance. After review of documentation supporting the above corrective actions, including the facility's investigation file, in-service/education records, QAPI documentation, and staff interviews, the survey team verified the facility implemented corrective actions including ongoing monitoring from 04/03/2026 to 04/08/2026, and past non-compliance was cited.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, review of a Facility Reported Incident (FRI) received by the State Agency, review of the facility's investigative file and review of a facility policy titled, Pharmacy Services Provider Pharmacy Requirements, the facility failed to ensure Resident Identifier (RI) #120's medication orders were faxed to the pharmacy in a timely manner to ensure RI #120's pain medication, Oxycodone 5 mg, was readily available for administration. This deficient practice affected RI #120, one of five residents reviewed for pain management. This deficiency was cited as a result of the investigation of complaint/report/FRI #2977469.Findings Include: On 04/06/2026 at 2:52 PM, the State Agency received by way of the Online Incident Reporting System an allegation of neglect indicating RI #120 left a Google review stating he/she did not receive medication for 38 hours. Review of a facility policy titled, Pharmacy Services Provider Pharmacy Requirements, with a reviewed date of 04/2020 revealed the following: . PolicyRegular reliable pharmaceutical service is available to provide residents with prescription and nonprescription medications, services . Procedures .5. The provider pharmacy provides routine and timely pharmacy service with emergency pharmacy service 24 hours per day, seven days per week . RI #120 was admitted to the facility on [DATE] at 3:35 AM with diagnoses to include Unspecified Fracture of Shaft of Right Fibula, Subsequent Encounter for Closed Fracture with Routine Healing and Discoloration of Right Ankle Joint, Subsequent Encounter.Contained within the facility investigative file was a typed statement dated 04/07/2026, made by the Admissions Coordinator (AC), which revealed the following: On 4/1/26 I received all DC (discharge) paperwork for (RI #120's) admission to (initials of nursing home). Once all DC paperwork was reviewed and checked, an admission alert was sent out on 4/1/26 @ (at) 2:30pm including all medications along with scripts. The next morning on 4/2/26 I reviewed all admissions from the previous day for our morning call and noticed that (RI #120) didn't admit until 4/2/26 .Later that afternoon on 4/2/26 roughly between 1:00pm-3:00pm our CTC (Care Transition Coordinator) came into my office and stated she received a phone call from (RI #120) and or (his/her) family regarding (him/her) being at the facility in pain and hadn't received any pain medications within the 6-8 hour window (he/she) had been admitted . On 05/15/2026 at 8:27 AM an interview was conducted with the AC. When asked what was the facility's process to ensure residents have ordered medications when they are admitted to the facility, the AC said she sends out the alert with all required admission paper work and then Medical Records fax all the medications and hard scripts to the pharmacy. The AC said she did receive all of RI #120's DC paperwork on 04/01/2026 and sent out an admission alert on 04/01/2026 at 2:30 PM that included all RI #120's medications and hard scripts for the pharmacy. The AC said Medical Records (MR) would have been responsible for faxing the medication list to the pharmacy. On 05/15/2026 at 9:29 AM an interview was conducted with the MR nurse, the person responsible for ensuing residents' medication orders are faxed to the pharmacy. The MR nurse said the pharmacy asked that the facility make sure all the orders get to them by 4:30 PM so they can be ready for delivery that day. The MR nurse said when she received the email from Admissions, she still faxed the orders to the pharmacy even if it was after 4:30 PM. When asked when she received the medication orders for RI #120's medications before he was admitted on [DATE], the MR nurse said it was on 04/01/2026 at 2:31 PM that the email was received. The MR nurse said she did not fax RI #120's medication orders to the pharmacy because she had a family emergency to come up at that time. The MR nurse said she was not sure when RI #120's medication orders were faxed to the pharmacy. The MR nurse said after the incident of RI #120 not receiving his/her pain medications when he/she requested them, facility