| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 015463 | A. Building<br>B. Wing | 03/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Knollwood Healthcare | 3151-A Knollwood Drive<br>Mobile, AL 36693 |

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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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055<br><br>Based on observations, interview, record review and review of a facility policy titled, Answering the Call Light, the facility failed to ensure Resident Identifier (RI) #43's call light was in reach on 03/18/2025 and 03/19/2025 for RI #43 to be able to summon staff as needed.<br><br>This deficient practice affected RI #43, one of 18 sampled residents.<br><br>Findings Include:<br><br>Review of a facility policy titled, Answering the Call Light, with a revised date of 10/2010, revealed the following:<br><br>. The purpose of this procedure is to respond to the resident's request and needs.<br><br>General Guidelines .<br><br>5. When the resident is in bed . be sure the call light is within easy reach of the resident .<br><br>RI #43 was admitted to the facility on [DATE] and had a diagnosis of Vascular Dementia.<br><br>RI #43's care plan with a need of potential for alteration in communication and impaired thought process related to vascular dementia, had an approach dated 02/18/2024, guiding staff to ensure/provide a safe environment with the call light in reach.<br><br>On 03/18/2025 at 10:46 AM, the surveyor observed RI #43's call light on the floor behind the head of RI #43's bed, not accessible to RI #43 at this time.<br><br>On 03/18/2025 at 12:16 PM, RI #43's call light remained on the floor behind the head of the bed out of RI #43's reach.<br><br>On 03/19/2025 at 8:35 AM, RI #43's call light remained on the floor out of reach of RI #43.<br><br>On 03/19/2025 at 2:40 PM, RI #43's call light remained on the floor behind the head of the bed out of RI #43's reach.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 03/19/2025 at 2:42 PM, the surveyor conducted an interview with the Registered Nurse (RN) Unit Manager/RN #17. RN #17 said RI #43 was able to use his/her call light. When asked how should RI #43's call light be positioned, RN #17 said on the bed where RI #43 could reach it. RN #17 said RI #43's call light was behind the bed on the floor and RI #43 could not reach it from that position. When asked why it would be important to ensure RI #43's call light was in easy reach, RN #17 said so if RI #43 needed anything like the aide or the nurse RI #43 could call and staff could get to RI #43 in a timely manner. RN #17 said it would be the responsibility of all staff to ensure RI #43's call light was in easy reach. |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>21055<br><br>Based on interviews and record review the facility failed to ensure the physician was notified when residents on the second and third floors did not receive their medications and treatments as ordered when the facility experienced an internet outage preventing access to the Electronic Health Record (EHR) system on 01/21/2025 and 01/22/2025.<br><br>Nurses did not have access to pre-printed paper documentation forms such as physician orders and MARs (Medication Administration Record) to administer medications on 01/21/2025 and 01/22/2025. The facility staff failed to notify the Director of Nursing (DON), residents, and resident representatives of residents not receiving their ordered medications and treatments on 01/21/2025 and 01/22/2025.<br><br>It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death. The Immediate Jeopardy (IJ) was cited in reference to 483.10 Resident Rights.<br><br>On 03/25/2025 at 4:15 PM, the Administrator (ADM), the Director of Nursing (DON), the Assistant Director of Nursing (ADON) and Executive Director of Operations were provided a copy of the IJ template and, notified of the finding of immediate jeopardy in the area of Resident Rights at F580-Notify of Changes (Injury/Decline/Room, Etc.).<br><br>The IJ began on 01/21/2025 and continued until 03/26/2025 when the facility implemented corrective action to remove the immediacy. On 03/27/2025 the immediate jeopardy was removed, F580 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.<br><br>This deficient practice affected residents on the second and third floors at the facility who were receiving medications.<br><br>This deficiency was cited as the result of the investigation of complaint/report number AL00050173.<br><br>Findings Include:<br><br>Cross-Reference F600, F658 and F760.<br><br>Review of the facility's After Action Report for the snowstorm January 21 to 23, 2025, documented the following:<br><br>Knollwood Healthcare experienced an unusual snowstorm on January 21 to January 23, 2025 .<br><br>We did have the modem go out for the computer Internet .<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | On 03/19/2025 at 3:53 PM, a telephone interview was conducted with Licensed Practical Nurse (LPN) #11, who was identified as a supervisor during the snowstorm on 01/21/2025. LPN #11 said she did remember when the facility's computer system was down during the snowstorm. LPN #11 said she was not sure if the residents received their medications or not. When asked if the DON or ADM knew the system was down, LPN #11 said she could not say yes or no whether they knew. When asked who would have been responsible for notifying them, LPN #11 said the supervisor.<br><br>On 03/20/2025 at 11:00 AM, the surveyor conducted an interview with the DON. When asked what she could tell the surveyor about the medication system being down on 01/21/2025 and 01/22/2025 when there was a snowstorm, the DON said she was not at the facility during that time and did not recall anyone informing her the system was down. The DON said she was not notified the residents did not receive their medications on those days. The DON said on 01/22/2025 she sent a text to LPN #11 asking LPN #11 how things were going and LPN #11 texted back going, no issues. The DON said she did not know that the residents did not receive their medications during the snowstorm until 03/20/2025.<br><br>On 03/21/2025 at 10:23 AM, the surveyor conducted an interview with the ADM. The ADM said the internet was down during the snowstorm back in January 2025. The ADM said he did not remember who informed him of this, but he told them to use the paper MARs. The ADM said he was not aware the residents did not receive their medications until he was made aware of this by the survey team. When asked if he should have been made aware that the residents did not receive their medications, the ADM said absolutely.<br><br>On 03/22/2025 at 9:42 AM, a follow-up interview was conducted with the DON. The DON said she should have been notified when the residents did not receive their medications on 01/21/2025 and 01/22/2025. When asked who would have been the supervisor on 01/21/2025 and 01/22/2025, the DON said LPN #11. The DON said the physician also should have been notified.<br><br>On 03/22/2025 at 10:18 AM, a telephone interview was conducted with the Physician/Medical Director (MD). The MD said back in January (2025) when there was a snowstorm in the area he was not informed that the facility's computer system was down and the residents did not receive their mediations. The MD said he would have liked to have been informed of this. When asked what were some of the things residents could potentially face when residents did not receive their medications as prescribed by their physician, the MD said it could be a blood pressure issues if the medication missed was for the blood pressure; it could be a clotting issues if the resident was on blood thinners; pain control could be an issue if the resident was on pain medication; and the blood sugar may be affected if insulin was not given as ordered.<br><br>**********<br><br>On 03/26/2025, the facility submitted an acceptable removal plan, which documented:<br><br>**********<br><br>1) Process: To ensure that in the event of a power/internet outage the most updated Medical Record Administration (MAR) will be available for nurses that provide care to the residents:<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | The medication administration Record (MAR) will be printed monthly by the Director of Nursing Assistant Director of Nursing or Unit Manager, by the 1st of each month. The paper MAR will be updated at the time the order is received or confirmed for all current resident and new admits by the RN/LPN who receives the order or confirms the new order for any medication changes including all new orders for new admits.<br><br>The updated MAR will be located by the nursing stations. All, 100% of LPNs and RNs were in-serviced and completed on March 26th, 2025. Inservice was to ensure nurses know where the paper MAR is located and to update it as soon as a new admission or whenever the physician changes an order in the MAR.