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

Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015455	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER: Elite Nursing and Rehabilitation Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 Royal Tower Drive 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33739 Based on observations, interviews, review of a facility policy titled Safe and Homelike Environment, the facility document titled Plan of correction for torn floors and complaint/report number AL00046076, the facility failed to ensure Resident Identifier (RI) #128's room's floor covering was not torn, ceiling tiles were not stained in RI #128's room, and that RI #128's room did not have a urine odor. This affected RI #128. The torn floors had the potential to affect residents in 47 rooms. Findings Include: Review of a facility policy Safe and Homelike Environment with a revised date of 12/2023 documented Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, . A review of a facility document titled Plan of correction for torn floors dated 03/28/2024 documented the floor replacements started on 02/14/2024 and would be completed by 05/01/2024. The plan indicated 52 rooms floors were to be replaced. The plan indicated five of the 52 rooms had been completed. A review of Complaint/Report number AL00046076 received to the State Agency 10/31/2023 documented . there are leaks all over the building. the floors are coming up and some are taped down. RI #128 was admitted to the facility on [DATE]. On 03/26/2024 at 5:07 PM and on 03/27/2024 at 9:08 AM the surveyor observed the floor covering in RI #128's room was torn in six places and the areas were taped. The tapes on covering the torn floor was rolling up. The room also had a strong smell of urine and three ceiling tiles were stained. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/28/2024 at 9:07 AM, during an observation and interview with the Director of Nursing (DON). The DON said the odor may have gotten into the floor; he said the facility was in the process of replacing all the floor covering on the unit. When asked about the floor covering in RI #128's room, the DON said it had been torn and covered with the tape. The DON said he was not sure how long the flooring had been torn and taped as he had only been there a few months. The DON said it was not homelike when the room smelled like urine and the floor covering torn. On 03/28/2024 at 9:21 AM, observations were made of RI #128's room with The Director of Maintenance (DOM). An interview with the DOM was conducted at the same time. The DOM said the floor covering was torn and tape was used to repair it. He said there were several rooms on the unit the same way. The DOM said RI #128's room smelled like urine. The DOM said other rooms also smelled like urine and he felt it was in the floor covering which was due to be replaced. The DOM said the ceiling tiles were stained or broken. The DOM said it was not homelike when the room smelled like urine, the ceiling tiles were stained, and the floor covering was torn. This deficiency was cited as a result of AL00046076.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44165 Based on interviews, resident record reviews, and review of the Centers for Medicare & (and) Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11, the facility failed to ensure Section N, Medications, of Resident Identifier (RI) #124's quarterly Minimum Data Set (MDS) was accurately coded for anticoagulant and antiplatelet medication. This deficient practice affected RI #124 one of twenty-six sampled residents whose MDS was reviewed during the survey. Findings Include: The Centers for Medicare &Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3. 0 User's Manual Version 1.18.11 October 2023 Section N documented: . N0415: High-Risk Drug Classes: Use and Indication .E. Anticoagulant (. warfarin, heparin, or low-molecular weight heparin) . Do not code antiplatelet medications such as aspirin . or clopidogrel as N0415E, Anticoagulant. N04151I Check if an antiplatelet medication (e.g., aspirin . clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days) . RI #124 was admitted to the facility on [DATE] with diagnoses of Cerebrovascular Disease, Nontraumatic Subdural Hemorrhage, Unspecified, and Essential (Primary) Hypertension. A review of RI #124's Order Summary Report revealed an order for Plavix (clopidogrel) Oral Tablet 75 Milligrams (MG) give one tablet by mouth one time a day related to Essential Hypertension ordered on 10/25/2023 and started on 10/26/2023. A review of Section N of RI #124's quarterly MDS with an Assessment Reference Date (ARD) of 01/26/2024 indicated RI #124 was coded as taking an anticoagulant and was not coded as taking an antiplatelet. On 03/29/24 at 09:23 AM an interview with the Minimum Data Set Coordinator (MDSC) was conducted. The MDSC stated RI #124's MDS with ARD of 01/26/2024 was inaccurately coded for an anticoagulant, because RI #124 did not have an order for an anticoagulant. The MDSC said RI #124 had an order for Plavix, an antiplatelet, and it was not coded accurately on the MDS. The MDSC the care plans would not be correct when the MDS was coded inaccurately. The MDSC stated she did not know why RI #124 was coded for anticoagulant instead of an antiplatelet.