nurses were in-serviced on the relieving of pain. The MR nurse said someone from the pharmacy came out and gave an education on how to get medications from the backup pharmacy and the protocol for that, and how to contact the pharmacy even after hours. The (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MR nurse said she now also has a back-up person who faxes the medication orders to pharmacy when she was not at the facility.On 05/14/2026 at 10:30 AM a telephone interview was conducted with Licensed Practical Nurse (LPN) #31, the LPN providing care for RI #120 on 04/02/2026 on the 6 AM - 2 PM shift. LPN #31 said when she provided care for RI #120 on 04/02/2026 RI #120 did ask for pain medication. LPN #31 said she looked in the Stat box and saw where the pain medication was not in the Stat box, so RI #120 was not provided with pain medication by her. When asked did the facility have a backup pharmacy that could be used while waiting for a resident's medication to be delivered to the facility, LPN #31 said at that time she was not familiar with the backup pharmacy until after the incident (incident where RI #120 did not receive pain medication as requested). LPN #31 said after the incident it was brought to her attention that the nurses could use the backup pharmacy for getting medications. On 05/15/2026 at 9:16 AM a telephone interview was conducted with the Consultant Pharmacist (CP). When asked what the facility's process was for ensuring a resident had their ordered medication before being admitted to the facility, the CP said as far as she knew the facility gets the discharge orders and then faxes them to the pharmacy. The CP said if the orders were faxed to them after hours, the facility would use their back up pharmacy. The CP said if a resident's narcotic pain medication were not available at the facility or in the stat box, the nurse should call the pharmacy and the pharmacy would check to see where the medication was, if the medication had already been faxed in to the pharmacy. When asked should a resident ever not have pain medication available for administration if it had been ordered, the CP said if the pain medication had not been delivered the nurse should check to see where it was, check the Stat box and if not in the Stat box, get the pain medication from the backup pharmacy. The CP said pain medication should always be available. On 05/15/2026 at 11:25 AM an interview was conducted with the Interim Director of Nursing (IDON). When asked what the facility's process was for ensuring a resident had their ordered medications before being admitted to the facility, the IDON said generally when the paperwork comes in the facility faxes the medication orders over to pharmacy. The IDON was asked what the nurse should do when a resident's pain medication was not available at the facility or in the Stat box. The IDON said the nurse was expected to call the doctor and get an order for something that was in the Stat box until the narcotic medication arrived. When asked what time the pharmacy delivered medications to the facility, the IDON said it was pretty late, anywhere between 11:00 PM and 2:00 AM. The IDON said the facility's backup pharmacy would be an alternative to getting pain medication that the facility did not have in the Stat emergency box. The IDON said the resident should always have pain medication available. The IDON said the results of the facility's investigation concerning RI #120 not having pain medication available were some processes needed to be fixed. The IDON said now when the MR nurse leaves the facility there is a backup person to fax medication orders to the pharmacy, in-services were done with the nurses to ensure that they knew how to use the backup pharmacy. The IDON also said in-services were done with the nurses; that if a medication was not in the Stat box to get an order for what was in the Stat box. Contained within the facility's investigative file was a form titled, VERFICATION OF INVESTIGATION, which revealed the following: NAME OF RESIDENT:(RI #120) .LOCATION OF INCIDENT:(RI #120's room number)TIME OF INCIDENT:8:00AMDATE OF INCIDENT:4/3/26 . PROVIDE SUMMARY AND OUTCOME OF INVESTIGATION: .An Emergency QAPI (Quality Assurance and Performance Improvement) identified an admission process failure resulting in a delay of a new admission receiving medications per MD (Medical Doctors) orders .CAUSAL/CONTRIBUTING FACTORS AND OBSERVATIONS .FACTOR 1:Pain medications not readily availableSPECIFY RECOMMENDATIONS/INTERVENTIONS TAKEN TO PREVENT REOCCURENCENurse to utilize back-up pharmacy when necessary . **********The facility took immediate action to correct the noncompliance including:********** PAIN QAPI ACTIONS Section 1: Corrections for identified resident 4/2/2026, DON entered orders for identified resident at 7:52 am. Pain level=7/10 per DON, resident was laughing and joking, no pain med requested.4/2/2026, Nurses evaluated pain level each shift (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015440	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntsville Health & Rehabilitation, LLC	4010 Chris Drive Huntsville, AL 35802