<br><br>2) In services<br><br>On 3/20/2025 - 03/26/2025 the Director of Nursing and Assistant Director of Nursing began to educate all nurses, all physical therapy staff and administrative staff (receptionist, Admissions Coordinator, Staffing Coordinator and Human Resources) and provided the education with 1:1 in-service to LPN #14, RN #15, LPN #11, RN #20, and RN #16. The in-services included:<br><br>a) the policy titled Policy on Computer or Internet Downtime and EHR,<br><br>b) the standard of practice to:<br><br>i) administer medication,<br><br>ii) monitor blood glucose,<br><br>iii) the implementation of the prescribing physicians' orders<br><br>iv) the importance of documenting medication administration at the time of administration.<br><br>c) Inservice included calling the physician as well as notify the Director of Nursing or Designee if staff including nurses are unable to carry out a physician's order.<br><br>d) Inservice included how it led to neglect and the facility's Abuse Policy titled Abuse Policy.<br><br>The in-service was completed on March 26th, 2025 for 21 of 21 nurses, 9/9 PT staff, 16/16 of administrative staff.<br><br>On 3/26/2025, 21 of 21 of the nursing staff were all educated by the Director of Nursing or Assistant Director of Nursing and 1:1 in-service to LPN #14, RN #15, LPN #11, RN #20, and RN #16. The in-service included that a printed MAR will be ready for the 1st of each month. A copy of the paper MAR will be kept at each nurses' station for use during downtime. Education included that RNs and LPNs who receives an order or confirms a new order for any medication changes including all new orders for new admits will update the paper medication administration records at the time the order is received or confirmed for all current resident and new admits.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | The Administrator educated the Director of Nursing and the Assistant Director of Nursing on 03/26/2025 that both of them are responsible to print the paper MAR to be ready for the 1st of each month and will be placed by each of the nurse's station. A monthly MAR print out schedule was created for clarity. The education included that the DON and the ADON will confirm that an accurate MAR for all residents is printed and available for use in the event of a forecasted severe storm such as tropical depression, tropical storm, hurricane, or winter snow storm or other reason to expect downtime.<br><br>A mock drill was conducted on 3/21/25 for the nursing personnel on shift.<br><br>2) Assessment<br><br>Due to the failure of functionality of the router which caused the internet outage in the facility, the facility replaced the router on January 30th, 2025 through its internet provider.<br><br>On 3/26/25 The entire Medical Record Administration was reprinted in the event of outage and nurses were all educated that any medication changes or new admissions will need to be updated in the paper medical administration records.<br><br>All residents that had the potential of being affected by this deficient practice from January 21st 2025 to January 22nd 2025. A report was generated from the electronic medical records to see which residents could have been affected during 1/21/25 - 1/22/25.<br><br>There was a total of 56 of 56 residents were assessed by the medical director and completed on March 26th, 2025. No adverse effects were identified by the physician due to this deficient practice and no recommendations were made.<br><br>2) Quality Assurance<br><br>An ad-hoc Quality Assurance meeting which included the entire IDT team ( Director of Nursing, Administrator, Rehab Director, Business Office Manager, Social Worker Director, Governing Body, Medical Director, Business Office Manager, Assistant Director of Nursing, Staffing Coordinator, Unit Manager, Dietary Director, Admissions Director) was conducted on March 25, 2025 in response to F600, F658, F580, and F760 to discuss the deficient practice and plan of correction. The nurses that were responsible were immediately educated about the in-proper practice that led to F600, F658, F580, and F760 and on the Policy on Computer or Internet Downtime and EHR access. The QA team discussed the needed in services/education for LPN #14, RN #15, LPN #11, RN #20, and RN #16.<br><br>This plan was completed on March 26th, 2025.<br><br>**********<br><br>After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 03/26/2025. |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055<br><br>Based on interviews, record review, and review of a facility policy titled, Confidentiality of Information and Personal Privacy, the facility failed to ensure personal privacy and confidentiality were maintained for Resident Identifier (RI) #52.<br><br>Specifically, on 01/29/2025, licensed staff provided medication, belonging to RI #52 and labeled with RI #52's information, to RI #308 upon discharge home from the facility.<br><br>This deficient practice affected RI #52, one of 18 sampled residents.<br><br>This deficient was cited as a result of the investigation or complaint/report number AL00050173.<br><br>Findings Include:<br><br>Review of a facility policy titled, Confidentiality of Information and Personal Privacy, with a revised date of 10/2017, revealed the following:<br><br>Policy Statement<br><br>Our facility will protect and safeguard resident confidentiality and personal privacy.<br><br>Policy Interpretation and Implementation .<br><br>2. The facility will strive to protect the resident's privacy regarding his or her: .<br><br>b. medical treatment .<br><br>RI #308 was admitted to the facility 01/09/2025 and discharged on [DATE].<br><br>RI #52 was admitted to the facility on [DATE].<br><br>RI #52's Order Summary Report (Physician Orders) revealed RI #52 was prescribed Cyclobenzaprine (Flexeril) HCL (Hydrochloric Acid) Oral Tablet 5 MG (milligrams) by mouth three times a day for muscle spasms for 14 days. This order had a start date of 01/16/2025.<br><br>On 03/19/2025 at 9:54 AM, a telephone interview was conducted with the RI #308's family member (FM). When asked about RI #308 being discharged home with someone's else medications, the FM said, her concern was someone not getting their medications because they went home with RI #308. The surveyor asked the complainant whose medications were sent home with RI #308. The complainant said, RI #52's name was the resident's name and the name of the medication in her possession was Cyclobenzaprine.<br><br>(continued on next page) |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 03/19/2025 at 8:45 PM, a telephone interview was conducted with Registered Nurse (RN) #13, the nurse who discharged RI #308 home. When asked how did RI #52's Flexeril medication get sent home with RI #308, RN #13 said, she had RI #308's medications put to the side and had RI #308's things ready to go home. RN #13 said when the ambulance service came to pick up RI #308, she must have unintentionally placed RI #52's medication card into RI #308's bag of medications.<br><br>On 03/20/2025 at 11:00 AM, an interview was conducted with the Director of Nursing (DON). When asked should a resident be sent home with another resident's medications, the DON said never. The DON said it would also be a privacy concern when someone, besides nursing staff, had information concerning the medications a resident was receiving.<br><br>On 03/26/2025 at 3:42 PM, a telephone interview was conducted with the Pharmacist. When asked what type of concern it would be if a resident's medications were sent home with another resident being discharged from the facility, the Pharmacist said, that would be privacy for the resident whose medications were sent home. When asked what guidance she would give to the facility if a resident's medications were accidentally sent home with another resident, the Pharmacist said, she would have informed the facility to try and retrieve the medicine from the family and bring it back to the facility. |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055<br><br>Based on interviews, record review and review of facility policies titled, Abuse Policy and Policy on Computer or Internet Downtime and EHR (Electronic Health Record) Access, the facility failed to protect the resident's right to be free from neglect when systems were not in place to ensure continuity of care and operations when the facility experienced a forecasted winter storm which caused internet outage preventing access to the EHR system on 01/21/2025 and 01/22/2025.<br><br>The facility failed to ensure pre-printed paper documentation forms such as physician orders and MARs were available and accessible for the licensed nursing staff to utilize for resident care, treatment, and medication administration prior to the internet outage.<br><br>The nurses and nurse supervisor on duty during that time failed to ensure residents received medications as ordered by the physician. Residents residing on the second floor and third floor did not receive their medications on 01/21/2025 and 01/22/2025 as ordered.<br><br>The staff further failed to notify management staff or the residents' physician of their inability to safely administer.<br><br>It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect, and Exploitation.