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33739 Based on record review, interview and review of the facility policy Resident Assessment - Coordination with PASARR Program, the facility failed to submit for a new Level I for Resident Identifier (RI) #14 when a new diagnosis for Psychotic Disorder was given on 07/07/2021. This affected RI #14 one of two residents reviewed for PASARR (Pre-admission Screening Annual Resident Review). Findings Include: Review of a facility policy Resident Assessment - Coordination with PASARR Program with a revised date of 12/2023 documented . Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions . a. PASARR Level I i. Negative Level I Screening - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder arises later. 9. any resident who exhibits a newly evident or possible serious mental disorder, . or related condition will be referred promptly to the state mental health . c. A resident transferred, admitted , or readmitted to the facility following an inpatient psychiatric stay or and equally intensive treatment . RI #14 was admitted to the facility 05/07/2009 and readmitted [DATE]. A review of RI #14's diagnoses information indicated Psychotic Disorder with Delusions with an onset date of 07/08/2021 and Dementia with Behavioral Disturbances with an onset date of 10/01/2022. On 03/28/2024 at 9:44 AM while reviewing the resident's record a Level I or II was not found in the record. On 03/28/2024 at 10:30 AM the Social Worker (SW) was asked for RI #14's PASARR, she said RI #14 had been in the facility for a long time and she would find it. On 03/29/2024 at 9:25 AM, the SW brought two pages of the Level I screening for RI #14 dated 03/29/2009, when asked where was the second page she said she could not find it because the resident had been there for some time. The SW said she called the OBRA office but had not received a return call. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/29/2024 at 10:07 AM, during an interview with the Social worker (SW), she said RI #14 was admitted to the facility 05/07/2009. The SW said RI #14 received the diagnosis of Psychotic Disorder with Delusions on 07/08/2021. When asked what was the date of the current PASARR, she said 03/23/2009. The SW said a submission for a new level I should have been done with the new diagnosis of the Psychotic Disorder with Delusions on 07/08/2021. The SW said she should have submitted for a new Level I when RI #14 returned with a new diagnosis dated 07/08/2021. The SW said the facility process for identifying residents with a possible Mental Disorder, Intellectual Disability or a related condition prior to admission to the facility was to review the admitting diagnosis, and it should match the Level I that comes with the resident. The SW said if the resident went to the hospital or had a new diagnosis a new Level I should be submitted. The SW said she did not submit for a new Level I. The SW said social services was responsible for making the referrals to the appropriate state designated authority when a resident was identified as having an evident or possible Mental Disorder, Intellectual Disability or related condition. The SW said it was an oversight that RI #14 was not submitted for a updated Level I.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47408 Based on interview ,record review and a facility policies titled Comprehensive Care Plans and Oxygen Administration, the facility failed to ensure a care plan was developed for Resident Identifier (RI) #13's use of oxygen therapy. This affected RI #13, one of 26 sampled residents whose plans of care were reviewed. Findings Include: A facility policy titled Comprehensive Care Plans revised 01/2023 indicated: .Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made . A facility policy titled Oxygen Administration revised 12/23 indicated . 4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as but not limited to: a. The type of oxygen delivery system. b. When to administer, such as continuous or intermittent and or when to discontinue. c. Equipment setting for the prescribes flow rates . RI #13 was readmitted to the facility on [DATE], with a diagnosis of Failure to thrive and COVID 19. A Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 01/19/2024, identified RI #13 as having received oxygen therapy during this assessment period. A review of RI #13's Active March 2024 Physicians Orders documented: . O2/2L via nasal cannula (N/C) , 02 Sat <90%. every shift for shortness of breath (3/6/2024) . On 03/28/2024 at 4:40 p.m., the surveyor reviewed RI #13's care plans. There were no care plan noted for the use of oxygen. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/29/2024 at 8:30 AM., the surveyor conducted an interview with the MDS Coordinator (MDSC). The MDSC looked in the computer and RI #13's medical records and stated she could not find that RI #13 had been care planned for the use of oxygen. The surveyor asked the MDSC should RI #13 be care planned for the use of oxygen and she replied yes. 29671 An interview was conducted with the Director of Nursing (DON) on 03/29/2024 at 11:43AM. The DON said a resident who received oxygen should have a care plan in place to ensure proper care was provided. The DON did not know why RI #13 did not have a care plan for use of oxygen but said he/she should have one in place.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29671 Based on record review and interview the facility failed to ensure Resident Identifier (RI) #483 had a physician's order for a urinary catheter when he/she was admitted to the facility with a Catheter on 08/20/2022. This affected one of three residents sampled for urinary catheter use. Findings Include: RI #483 was admitted to the facility on [DATE]. A review of RI #483's Physician Orders for August 2022 revealed no order for the use of a catheter. A review of RI #483's progress notes from 08/28/2022 documented that RI #483's catheter was removed. A telephone interview with the Medical Director revealed that he gave a verbal order to remove the catheter on 08/28/2022. On 03/28/2024 at 10:54 AM an interview was conducted with the Admissions Nurse (AN). The AN stated that RI #483 was admitted to the facility on [DATE] with a foley catheter. On 03/29/2024 at 11:43AM an interview was conducted with the Director of Nurse (DON). The DON said that if a resident was admitted with a catheter a physician's order for the use of the catheter was needed. He said that an order was needed to ensure proper care. When asked about RI #483 the DON said the facility should have called and gotten a physician's order when he/she was admitted to the facility with a catheter on 08/20/2022. This deficiency was cited as a result of complaint AL00045866 ,

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 29671 Based on observations, interviews, the 2022 United States (U.S.) Food and Drug Administration (FDA) Food Code, and a facility's policy titled Sanitation Inspection, the facility failed to ensure the stove top, knobs, handles, and drip pans were free of a heavy grease build up. This had the potential to affect 129 of 130 residents who received meals from the facility's kitchen. Findings Include: A review of 2022 United States (U.S.) Food and Drug Administration (FDA) Food Code, documented: (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean . A review of policy titled Sanitation Inspection dated 12/23 documented: .It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary .1. All food service areas shall be kept clean, sanitary . On 03/26/2024 at 2:31 PM, the initial kitchen tour was conducted by the Surveyor with the Dietary Manager. During the tour, it was observed that there was a significant accumulation of grease on the stove top, knobs, and handles. Additionally, the drip pans had a grease build up on the aluminum foil in both pans. The Dietary Manager mentioned that the cleaning schedule for these areas was on Wednesdays and Fridays. When questioned about the reason behind the grease build up, the Dietary Manager explained that there was an employee who was not cleaning properly and had been terminated the previous day. The Dietary Manager said that the problem with grease accumulation would be cross-contamination. This deficiency was cited as a result of AL00047294

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44165 Based on observations, interviews, and facility policies titled Hand Hygiene, Standard Precautions Infection Control, Handling Clean Linen, and Water Management Program the facility failed to ensure: 1) Laundry Staff (LS) #7 washed her hands after leaving Resident Identifier (RI) #54 and RI #10's room with contaminated laundry hangers and touching clean clothing for RI #74. 2) LS #9 kept clean sheets off the floor and off her clothing while folding clean laundry on 03/28/24. 3) Clean blankets for the residents were stored in a clean dust free area and ensured the blankets were not touching the wall. 4) Certified Nursing Assistant (CNA) #10 washed or sanitized her hands after leaving RI #115's room and before picking up RI #23's meal tray while delivering meals on 3/28/24. 