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after this. Pain was not described as higher than 2/10 until pain medication was administered 4/3/26.4/2/2026 at 12:49 pm, pain medication received from pharmacy and Identified resident received pain medication on 4/3/26 at 7:57 am.4/3/2026. Identified resident went to hospital by ambulance at (his/her) request due to complaint of pain at 8:12 am. Pain level at this time = 8/10 Section 2: How did the facility determine other residents who may be affected. Residents admitted with-in previous 30 days were reviewed to ensure necessary medications were received and available. Any identified will have medications obtained at that time by nurses.4/7/2026, resident interviews were conducted with alert and oriented residents regarding abuse/neglect. No concerns were identified. Section 3: Corrective actions/systemic changes 4/6/2026, Administrator/DON educated nurses on narcotic substitution, med availability/pharmacy policy and pain evaluations4/7/2026, Admissions uploads new admits into a document folder, Medical records nurse began emailing confirmation replies back to admissions group that orders were entered into MatrixCare.4/8/2026, Administrator/DON educated nurses on the admission process for after hours including order entry. Section 4: Monitoring process-Administrator/DON or other designee 5 new admits will be reviewed weekly x 4 to ensure mediation availability. Any concerns with medication will be addressed at that time and corrected immediately.Then once 4 weeks are complete, 10 new admits will be reviewed the next month, then quarterly. Results will be reported to the QAPI committee to guide actions and ensure compliance**********After review of documentation supporting the above corrective actions, including the facility's investigation file, in-service/education records, QAPI documentation, and staff interviews, the survey team verified the facility implemented corrective actions including ongoing monitoring from 04/03/2026 to 04/08/2026, and past non-compliance was cited.

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	015440	A. Building B. Wing	05/21/2026

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews and review of facility policy title, Laundry- Storage, Collection& Transportation the facility failed to implement and maintain an effective infection control program to prevent the potential transmission of pathogens related to improper handling of clean laundry. Facility staff were observed folding laundry while allowing the clean laundry to come in contact with Laundry Staff (LS) #45's clothing, which had the potential to contaminate resident items.This deficient practice had the potential to affect all residents who received laundered clothing and linens from the facility laundry process. Findings include:Review of the facility policy titled Laundry- storage, collection& transport undated included the following:Policy:All linens will be stored, handled, transported and processed in a manner that prevents the transmission of microorganisms to other patients and areas. On 05/19/2026 at 9:37 AM an observation was made of LS #45 folding clean flat sheets in the clean laundry area. During the observation, multiple clean flat bed sheets were observed touching the front of LS #45's clothing while she was not wearing an apron.On 05/19/2026 at 9:39 AM during an interview with the Environmental Service Director (ESD), the surveyor asked what was the potential when staff were folding linen and staff place the linen up against their clothes. The ESD replied, Infection control. On 05/20/2026 at 8:59 AM an interview was conducted with Clinical Care Coordinator/Interim DON. When asked about the concern of clean linen touching the front of laundry staff's clothing while folding the linen, the IDON replied, that would be an infection control concern.