<br><br>On 03/25/2025 at 4:15 PM, the Administrator (ADM), the Director of Nursing (DON), the Assistant Director of Nursing (ADON), and Executive Director of Operations were provided a copy of the IJ template and notified of the finding of immediate jeopardy substandard quality of care in the area of Freedom from Abuse, Neglect, and Exploitation at F600- Free from Abuse and Neglect.<br><br>The IJ began on 01/21/2025 and continued until 03/26/2025 when the facility implemented corrective action to remove the immediacy. On 03/27/2025 the immediate jeopardy was removed, F 600 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.<br><br>This deficient practice affected all residents at the facility who received medications.<br><br>This deficiency was cited as the result of the investigation of complaint/report number AL00050173.<br><br>The facility further failed to protect Resident Identifier (RI) #15's right to be free from verbal abuse perpetrated by Certified Nursing Assistant (CNA) #10.<br><br>Specifically, on 01/30/2025, the facility failed to ensure RI #15 was not verbally abused by CNA #10, who stated she was tired and frustrated from working a double the day before, and who called RI #15 a stupid mother fucker while providing assistance to RI #15 who needed assistance to stand. RI #15 said, he/she was shocked when CNA #10 spoke to him/her that way.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | This deficient practice was cited as the result of the investigation of complaint/report number AL00050214 and affected RI #15, one of three residents sampled for abuse, and did not rise to the jeopardy level.<br><br>Findings Include:<br><br>1) Cross-Reference F580, F658 and F760.<br><br>Review of the facility's policy titled, Abuse Policy, updated 08/2022, revealed the following:<br><br>Our residents have the right to be free from . neglect .<br><br>Policy Interpretation and Implementation Definitions .<br><br>9. Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s) . Neglect includes cases where the facility's indifference or disregard for resident care, comfort, or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person. Examples of individual failures include, but are not limited, to the following: .<br><br>Failure to provide supervision and/or monitoring of the delivery and implementation of care; .<br><br>Failure to provide orientation and/or training to staff;<br><br>Failure to provide trained on . new procedures . required for the care of a specified resident or required due to changes in standards of practice;<br><br>Failure to oversee the implementation of resident care policies;<br><br>Failure to identify, assess, and/or contact a physician and/or prescriber for an acute change in condition, and/or a change in condition that require the plan of care to be revised to meet the resident's needs in a timely manner;<br><br>Failure to implement effective communication systems across all shifts for communicating necessary care and information between staff, practitioners, and resident representatives .<br><br>On 03/19/2025 at 3:09 PM, a telephone interview was conducted with Licensed Practical Nurse (LPN) #14, the licensed staff member assigned to work the Second Floor (back hall cart) on 01/21/2025 on the 2:00 PM to 10:00 PM shift. LPN #14 said one specific night the computer system at the facility was not working and was down because of a storm. When asked how she passed medications that evening, LPN #14 said she was not able to pass medications. LPN #14 said LPN #11 was the Second Floor supervisor at that time and when she informed LPN #11 that she was not able to pass medications, LPN #11 said she did not know what to do.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | On 03/21/2025 at 11:33 AM a follow-up interview was conducted with LPN #14 who said she was not aware the facility had paper MARs at the time of the storm on 01/21/2025.<br><br>On 03/22/2025 at 1:43 PM, a follow-up telephone interview was conducted with LPN #14. LPN #14 said in addition to not being able to pass medications when the internet was down on 01/21/2025, she was not able to perform capillary blood glucose (CBG) monitoring checks because she did not know who needed them. LPN #14 said she did not feel comfortable to administer anything without the MAR. When asked about how many CBG checks she thought she had on her cart, LPN #14 said two to four.<br><br>On 03/19/2025 at 9:50 AM an interview was conducted with RI #308's family member (FM). The FM said RI #308 did not receive his/her seizure medication as ordered while a resident. The FM said it was concerning because RI #308 had a very short window to take his/her seizure medications. The FM said before RI #308 was admitted to the facility he/she had received all of his/her medications for seizures except for two since his/her accident in 2019. The FM identified LPN #14 as the nurse that did not administer RI #308's medications as ordered.<br><br>On 03/21/2025 at 11:58 AM, a telephone interview was conducted with Registered Nurse (RN) #15, the licensed staff member assigned to work the Second Floor (front hall cart) on 01/21/2025 on the 6:00 AM to 2:00 PM and 2:00 PM to 10:00 PM shift. RN #15 said she was able to pass medications that morning, but something happened that she could not administer medications that evening. RN #15 said she was hired in January and was not told to use the paper MARs if there was an internet outage. RN #15 said she informed LPN #11 she was not able to administer medications to residents. RN #15 said LPN #11 did not tell her what to do. RN #15 said when the snowstorm occurred back in January 2025, LPN #11 did not inform her to use the residents' paper MARs.<br><br>On 03/19/2025 at 3:53 PM, a telephone interview was conducted with LPN #11, the LPN supervisor. LPN #11 said she did remember when the facility's computer system went down back in January of 2025 when a snowstorm hit. The surveyor asked LPN #11 if the system was down, how did the residents receive their scheduled medications. LPN #11 said on that shift there were new nurses and nothing could be printed out for the new nurse to use to give the medications by. When asked did the residents receive their medications, LPN #11 said she was not sure. LPN #11 said she did not recall anyone reporting to her that the residents did not get their medications. LPN #11 said there should have been a backup plan in place to ensure the residents received their medications. When asked did the DON and ADM know the system was down, LPN #11 said she could not say yes or no if they knew.<br><br>On 03/21/2025 at 12:36 PM, a follow-up telephone interview was conducted with LPN #11 who said she could not get into the computer to print the paper MARs to give to the nurses and she could not find the paper MARs in the binder. LPN #11 said she did not recall telling the new nurses about the paper MARs because she could not print them. When asked who would have been responsible for ensuring the paper MARs were in the binder, LPN #11 said the unit manager. LPN #11 said it would be important to ensure the paper MARs were in the binders to make sure the nurses had something to give medications by if there was an internet outage.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | On 03/24/2025 at 11:16 AM, a telephone interview was conducted with RN #16, the licensed staff member working on the Third Floor on 01/21/2025 on the 2:00 PM to 10:00 PM and 10:00 PM to 6:00 AM shifts; and working on the Second Floor on 01/22/2025 on the 2:00 PM to 10:00 PM and 10:00 PM to 6:00 AM shifts. RN #16 said the paper MARs were kept on the unit near the nurses' station and during the downtime she did not see the paper MARs. When asked did she report to anyone that she could not find the paper MARs, RN #16 said she could not remember if she did or not. RN #16 said if anyone CBG required monitoring such as a sliding scale, she could not provide that because she did not have the paper MAR or eMAR to see who needed CBG checks. When asked what was the rationale for having preprinted MARs, RN #16 said in case of an emergency like the internet going down of if there was a power outage the nurses would have a place to document that the medications had been given.<br><br>On 03/20/2025 at 4:49 PM an interview was conducted with LPN #18 who recalled that the DON was at home and LPN #11 was the supervisor. LPN #18 said LPN #11 told her to pass medications using the prepackaged medications that had the residents' name, medication name, dosage, and the time it was to be given. LPN #18 said she always checked those things against the MAR as well. LPN #18 said she asked LPN #11 where were the paper MARs and LPN #11 said she did not know. LPN #18 said each floor should have had a book with monthly paper MARs and she thought there should be a policy about that. LPN #18 said there should be something in place for giving medications when there was a power outage or computers go down or anything like that.