5) Maintenance Director (MD) implemented a water management program to prevent and identify Legionella This affected five of 26 sampled residents and had the potential to affect all residents residing in the facility. Findings Include: 1) Review of the facility policy titled Hand Hygiene with an implemented date of 12/22 and a reviewed date of 12/23 revealed: . Policy: . All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. Review of the facility's undated table titled Hand Hygiene Table revealed: . Between resident contacts .Before performing resident care procedures . RI #10 was admitted to the facility on [DATE]. RI #54 was admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	RI #74 was admitted to the facility on [DATE]. An observation on 03/27/24 at 10:23 AM of LS #7 coming out of RI #54 and RI #10's room with 3 dirty hangers in her hand then placing the dirty hangers on the left side of the clean clothes hanging cart. Then LS #7 pushed the laundry hanging cart in front of RI #74's room. LS #7 then picked up pants that were on a hanger from the right side of the laundry hanging cart and went into RI #74's room without washing or sanitizing her hands. On 03/27/24 at 10:25 AM an interview with LS #7 was conducted. LS #7 stated that she was hanging clothes for RI #54 and RI #10 in the closet. LS #7 stated that she brought used clothes hangers from RI #54 and RI #10's closet. LS #7 stated the hangers had been used and were contaminated. LS #7 stated she picked up RI #74's clothes and went into his/her room and hung them in the closet. LS #7 stated that she should have washed her hands after touching the contaminated hangers. LS #7 stated that there was a risk of passing germs after touching contaminated items and then touching clean clothing. LS #7 stated that she should have washed her hands before picking up the clean clothes. On 03/29/2024 at 10:52 AM a follow-up interview was conducted with ADM/IP. ADM/IP stated that staff should not pick up dirty hangers until they are done passing out clean laundry to residents. She stated that when staff picks up the dirty laundry hangers, they should put them in a bag and take them to laundry to be disinfected. ADM/IP stated that staff should wash or sanitize their hands after handling laundry hangers that had been used. She stated there would be a risk of cross contamination if staff did not wash or sanitize their hands after touching a contaminated item. ADM/IP stated that facility policy for hand hygiene was to wash or sanitize hands after coming in contact with anything contaminated, before and after entering a room, and before picking up meal trays. 2) Review of the facility policy titled Handling Clean Linen with an implemented date of 12/22 and a reviewed date of 12/23 revealed: . Policy: It is the policy of this facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection. 2. Linen can become contaminated with pathogens from contact with intact skin or body substances, or from environmental contaminants or contaminated hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/28/24 at 10:55 AM an observation of LS #9 folding sheets in the clean area of the laundry room. LS #9 picked up a top sheet from the clean laundry basket and the other side of the sheet touched the floor. Two personal phones and personal glasses were on the clean laundry folding table and at the end of the clean folding table was a box fan. LS #9 had long braids that touched the clean laundry when she turned or bent down. LS #9 picked up a sheet out of the basket and another sheet fell to the floor. LS #9 picked up the sheet off of the floor with her left hand and put it back into the clean cart. LS #9 folded the other sheet she was holding in her right hand touching her clothing, she was wearing a blue zipper jacket. LS #9 put the folded sheets on the blue covered cart in stacks. LS #9 picked up another sheet dropping one end of the sheet on the floor and put it on the clean folding table. LS #9 picked up another sheet out of the clean laundry basket and put it on the table. LS #9 picked up another sheet dropping one end of the sheet on the floor and then folded the sheet and put it on the clean folding table. On 03/28/24 at 11:00 AM an interview was conducted with LS #9. LS #9 stated that the sheets she folded touched, the table, the floor and her clothing. LS #9 stated that the sheets should not have touched the floor or her clothing. LS #9 stated that the sheets had a risk of getting dirt on them if the sheet touched the floor. LS #9 stated the sheets should be held away from her clothing and not touching the floor. On 03/28/24 at 11:30 AM an interview with ADM/IP was conducted. ADM/IP stated that clean linen should be handled away from the body and not to touch the floor. She stated that if clean linen were to touch the floor or touch a staff member's clothing it should be rewashed. On 03/29/2024 at 10:52 AM a follow-up interview was conducted with ADM/IP. ADM/IP stated that staff were supposed to keep clean laundry away from their body and clothing, and/or any other contaminated surfaces. ADM/IP stated that staff should hold clean laundry away from their body and off of the floor. She stated clean laundry is considered contaminated when touching the floor. ADM/IP stated there would be a risk of cross contamination if staff did not wash or sanitize their hands after touching a contaminated item. She stated that facility policy for hand hygiene was to wash or sanitize hands after coming in contact with anything contaminated, before and after entering a room, and before picking up meal trays. ADM/IP stated that clean laundry was considered contaminated/dirty if it touched the floor. She said that there was a risk of contamination of putting a sheet back into the clean laundry basket that had touched the floor. 