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	015440	A. Building B. Wing	05/21/2026

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations, an interview, and review of a facility form titled REPORTS OF NURSING STAFF DIRECTLY RESPONSIBLE FOR RESIDENT CARE, the facility failed to ensure nurse staffing was posted for the night (3rd) shift on 04/21/2026, 04/23/2026, 04/28/2026, 04/29/2026, 05/01/2026, 05/04/2026, 05/06/2026, and 05/19/2026; and on the evening (2nd) shift on 05/19/2026. This was observed on seven of 36 days of the survey and had the potential to affect all residents residing in the facility.Findings Include:On 04/22/2026 at 7:30 AM, the REPORTS OF NURSING STAFF DIRECTLY RESPONSIBLE FOR RESIDENT CARE form, dated 04/21/2026, was observed in the front lobby in a clear acrylic stand-alone frame. The night shift had not been completed for the number of staff or total hours worked. The posting also did not include the census. On 04/24/2026 at 7:40 AM, the REPORTS OF NURSING STAFF DIRECTLY RESPONSIBLE FOR RESIDENT CARE form, dated 04/23/2026, was observed in the front lobby in a clear acrylic stand-alone frame. The night shift had not been completed for the number of staff or total hours worked. The posting also did not include the census. On 04/29/2026 at 7:30 AM, the REPORTS OF NURSING STAFF DIRECTLY RESPONSIBLE FOR RESIDENT CARE form, dated 04/28/2026, was observed in the front lobby in a clear acrylic stand-alone frame. The night shift had not been completed for the number of staff or total hours worked. The posting also did not include the census. On 04/30/2026 at 7:30 AM, the REPORTS OF NURSING STAFF DIRECTLY RESPONSIBLE FOR RESIDENT CARE form, dated 04/29/2026, was observed in the front lobby in a clear acrylic stand-alone frame. The night shift had not been completed for the number of staff or total hours worked. The posting also did not include the census. On 05/02/2026 at 8:45 AM, the REPORTS OF NURSING STAFF DIRECTLY RESPONSIBLE FOR RESIDENT CARE form, dated 05/01/2026, was observed in the front lobby in a clear acrylic stand-alone frame. The night shift had not been completed for the number of staff or total hours worked. The posting also did not include the census. On 05/05/2026 at 7:30 AM, the REPORTS OF NURSING STAFF DIRECTLY RESPONSIBLE FOR RESIDENT CARE form, dated 05/04/2026, was observed in the front lobby in a clear acrylic stand-alone frame. The night shift had not been completed for the number of staff or total hours worked. The posting also did not include the census. On 05/07/2026 at 7:30 AM, the REPORTS OF NURSING STAFF DIRECTLY RESPONSIBLE FOR RESIDENT CARE form, dated 05/06/2026, was observed in the front lobby in a clear acrylic stand-alone frame. The night shift had not been completed for the number of staff or total hours worked. The posting also did not include the census. On 05/20/2026 at 7:30 AM, the REPORTS OF NURSING STAFF DIRECTLY RESPONSIBLE FOR RESIDENT CARE form, dated 05/19/2026, was observed in the front lobby in a clear acrylic stand-alone frame. The evening shift and the night shift had not been completed for the number of staff or total hours worked. The posting also did not include the census for either shift. On 05/20/2026 at 4:15 PM, the surveyor conducted an interview with the Interim Director of Nursing (IDON). When asked who was responsible for posting the daily nurse staffing, the IDON replied the scheduler and a chosen night shift charge nurse would update the form as needed. The surveyor asked the IDON what information should be on the form according to regulation. The IDON stated the facility name, the date, total number and actual hours worked by Registered Nurse, Licensed Practical Nurse, Certified Nursing Assistant, and resident census. The surveyor asked the IDON when did the regulations say staff posting should be done. The IDON said at the beginning of the shift. The surveyor asked the IDON to look at the noted dates and identify which shifts did not have staffing information filled out. The IDON said the night shift on 04/21/2026, 04/23/2026, 04/28/2026, 04/29/2026, 05/01/2026, 05/04/2026, 05/06/2026, and on 05/19/2026 the night shift and the evening shift were not filled out. The surveyor asked the IDON why would it be important for the nurse staff posting to be filled out. The IDON stated it would be important for correct staffing count per population of residents and the need to have a correct count for emergency situations.