<br><br>On 03/22/2025 at 6:26 PM an interview was conducted with RN #17, Unit Manager for the Third Floor. RN #17 said that in preparation for the storm the ADM informed staff that everyone needed to be prepared to come to work if it was safe. RN #17 said when she left around 2 PM she thought the internet was still up. RN #17 said no one informed her that the residents did not get their medications because the internet was down. RN #17 said she did not know how nurses passed medications after the internet went down because she was not there and she did not know who the Supervisor was on those days. RN #17 said staff should have gotten the paper MAR and passed medications from it, and then once the internet was back up the staff should have transferred the information onto the eMAR (Electronic Medication Administration Record). RN #17 had no idea why that was this not implemented when there was an internet outage on 01/21/2025 and 01/22/2025. RN #17 said the Unit Manager or anybody in Administration can place the printed MARs in the binders on each floor. RN #17 said she did not know if the printed MARs were on the Second Floor at the time of the storm, and said they should have been on the Third Floor.<br><br>On 03/21/2025 at 10:54 AM, an interview was conducted with the DON. The DON said the facility's computer system was run by the internet. The DON said the facility's policy indicated that staff should initiate downtime procedures when the outage is more than 30 minutes. The DON said paper documentation should occur during downtime and this would include the MAR as well. The DON said pre-printed downtime forms should be kept at the nurses' station in the binders behind the nurses station. When asked where would there be evidence these forms were used on 01/21/2025 and 01/22/2025 when the internet was down, the DON said the evidence would be on the paper MAR where the nurses signed their initials. The DON said she had not seen any paper MARs from January 2025 with initials that medications had been administered. The DON said all nurses should have had knowledge of the downtime procedure before 01/21/2025.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | On 03/22/2025 at 9:42 AM during a follow-up interview with the DON she said she should have been notified when residents did not receive their medications on 01/21/2025 and 01/22/2025. The DON said she would have asked them where was the paper MARs. The DON said anybody, like DON, ADON, unit managers could place the MARs in the book/binders.<br><br>On 03/23/25 at 4:42 PM a follow-up interview was conducted with the DON. The DON was asked about a previous interview when she stated the ADON, the unit manager or the supervisor could print and place the printed MAR in the binders on the floors, and who would be responsible for verifying the MARs had been printed and placed in the binders. The DON said, no one in particular, it was just a team effort.<br><br>On 03/21/2025 at 10:23 AM an interview was conducted with the ADM. The ADM said he first became aware during the survey that residents' medications had not been administered during the internet downtime on 01/21/2025 and 01/22/2025.<br><br>**********<br><br>On 03/26/2025, the facility submitted an acceptable removal plan, which documented:<br><br>**********<br><br>On January 21st, 2025 in the afternoon, we encountered a major snow storm and our modem was not functioning. Due to the impact of the storm, we were unable to get a technician into the facility to restore the internet until January 22nd, 2025 at approximately 6:00 pm. Unfortunately, the facility failed to ensure residents were free of significant medications when licensed nursing staff failed to administer medications including insulin and other significant medications.<br><br>Deficiencies<br><br>The facility failed to protect the resident's right to be free from neglect when systems were not in place to ensure continuity of care and operations when the facility experienced a forecasted winter storm which caused internet outage preventing access to EHR system on 01/21/2025 and 01/22/2025.<br><br>The facility failed to ensure pre-printed paper documentation forms such as physician orders and MARs were available and accessible for the Licensed Nursing Staff to utilize for resident care, treatment, and medication administration prior to the internet outage. This affected all residents in the facility.<br><br>The nurses and nurse supervisor on duty during that time failed to ensure residents received medications and treatments as ordered by physician. Residents residing on the second floor and third floor did not receive their medications and treatments on 01/21/2025 and 01/22/2025 as ordered.<br><br>The staff further failed to notify management staff or the residents' physician of their inability to safely administer medication which contributed to medications and other resident care not being performed for greater than 24 hours. All the residents had the potential to be affected by this deficient practice.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | 1) Process: To ensure that in the event of a power/internet outage the most updated Medical Record Administration (MAR) will be available for nurses that provide care to the residents:<br><br>The medication administration Record (MAR) will be printed monthly by the Director of Nursing Assistant Director of Nursing or Unit Manager, by the 1st of each month. The paper MAR will be updated at the time the order is received or confirmed for all current resident and new admits by the RN/LPN who receives the order or confirms the new order for any medication changes including all new orders for new admits.<br><br>The updated MAR will be located by the nursing stations. All, 100% of LPNs and RNs were in-serviced and completed on March 26th, 2025. Inservice was to ensure nurses know where the paper MAR is located and to update it as soon as a new admission or whenever the physician changes an order in the MAR.<br><br>2) In services<br><br>On 3/20/2025 - 03/26/2025 the Director of Nursing and Assistant Director of Nursing began to educate all nurses, all physical therapy staff and administrative staff (receptionist, Admissions Coordinator, Staffing Coordinator and Human Resources) and provided the education with 1:1 in-service to LPN #14, RN #15, LPN #11, RN #20, and RN #16. The in-services included:<br><br>a) the policy titled Policy on Computer or Internet Downtime and EHR,<br><br>b) the standard of practice to:<br><br>i) administer medication,<br><br>ii) monitor blood glucose,<br><br>iii) the implementation of the prescribing physicians' orders<br><br>iv) the importance of documenting medication administration at the time of administration.<br><br>c) Inservice included calling the physician as well as notify the Director of Nursing or Designee if staff including nurses are unable to carry out a physician's order.<br><br>d) Inservice included how it led to neglect and the facility's Abuse Policy titled Abuse Policy.<br><br>The in-service was completed on March 26th, 2025 for 21 of 21 nurses, 9/9 PT staff, 16/16 of administrative staff.<br><br>On 3/26/2025, 21 of 21 of the nursing staff were all educated by the Director of Nursing or Assistant Director of Nursing and 1:1 in-service to LPN #14, RN #15, LPN #11, RN #20, and RN #16. The in-service included that a printed MAR will be ready for the 1st of each month. A copy of the paper MAR will be kept at each nurses' station for use during downtime. Education included that RNs and LPNs who receives an order or confirms a new order for any medication changes including all new orders for new admits will update the paper medication administration records at the time the order is received or confirmed for all current resident and new admits.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | The Administrator educated the Director of Nursing and the Assistant Director of Nursing on 03/26/2025 that both of them are responsible to print the paper MAR to be ready for the 1st of each month and will be placed by each of the nurse's station. A monthly MAR print out schedule was created for clarity. The education included that the DON and the ADON will confirm that an accurate MAR for all residents is printed and available for use in the event of a forecasted severe storm such as tropical depression, tropical storm, hurricane, or winter snow storm or other reason to expect downtime.<br><br>A mock drill was conducted on 3/21/25 for the nursing personnel on shift.<br><br>2) Assessment<br><br>Due to the failure of functionality of the router which caused the internet outage in the facility, the facility replaced the router on January 30th, 2025 through its internet provider.<br><br>On 3/26/25 The entire Medical Record Administration was reprinted in the event of outage and nurses were all educated that any medication changes or new admissions will need to be updated in the paper medical administration records.<br><br>All residents that had the potential of being affected by this deficient practice from January 21st 2025 to January 22nd 2025. A report was generated from the electronic medical records to see which residents could have been affected during 1/21/25 - 1/22/25.