3) Review of the facility policy titled Handling Clean Linen with an implemented date of 12/22 and a reviewed date of 12/23 revealed: . Policy: It is the policy of this facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection. . 5. Guidelines for the storage of clean linen include, but are not limited to, the following: . c. A separate room, closet or other designated space with a closing door will be used to store clean linen to reduce the risk of accidental contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/28/24 at 10:34 AM an observation was made in the laundry room of shelves adjacent to the entrance. The surveyor observed white blankets not covered and touching the wall. On 03/28/24 at 10:38 AM an interview was conducted with Laundry Aide (LA). LA has worked at the facility for four years. LA stated that blankets should be away from the wall. LA stated that according to facility policy the blankets should be in a place free of dust and dirt. She stated that the blankets touching the wall could cause contamination. On 03/29/24 at 10:52 AM an interview was conducted with Infection Preventionist/Administrator (ADM/IC). She stated that the Laundry Supervisor had only been in that position a couple of weeks. ADM/IC stated that there was a risk for contamination with the blankets being uncovered and stored on the shelves by the door in the laundry room. She stated that the blankets should not have touched the wall in the laundry room due to cross contamination. 4) Review of the facility policy titled Hand Hygiene with an implemented date of 12/22 and a reviewed date of 12/23 revealed: . Policy: . All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. Review of the facility table titled Hand Hygiene Table revealed: . Between resident contacts .Before performing resident care procedures . RI #23 was admitted to the facility on [DATE]. RI #115 was admitted to the facility on [DATE]. On 03/28/24 at 11:40 AM an observation was made of CNA #10 on unit 2 passing out lunch trays. CNA #10 brought a lunch tray into RI #115's room and set up the tray for the resident. CNA #10 lifted the plate cover, opened the straw and put the straw in the tea, CNA #10 put sugar in the tea for the resident. CNA #10 then walked out of the room without washing or sanitizing her hands. CNA #10 without washing or sanitizing her hands picked up the lunch tray for RI #23. CNA #10 set the lunch tray on the bedside table next to RI #23. On 03/29/2024 at 10:52 AM a follow-up interview was conducted with ADM/IP. ADM/IP stated that the risk of not washing or sanitize hands was cross contamination. ADM/IP stated staff should wash or sanitize hands after coming in contact with anything contaminated before and after entering a room and before picking up meal trays. She stated that there would be a risk of cross-contamination. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015455	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER Elite Nursing and Rehabilitation Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Royal Tower Drive 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 (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 - Many	On 03/28/24 at 12:20 PM an interview was conducted with CNA #10. CNA #10 stated that she did not wash or sanitize her hands. CNA #10 stated that she did not wash her hands after coming out of RI #115's room, and further stated she should have washed her hands. 5) Review of the facility policy titled Water Management Program with an implemented date of 12/22 and a reviewed date of 12/23 revealed: . Policy: It is the policy of this facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens . in the facility's water systems based on nationally accepted standards . Policy Explanation and Compliance Guidelines: 1. A water management team has been established to develop and implement the facility's water management program, including facility leadership, the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff, and Director of Nursing. 2. The Maintenance Director maintains documentation that describes the facility's water system. 