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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>015455 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY COMPLETED<br><br>10/02/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Elite Nursing and Rehabilitation Care Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>300 Royal Tower Drive<br>Birmingham, AL 35209 |  |

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

| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48195</p> <p>Based on interviews, resident record review, review of the facility investigative file, review of a Facility Reported Incident (FRI), and review of a facility policy titled Abuse, Neglect and Exploitation, the facility failed to conduct a thorough investigation of an allegation of physical abuse on 09/13/2024 to include determining the time the alleged incident occurred.</p> <p>This citation resulted from the investigation of complaint/report number AL00048805 and had the potential to affect Resident Identifier (RI) #1, one of six residents sampled for abuse.</p> <p>Findings include:</p> <p>A facility policy titled Abuse, Neglect and Exploitation, reviewed 01/2024, documented: .</p> <p>Definitions:</p> <p>Abuse means the willful infliction of injury . Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking.</p> <p>V. Investigation of Alleged Abuse, Neglect and Exploitation .</p> <p>6. Providing complete and thorough documentation of the investigation.</p> <p>RI #1 was readmitted to the facility on [DATE] and had diagnoses to include Dementia.</p> <p>RI #1's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 07/11/2024 noted a Brief Interview for Mental Status (BIMS) score of three of 15 which indicated severe cognitive impairment.</p> <p>On 09/13/2024 at 3:10 PM the State Agency received an Online Incident Report from the facility alleging physical abuse occurred on 09/13/2024 at 1:15 PM when Floor Technician (FT) #7 observed Certified Nursing Assistant (CNA) #8 push RI #1 in the back of the head.</p> <p>On 10/02/2024 at 9:50 AM, FT #7 said the incident on 09/13/2024 occurred in the hallway outside of the shower. FT #7 said, he must have misunderstood what he saw when CNA #8 had a towel drying RI #1's hair. FT #7 did not remember what time the incident occurred or what time he reported the incident.</p> <p>(continued on next page)</p> |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The facility's investigative file was reviewed, and a report titled Investigation Summary dated 09/16/2024 for RI #1 documented: . On 9-13-24 it was reported . by . (FT #7) that (CNA #8) was observed pushing . (RI #1) on the back of (his/her) head. Upon interviewing (CNA #8) informed that she and another CNA were assisting (RI #1) with a shower . (CNA #8) denied pushing the resident in the back of (his/her) head, stating that she only dried residents' hair with a towel. Resident stated, they was messing with me, when asked how resident stated, they washed my hair. yea its ok. The Investigation Summary did not indicate what time the incident occurred and did not include documentation of efforts made to determine when the incident occurred.</p> <p>FT #7's witness statement included in the facility's investigative file was reviewed and it did not include documentation of when the alleged incident occurred.</p> <p>CNA #8's witness statement included in the facility's investigative file was reviewed and it did not include documentation of when the alleged incident occurred or when the statement was written.</p> <p>Further review of the facility investigative file revealed no documented evidence of efforts made by the facility to confirm when the abuse allegedly occurred.</p> <p>On 10/02/2024 at 11:11 AM CNA #8 was interviewed and reported she and CNA #9 showered RI #1 around 6:30 AM the morning of 09/13/2024 and RI #1 became upset during hair washing while in the shower. CNA #8 said, she tried to calm RI #1 and said she would get RI #1's coffee.</p> <p>On 10/02/2024 at 11:47 AM CNA #9 was asked about the incident on 09/13/2024. CNA #9 said, she assisted CNA #8 with RI #1's shower the morning of 09/13/2024 around 6:30 AM when RI #1 became upset and requested to go back to bed before breakfast.</p> <p>On 10/02/2024 at 2:02 PM Human Resources Director (HRD) #5 was interviewed and said he/she was notified around 12:45 or 1:00 PM on 09/13/2024 by FT #7 of the allegation of abuse.</p> <p>On 10/02/2024 at 3:45 PM the Director of Nursing (DON) was asked about the incident involving RI #1. The DON said she was notified of the alleged abuse allegation on 09/13/2024 around 1:00 PM. When asked what the process was for investigating an abuse allegation, the DON said, to protect the resident and start the investigation process of obtaining witness interviews and statements. The DON said, witness statements would include names, dates, and times. When asked what time the alleged incident occurred, the DON said she assumed right then when they were notified which was around 1:00 PM. The DON said, she was not aware of a time discrepancy of when the incident occurred. When asked why she was not aware, she said she just assumed it happened at that time it was reported. CNA #8 and CNA #9's facility witness statements were reviewed with the DON and she said, CNA #8's statement did not have a date or time documented, and CNA #9's statement did not have a time documented that the incident occurred. The DON said, the importance of obtaining times and verifying when an incident occurred would be for resident protection and for the integrity of the investigation. When the DON was asked if the facility completed a thorough investigation of the allegation, she said no.</p> |