<br><br>There was a total of 56 of 56 residents were assessed by the medical director and completed on March 26th, 2025. No adverse effects were identified by the physician due to this deficient practice and no recommendations were made.<br><br>2) Quality Assurance<br><br>An ad-hoc Quality Assurance meeting which included the entire IDT team ( Director of Nursing, Administrator, Rehab Director, Business Office Manager, Social Worker Director, Governing Body, Medical Director, Business Office Manager, Assistant Director of Nursing, Staffing Coordinator, Unit Manager, Dietary Director, Admissions Director) was conducted on March 25, 2025 in response to F600, F658, F580, and F760 to discuss the deficient practice and plan of correction. The nurses that were responsible were immediately educated about the in-proper practice that led to F600, F658, F580, and F760 and on the Policy on Computer or Internet Downtime and EHR access. The QA team discussed the needed in services/education for LPN #14, RN #15, LPN #11, RN #20, and RN #16.<br><br>This plan was completed on March 26th, 2025.<br><br>**********<br><br>After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 03/26/2025.<br><br>**********<br><br>47408<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | 2.) Cross reference F609, F610, F745, F867, and F943.<br><br>On 01/30/2025 at 3:04 PM, the State Agency (SA) received an Online Incident Report (FRI) from the facility alleging RI #15 was verbally abused by CNA #10 after RI #15 reported to Licensed Physical Therapy Assistant (LPTA) #7 that a CNA had been mean to him/her (RI #15) and called him/her (RI #15) a Stupid Motherfucker. The FRI documented the LPTA became aware of the incident at 10:50 AM and the ADM was made aware of the incident at 11:20 AM, more than three hours before the SA was informed. The FRI report further documented the CNA had been rough with RI #15's legs, RI #15 was not hurt, but was scared of that CNA. The FRI documented actions taken included suspending CNA #10 pending the investigation, calling the mental health nurse to review, and initiating abuse and customer service in-services. The FRI also included that RI #15 was no longer scared since the CNA was gone.<br><br>Further review of the facility's Abuse Policy, revealed the following:<br><br>Our residents have the right to be free from abuse .<br><br>To help with recognition of incidents of abuse, the following definitions of abuse are provided:<br><br>1. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.<br><br>2. Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents . within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability.<br><br>RI #15 was readmitted to the facility on [DATE] and had diagnoses to include: Cellulitis of Left and Right Lower Limb, Need for Assistance with Personal Care, Abnormalities of Gait and Mobility, Hemiplegia and Hemiparesis following Cerebral Infarction.<br><br>RI #15's Significant Change in Status Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/24/2024 revealed a Brief Interview for Mental Status (BIMS) score of 12 of 15 which indicated moderately impaired cognition.<br><br>The facility investigative file contained a summary of the incident involving RI #15 and CNA #10, dated 02/06/2025, signed by the Administrator (ADM) that documented: . (RI #15) alleged that . (CNA #10), cursed (him/her) out and was rough with (his/her) legs .<br><br>After discussing the allegation . we suspended the C.N.A. pending investigation. Based on the statements and interviews with staff . we have concluded (CNA #10) did curse (RI #15) . going to substantiate the allegation of verbal abuse in this instance. We have initiated abuse in-services for all staff. We are going to terminate the C.N.A.<br><br>The facility investigative file contained a form titled DIVERSICARE PERSONNEL CHANGE/TERMINATION FORM dated 02/07/2025 for CNA #10 with a reason for termination of abuse.<br><br>CNA #10's facility time sheet indicated CNA #10 had not worked at the facility since she was clocked out at 12:48 PM on 01/30/2025.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | On 03/18/2025 at 10:25 AM, an interview was conducted with RI #15. RI #15 told the surveyor CNA #10 came into his/her room on 01/30/2025 to get him/her dressed told him/her to get up and stand up you stupid mother fucker, get up you are going to stand today. RI #15 said, he/she fell back in the bed and CNA #10 called him/her a stupid mother fucker again. RI #15 said, he/she did not care for the CNA to be in his/her room. RI #15 said, CNA #10 told him/her during the incident that she had a bad day the day before.<br><br>During a follow up interview on 03/22/2025 at 12:24 PM, the surveyor asked RI #15 how it made him/her feel when CNA #10 called him/her a stupid motherfucker. RI #15 stated, stunned and shocked.<br><br>Contained within the facility's investigative file was a handwritten statement signed by CNA #10 dated 01/30/2025, which documented she was tired and frustrated at the time RI #15 was verbally abused, as follows:<br><br>I (CNA #10's name) went to (RI #15's) room to change (him/her) to get (him/her) up for activities . I said a few words like I was tired from . doing a double on the previous shift from the day before and I wasn't directly saying it to (RI#15) just whisper it under my breath due to the frustration .<br><br>Unsuccessful attempts were made to contact CNA #10 during the survey.<br><br>Contained within the facility's investigative file was a handwritten statement given by the LPTA dated 01/30/2025 at 10:50 AM, which documented the following:<br><br>Entered (RI #15's room number) and asked (RI #15) how (he/she) was feeling today. (He/She) responded, I'm being abused. That lady called me a 'stupid mother fucker.' When asked who called (him/her) that, (he/she) stated that it was a CNA.<br><br>On 03/19/2025 at 3:49 PM, in an interview with the LPTA she stated, on 01/30/2025 RI #15 told her that a CNA called him/her a mother fucker. The LPTA stated, RI #15 appeared to be mad. The LPTA stated, she reported to her supervisor the Therapy Director (TD) and the ADM. When asked what type of abuse this would be considered, she stated it would be verbal and emotional.<br><br>During an interview on 03/19/2025 at 3:31 PM with the TD she stated, she was notified of the allegation on 01/30/2025 by the LPTA who stated RI #15 told her that a CNA used aggressive language toward him/her. The TD stated she had the LPTA to write out a statement and notified the ADM. When asked what type of abuse this would be considered the TD stated verbal.<br><br>Contained within the facility's investigative file was a handwritten statement given by CNA #8 dated 12/30/25, which documented the following:<br><br>Today (RI #15) said to me after I walked into (his/her) room because (CNA #10) stormed out heated that she was getting a attitude with (him/her) and calling (him/her) names because (he/she) didn't stand up .<br><br>An interview was conducted on 03/19/2025 at 4:16 PM, with CNA #8. CNA #8 stated that she went into RI #15's room and he/she told her that CNA #10 called him/her a stupid mother fucker.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Contained within the facility's investigative file was a written statement given by CNA #9 dated 01/30/2025, which documented the following:<br><br>I walked (room number of RI #15) to help (him/her) get up and (he/she) said (CNA #10) left (him/her) and was mean to (him/her) and called (him/her) a dumb mother fucker.<br><br>A telephone interview was conducted on 03/19/2025 at 04:32 PM, with CNA #9. CNA #9 stated that on 01/30/2025 that she and CNA #8 were in RI #15's room providing personal care and that he/she told her a CNA was rude, nasty and called him/her a mother fucker. CNA #9 stated this was verbal abuse.<br><br>Contained within the facility's investigative file was a handwritten statement signed by the ADM dated 01/30/2025 when he interviewed RI #15, which documented the following:<br><br>. I asked (RI #15) who was treating (him/her) bad and (he/she) replied (CNA #10). I asked what was said and (CNA #10) called me a stupid motherfucker . I asked (him/her) if (he/she) was scared (he/she) stated yes of her (CNA #10) .<br><br>During an interview on 03/20/2025 at 11:32 AM the ADM stated he became aware of the allegation of abuse involving RI #15 on 01/30/2025 at about 11:20 AM by the TD. The ADM stated, the TD was told by the LPTA that CNA #10 called RI #15 a stupid mother fucker. The ADM stated, he initiated an investigation. The ADM stated RI #15 told him that CNA #10 called him/her a stupid mother fucker. The ADM said this allegation was substantiated and it would be considered verbal abuse. |