3. A risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facilitiy's water systems. The risk assessment will consider the following elements: . b. Clinical equipment: This includes medical devices and other equipment utilized in the facility that can spread Legionella through aerosols or aspiration. On 03/29/2024 at 10:52 AM an interview was conducted with the Maintenance Director (MD). MD stated that he had a plan typed up for Legionella prevention, but it had not been implemented at that time. On 03/29/24 at 10:52 AM an interview with ADM/IP was conducted. ADM/IP stated that the facility was working on a plan for legionella prevention. She stated the facility had not yet implemented a plan or procedure. ADM/IP stated they were not monitoring for legionella. ADM/IP stated that she did not have an answer for why the facilitiy did not have a plan for prevention of Legionella. ADM/IP stated that the risk of not testing for legionella is the residents could become exposed to Legionella.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015455	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER Elite Nursing and Rehabilitation Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Royal Tower Drive Birmingham, AL 35209	

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44165 Based on interviews, record review, and facility's policy titled Infection Prevention and Control Program the facility failed to ensure the facility employed a certified infection preventionist from 1/5/2022 until 3/29/2024. This deficient practice affected 130 residents in the facility. Findings Include: A review of a facility policy titled Infection Prevention and Control Program with an implemented date of 12/22, and a reviewed date of 12/2023 revealed: . Policy Explanation and Compliance Guidelines. 1. The designated Infection Preventionist is responsible for oversight of the program and serves a consultant to our staff on infectious diseases. A review of the facility's employment record for the previous certified infection preventionist revealed a hire date of 03/27/2020 and last day of employment as 01/05/2022. A review of TRAIN TRAINING PLAN PROOF OF COMPLETION for ADM/IC revealed: . (ADM/IC) has successfully completed Nursing Home Infection Preventionist Training Course as of 03/29/2024 On 03/29/2024 at 10:52 AM an interview was conducted with Administrator/Infection Control (ADM/IC). ADM/IC stated that she worked at the facility for [AGE] years. ADM/IC stated that she had been the infection preventionist for four years but really for just the last year. ADM/IC stated that she did not have all the modules completed for the infection preventionist. ADM/IC stated that the Previous Infection Preventionist (PIP) had been a Certified Infection Preventionist. On 03/29/2024 at 03:59 PM a follow up interview with ADM/IC was conducted. ADM/IC stated the last Certificated Infection Preventionist in the facility had a last day of 01/05/2022. ADM/IC stated that she thought she had completed her Infection Preventionist Certificate, but she had not finished the training. ADM/IC stated that it was the facility's policy to have a Certified Infection Preventionist in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015455	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 48195 Based on observations, interviews, and a review of the United States (U.S.) Food and Drug Administration (FDA) 2022 Food Code, the facility failed to ensure 1) Two ovens in the kitchen had exposed electrical wiring and were in working condition 2) The walk-in freezer was free from excessive ice buildup on two fans, the floor, ceiling, and boxes containing food products. This was observed on the initial tour of the kitchen on 03/26/2024. This had the potential to affect 129 of 130 residents receiving meals from the facility kitchen. Findings Include: The 2022 U.S. Food and Drug Administration documents the following: . Maintenance and Operation 4-501.11 Good Repair and Proper Adjustment A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements . On 03/26/2024 at 2:31 PM during the initial kitchen tour, two ovens were observed with exposed wiring at the base of both ovens. The Dietary Manager (DM) was interviewed and asked why the ovens had exposed wiring. The DM stated that the ovens were not working. When asked how long the ovens had not been working, she said that the ovens went out several times last year. The DM stated they had been completely out since around December 2023 or January 2024. On 03/26/2024 at 2:41 PM during the initial kitchen tour, the walk-in freezer was observed with excessive ice buildup on two fans, the floor, ceiling, and boxes containing food products. When asked how long the heavy ice buildup had been there, she said since January. When asked if this had been reported, she said yes both the oven and freezer had been reported to corporate office. She further stated a repair company was at the facility in February to work on the freezer. On 03/27/2024 at 8:41 AM a review of local repair company documentation with a work order date of 02/02/2024 revealed: . walk in freezer accumulating condensation and freezing- checked door seal and any pass thus. Foamed two opening in top of box. Insulation for box is likely compromised due to age of box. Replacement would be only permanent solution .