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| | 015463 | A. Building<br>B. Wing | 03/27/2025 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>47408<br><br>Based on interview, record review, review of a facility policy titled Abuse Policy, and review of a Facility Reported Incident (FRI), the facility failed to report to the State Agency an allegation of verbal abuse within two hours after the allegation was reported to the Administrator at approximately 11:20 AM on 01/30/2025. The State Agency did not receive the FRI alleging Certified Nursing Assistant (CNA) #10 verbally abused Resident Identifier (RI) RI #15, calling RI #15 a stupid mother fucker, until after 3:00 PM on 01/30/2025.<br><br>This deficient practice affected RI #15; one of three residents sampled for Abuse.<br><br>Findings Include:<br><br>A facility policy titled Abuse Policy, updated 8/2022, documented:<br><br>. The following table describes the different reporting requirements.<br><br>What is to be reported. All alleged violations of abuse, neglect, .<br><br>When . All alleged violations- 1) Immediately but no later than 2 hours if the allegation involves abuse .<br><br>On 01/30/2025 at 3:04 PM, the State Agency (SA) received an Online Incident Report (FRI) from the facility alleging RI #15 was verbally abused by CNA #10 who called RI #15 a Stupid Motherfucker. The FRI documented the Licensed Physical Therapy Assistant (LPTA) became aware of the incident at 10:50 AM and the ADM was made aware of the incident at 11:20 AM.<br><br>Contained within the facility's investigative file was a handwritten statement signed by the LPTA dated 01/30/2025 at 10:50 AM, which documented the following:<br><br>Entered (RI #15's room number) and asked (RI #15) how (he/she) was feeling today. (He/she) responded, I'm being abused. That lady called me a 'stupid mother fucker.' When asked who called (him/her) that, (he/she) stated that it was a CNA.<br><br>On 03/19/2025 at 3:49 PM an interview was conducted with LPTA. The LPTA stated RI #15 told her a CNA called him/her a motherfucker. The LPTA stated she reported the allegation of abuse to her supervisor and the Administrator (ADM). The LPTA stated abuse was to be reported immediately and the incident was verbal abuse.<br><br>An interview was conducted with the ADM on 03/20/2025 at 11:32 AM. The ADM said he became aware of the abuse allegation involving RI #15 on 01/30/2025 at 11:20 AM and submitted the initial report to the SA on 01/30/2025 at 3:04 PM.<br><br>A follow-up interview was conducted on 03/21/2025 at 5:38 PM with ADM who said the timeframe for reporting abuse to the SA was no later than two hours after the abuse. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47408<br><br>Based on interviews, resident record review, review of a facility policy titled Abuse Policy, Facility Reported Incidents (FRIs) received by the State Agency, and review of the facility's investigative files, the facility failed to conduct a thorough investigation for an incident of verbal abuse and take appropriate corrective actions to prevent recurrence.<br><br>On 01/30/2025 during resident care Resident Identifier (RI) #15 was verbally abused by Certified Nursing Assistant (CNA) #10 who at the time of the verbal abuse, voiced being frustrated and tired from working double shifts the day prior. Because the facility's investigation failed to identify potential contributing factors of the verbal abuse, the facility was unable to develop and implement any new measures or actions to prevent recurrence.<br><br>Further, handwritten statements in the investigative file failed to clearly and accurately reflect from whom the statements were obtained; and the facility failed to have any evidence in the investigative file or interviews to ensure other residents had not been verbally abused by CNA #10.<br><br>This deficient practice was cited as a result of the investigation of complaint/report number AL00050214 and affected RI #15, one of three residents sampled for abuse.<br><br>Findings Include:<br><br>A facility policy titled Abuse Policy updated 08/2022 documented:<br><br>Our residents have the right to be free from abuse, neglect .<br><br>Prevention: .<br><br>2. Our abuse prevention/intervention program includes, but is not necessarily limited to, the following:<br><br>4. Allowing staff to express frustrations with their job; or in working with difficult residents;<br><br>8. Helping staff to deal appropriately with stress and emotions;<br><br>17. Identifying areas within the facility that may make abuse and/or neglect more likely to occur .<br><br>18. Striving to maintain adequate staffing on all shifts to ensure that the needs of each resident are met .<br><br>Screening:<br><br>1. Monitoring staff on all shifts to identify inappropriate behaviors towards residents (e.g., using derogatory language, rough handling of residents .)<br><br>5. Identifying areas within the facility that may make abuse and/or neglect more likely to occur .<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protection/Investigation:<br><br>The facility protects individuals from abuse during investigation of any allegation of abuse.<br><br>1. Allegation must be reported to the Administrator and other officials.<br><br>2. Investigation will be initiated immediately.<br><br>3. Steps will be taken to prevent further potential abuse, and should include:<br><br>Immediate suspension of the employee pending outcome of the investigation<br><br>Potential staffing changes<br><br>Potential increased supervision,<br><br>Protection from retaliation, and<br><br>Follow-up counseling for the resident(s). if warranted<br><br>Corrective measures will be implemented to prevent recurrence.<br><br>Response:<br><br>The facility must ensure that any incidents of substantiated abuse are reported and analyzed and the appropriate corrective, remedial, disciplinary action occurs .<br><br>11. Upon receiving information concerning a report of abuse, the Director of Nursing Services will request that a representative of the Social Services Department monitor the resident's reactions to and statements regarding the incident and his/her involvement in the investigation.<br><br>12. Unless the resident requests otherwise, the social service representative will give the Administrator and the Director of Nursing Services a written report of his/her findings.<br><br>13. All phases of the investigation will be kept confidential . medical records. Administrative policies . notification of the resident's representative(sponsor) and Attending Physician .<br><br>15. Report to the State nurse aide registry . any knowledge it has of actions .an employee, which would indicate unfitness for service as a nurse aide .<br><br>Assessment:<br><br>The nurse will assess the individual and document related findings. Assessment data will include: .<br><br>q. The physician and staff will help identify risk factors for abuse within the facility .<br><br>Cause Identification<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1. The staff . will investigate alleged occurrences of abuse . to clarify what happened and identify possible causes.<br><br>Monitoring and Follow-Up<br><br>1. The staff . will monitor individuals who have been abused at least until their . mood, and function have stabilized, and periodically thereafter.<br><br>On 01/30/2025 the State Agency received an Online Incident Report (FRI) from the facility alleging RI #15 was verbally abused by CNA #10, who called RI #15 a Stupid Motherfucker. The FRI documented actions taken included suspending CNA #10 pending the investigation, calling the Mental Health Nurse to review, initiating abuse and customer service in-services, and skin assessments were to be done on all residents with a Brief Interview for Mental Status (BIMS) score less than 12.<br><br>RI #15 was admitted to the facility on [DATE] and readmitted on [DATE].<br><br>Contained within the facility's investigative file was a handwritten statement signed by the Administrator (ADM) dated 01/30/2025 which documented his interview with RI #15 as follows: . I was asked by a staff member to go see (RI #15) (He/she) was asking for me. I had just been made aware of the allegation of verbal abuse. (RI #15) and I discussed (his/her) issue. (RI #15) discussed with me that some people were treating (him/her) bad. (RI #15) said, (CNA #10s name). I asked (him/her) what was said She called me a stupid motherfucker and was rough with my legs when I was in bed. I told (him/her) that we would take care of (him/her) and (he/she) would not have to worry about that CNA. The handwritten interview also included that RI #15 denied pain and said CNA #10 was the only one who had been mean.<br><br>The facility investigative file contained a summary of the incident involving RI #15 and CNA #10, signed by the ADM and dated 02/06/2025, documenting that after discussion of the allegation with RI #15, CNA #10 was suspended pending the investigation. The summary documented that discussions were had with the resident, roommate, and staff; statements were taken from each. Based on statements and interviews the facility concluded CNA #10 did curse RI #15 and was inappropriate in her handling of RI #15. The incident of verbal abuse was substantiated by the facility, abuse in-services for all staff were initiated, and they were going to terminate CNA #10.<br><br>During an interview with the ADM on 03/20/2025 at 11:32 AM he stated, he became aware of RI #15 being verbally abused on 01/30/2025 at 11:20 AM. The ADM said, he went to talk to RI #15 who said the CNA called him/her a stupid motherfucker and was rough with his/her legs. The ADM said, actions taken to protect the alleged victim and other residents from abuse while the investigation was in process included suspension of CNA #10, and statements were obtained from the alleged abuser and witnesses (staff to whom RI #15 reported). When asked about the Mental Health Evaluation performed on RI #15, the ADM said, the psychiatric nurse practitioner was to see RI #15 on her next visit. The facility did not have evidence of a Mental Health visit conducted with RI #15 since the verbal abuse incident had occurred.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Contained within the facility's investigative file was a handwritten statement titled Roommate Statement dated 1/30/29 signed by RI #15 and CNA #12 which documented the following: Upon getting the patient ready for lunch (he/she) stated to me that the other CNA that had (him/her) was very mean . and called (him/her) a stupid mother-fucker and (he/she) state that she said she is (tired) of you all acting like yall can't do anything. and (He/she) said, that the CNA was (also) upset because (his/her) clothes was dirty .<br><br>During a follow up interview with ADM on 03/21/2025 at 5:38 PM the ADM was asked about the handwritten statement titled Roommate Statement since the statement was confusing as to who wrote it and who it was about. The ADM said, it appeared to be what RI #15 told one of the CNAs, it was a statement from the Restorative CNA #12. The ADM said, he did not take a statement from RI #15's roommate who was unable to give a statement, and Roommate Statement was written on the statement in error. When asked what discussions were held with the resident, roommate, and staff, as mentioned in the summary, the ADM said, there were not any discussions other than the handwritten witness statements from staff to whom RI #15 had initially reported to that he/she had been verbally abused. The ADM was asked about the handwritten statements in the investigative file having unclear signatures and not including job classifications because the LPTA's statement signature was not clear and there was no job classification, and CNA #12's statement was titled Roommate Statement and the signature was not clear and had no job classification. When asked how anyone reviewing the file would know who gave or wrote the statements and their job classification, the ADM said, human resources could pull the job classifications, but going forward he would ensure titles were assigned to the statements. Because the facility investigative file review revealed no interviews with other residents nor staff to determine if they had knowledge of any other instances of unreported abuse that involved CNA #10, the ADM was asked if any interviews were conducted with residents to find out if anyone else had been affected by CNA #10. The ADM said, no interviews were conducted with residents after RI #15's verbal abuse. When asked where the root cause analysis was documented, the ADM said, they had not done a root cause analysis to address RI #15's verbal abuse. When asked how the resident abuse could have been prevented, the ADM said, continuing education for abuse and they could have done some burnout training. When asked about a Quality Assurance Performance Improvement (QAPI) review or action plan, the ADM said, he did not know they were to write out a plan.<br><br>Contained within the facility's investigative file was a handwritten statement signed by CNA #10 dated 01/30/2025, which documented she was tired and frustrated at the time RI #15 was verbally abused, as follows:<br><br>I (CNA #10's name) went to (RI #15's) room to change (him/her) to get (him/her) up for activities . I said a few words like I was tired from . doing a double on the previous shift from the day before and I wasn't directly saying it to (RI#15) just whisper it under my breath due to the frustration .<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In the continued interview with the ADM on 03/21/2025 at 5:38 PM, the ADM was asked what type of supervision or monitoring was in place for staff who worked double shifts or extra hours, to make sure they were not burned out, frustrated, or too tired. The ADM, said, they did not have that. When asked what type of training the staff received specifically about burnout or frustration after working increased hours, the ADM said, there was not one being done. When asked what evidence there was that CNA #10 received training on burnout or frustration prior to her verbal abuse against RI #15, the ADM said, she had not received that type of training. When asked what type of process the facility had to encourage staff to express concerns, the ADM said, they did not have that type of process currently. When asked if Social Services or Mental Health Nurses had evaluated RI #15 after the verbal abuse, the ADM said, no.<br><br>An interview was conducted on 03/22/2025 at 12:35 PM with Social Services Director (SSD). When asked about RI #15, the SSD said, she just learned of RI #15's abuse during the survey a few days ago and she had not assessed RI #15. The SSD said, she had not been informed a Mental Health Nurse was to evaluate RI #15. The SSD said, she should have been made aware.<br><br>During an interview with Director of Nursing (DON) on 03/22/2025 at 5:51 PM, she was given a copy of the Facility Reported Incident (FRI) submitted on 01/30/2025 per ADM to read. The DON stated there was no notification of SSD nor the Mental Health Nurse. The DON stated that not notifying the SSD or Mental Health Nurse could have resulted in emotional distress for RI #15. |

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| F 0658<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>21055<br><br>Based on interviews, record review, review of facility policies titled Administering Medications, and Policy on Computer or Internet Downtime and EHR (Electronic Health Record) Access, the facility failed to ensure Licensed Practical Nurse (LPN) #14, Registered Nurse (RN) #15, RN #16, RN #20, and LPN #18 followed standards of practice and facility's policies.<br><br>Specifically, LPN #14 and RN #15 failed to follow standards of practice to administer medications and perform Capillary Blood Glucose (CBG) monitoring as ordered by the physician on 01/21/2025 during the 2 PM to 10 PM shift on the Second Floor.<br><br>The nurses did not notify the residents' physician, DON, or the Administrator that medications were not being administered and CBG checks were not being performed.<br><br>It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death. The Immediate Jeopardy (IJ) was cited in reference to 483.21 Comprehensive Resident Centered Care Plan.<br><br>On 03/25/2025 at 4:15 PM, the Administrator (ADM), the DON, the Assistant Director of Nursing (ADON), and Executive Director of Operations were provided a copy of the IJ template and notified of the finding of immediate jeopardy in the area Comprehensive Resident Centered Care Plan at F658-Services Provided Meet Professional Standards.<br><br>The IJ began on 01/21/2025 and continued until 03/26/2025 when the facility implemented corrective action to remove the immediacy. On 03/27/2025 the immediate jeopardy was removed, F658 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.<br><br>In addition, RN #20 and RN #16 failed to follow standards of practice when they administered medications using the pre-packaged medications without following the rights of medication administration to verify the physician's order. RN #20 and RN #16 did not document that they administered the residents' medications at the time of administration or when the EHR system was restored.<br><br>Further LPN #18 failed to administer and document medication administration per standards of practice and facility's policy.<br><br>This affected residents on the Second and Third Floors who were received medications at the facility, 48 of 52 residents who resided at the facility on 01/21/2025 and 01/22/2025.<br><br>This deficiency was cited as the result of the investigation of complaint/report number AL00050173.<br><br>Findings Include:<br><br>Cross-Reference F580, F600 and F760.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Review of an undated facility policy titled, Policy on Computer or Internet Downtime and EHR (Electronic Health Record) Access, revealed the following:<br><br>Purpose<br><br>To establish procedures for maintaining continuity of care and operations when the facility experiences a computer or internet outage that prevents access to the Electronic Health Record (EHR) system .<br><br>Procedures<br><br>1. Notification Process .<br><br>If the outage is expected to last more the 30 minutes, staff will initiate downtime procedures.<br><br>2. Documentation During Downtime<br><br>Paper documentation will be used for all resident care activities, including but not limited to:<br><br>Medication Administration Records (MARs) .<br><br>3. Medication Administration<br><br>Nurses will refer to printed MARs/TARs (Treatment Administration Records) or previously printed backup records if available .<br><br>4. Restoring EHR Data<br><br>Once systems are restored, all paper documentation must be entered into the EHR system as soon as possible . Nursing and administrative staff will verify that all data has been accurately transferred before discounting paper documentation .<br><br>The facility policy titled, Administering Medications, with a revised date of 04/2019, revealed the following:<br><br>Policy Statement<br><br>Medications are administered in a safe and timely manner, and as prescribed.<br><br>Policy Interpretation and Implementation .<br><br>4. Medications are administered in accordance with prescriber orders, including any required time frames .<br><br>7. Medications are administered within (1) hour of their prescribed time . 10. The individual administering the medication check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | 22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication .<br><br>23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record:<br><br>a. The date and time the medication was administered;<br><br>b. The dosage;<br><br>c. The route of administration .<br><br>g. The signature and title of the person administering the drug .<br><br>A review of the facility's Midnight Census Report documented a facility census of 52 residents on 01/21/2025 with 27 residents on the Second Floor and 25 residents on the Third Floor.<br><br>Second Floor<br><br>The DAILY ASSIGNMENT SHEET indicated that LPN #14 was assigned the Second Floor back hall medication cart 01/21/2025 on the 2 PM to 10 PM shift.<br><br>On 03/22/2025 at 1:43 PM, a telephone interview was conducted with LPN #14, who said on 01/21/2025 she could not pass medications because the internet was down, and she did not have the MARs to see what needed to be done. LPN #14 said she did not check residents CBG either during that time.<br><br>LPN #14's assigned residents' MARs and physician orders were reviewed. The review revealed that 12 residents including RI #4, 35, 12, 38, 7, 21, 2, 52, 158, 6, 308, and 30 had scheduled medications that were not administered during the 01/21/2025 2 PM to 10 PM shift. A total of 85 doses of residents' medications were not administered, and 2 residents missed CBG checks as ordered during her shift on 01/21/2025. Medications not administered included, but not limited to, Metformin, Symbiotic Inhalation, Novolin Insulin, and Memantine Tablet.<br><br>The DAILY ASSIGNMENT SHEET indicated that RN #15 was assigned the Second Floor front hall medication cart 01/21/2025 on the 2 PM to 10 PM shift.<br><br>On 03/22/2025 at 2:40 PM during an interview with RN #15, she indicated she worked the Second Floor on 01/21/2025 from 6 AM to 10 PM. RN #15 said she could not administer medications during the 2 PM to 10 PM shift as ordered because the computers were not working. RN #15 said she reported that she was unable to administer medications to the Supervisor at the facility, LPN #11. RN #15 said she was unable to administer any medications except controlled pain medications upon resident's request. RN #15 said she did not check anyone's CBG because the computer was down.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | RN #15's assigned resident MARs and physician orders were reviewed. The review revealed 13 residents including RI #3, 56, 31, 27, 32, 17, 51, 20, 34, 46, 24, 159, and 15 had scheduled medications that were not administered during the 01/21/2025 2 PM to 10 PM shift. A total of 77 doses of residents' medications were not administered as ordered, and 2 residents missed CBG checks during RN #15's shift on 01/21/2025. Medications not administered included, but not limited to, Tamiflu Capsule, Carvedilol, Valproic Acid, Remeron, Hydralazine, Metoprolol Tartrate, Insulin Lispro, and Dilantin Capsule.<br><br>On 03/19/2025 at 3:53 PM, during a telephone with LPN #11, she said on 01/21/2025 the computer system went down and there were new nurses working. LPN #11 continued to say the facility did not print MARs for the new nurses to use to administer residents' medications. LPN #11 said the physician orders were not being followed if the residents do not get their medications.<br><br>The DAILY ASSIGNMENT SHEET indicated that RN #20 was assigned both medication carts on the Second Floor on 01/22/2025 on the 6 AM to 2 PM shift.<br><br>On 03/22/2025 at 5:14 PM an interview was conducted with RN #20. Regarding medication administration on 01/22/2025, RN #20 said she administered medications using the prepacked medications that were labeled with resident's name, medication, dose, and time it was due. RN #20 said residents who had orders for over-the-counter (OTC) or stock medication would not have received those medications without the printed MARs because those medications were not prepackaged. RN #20 said she was able to check residents' CBG because she had a report sheet. RN #20 said she was unable to document anything in the residents' medical records.<br><br>The DAILY ASSIGNMENT SHEET indicated that RN #16 was assigned to both medication carts on the Second Floor on 01/22/2025 on the 2 PM to 10 PM shift and 10 PM to 6 AM shift.<br><br>On 03/22/2025 at 5:47 PM an interview was conducted with RN #16 who worked on the Third Floor on 01/21/2025 and Second Floor on 01/22/2025. RN #16 said she also used the prepackaged medications to administer medications during her shifts and was unable to document medication administration because she did not have paper MARs. RN #16 said if anyone required CBG monitoring such as a sliding scale, she could not have administered it, because the facility did not have the paper MAR or eMAR. RN #16 said she could administer residents with scheduled doses of insulin because she knew which residents were routine.<br><br>Residents' who resided on the Second Floor MARs and physician's orders were reviewed. The reviews revealed 4 residents with orders for CBG monitoring and 25 residents had medications that were not documented as administered on 01/22/2025. A total 410 doses of residents' medication were not documented as administered on 01/22/2025 between all shifts. Medications not administered included, but not limited to, sliding scale insulin and OTC medications such as Aspirin, Multivitamins, Colace, and Miralax.<br><br>Third Floor<br><br>The DAILY ASSIGNMENT SHEET indicated that RN #16 was assigned to administer medications on the Third Floor on 01/21/2025 on the 2 PM to 10 PM shift and 10 PM to 6 AM shift.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | RN #16's assigned residents' MARs and physician's orders were reviewed and revealed that 21 residents including RI #36, 37, 45, 25, 39, 29, 44, 161, 48, 47, 23, 22, 19, 43, 162, 50, 33, 9, 42, 14, and 40 had scheduled medications that had not been documented as administered on 01/22/2025 during the 2 PM to 10 PM shift. A total of 68 doses of residents' medications were not documented as administered and 3 residents CBG checks were not documented as completed during RN #16's shift on 01/21/2025. Medications not documented as administered included Eliquis, Insulin Detemir, Metoprolol Succinate Extended Release, Multivitamin tablets, Docusate Sodium, and Miralax.<br><br>Further review of Third Floor residents MARs and physician's orders revealed 5 residents including RI #36, 19, 2, 59, and 33 had scheduled medications that were not documented as administered on 01/22/2025 at 6:00 AM. A total of a total of 36 doses of residents' medications were not documented as administered on 01/22/2025 at 6:00 AM. Medications that were not documented as administered included, but not limited to, Amlodipine Besylate, Cymbalta, Ferrous Sulfate, Tamsulosine, and Telmisartan.<br><br>The DAILY ASSIGNMENT SHEET indicated that LPN #18 was assigned to administer medications on the Third Floor on 01/22/2025 on the 6 AM to 2 PM shift and 2 PM to 10 PM shift.<br><br>On 03/20/2025 at 4:49 PM, an interview was conducted with LPN #18 who said she used her cellular hotspot to connect to the internet so she could administer residents' medications and document on their eMAR (Electronic Medication Administration Record). LPN #18 said the evidence that the resident had received their medications as ordered by the physician would be the initials on eMAR. LPN #18 said the physician orders were not followed if the residents did not receive their medications. When asked why it would be important for residents to receive their medications as ordered by the physician, LPN #18 said because residents need to get their medications. LPN #18 said if residents do not get their seizure medications, they might have a seizure, if they did not get their blood pressure medication their blood pressure might go up or down.<br><br>LPN #18's assigned residents' MARs and physician's orders were reviewed. The review revealed 10 residents including RI #25, 47, 22, 19, 50, 33, 9, 42, 14, and 40 had medications that were not documented as administered and 1 resident had CBG ordered, but not documented on 01/22/2025 during LPN #18's shift. Medications not documented as administered included, but not limited to, Insulin Detemir, Docusate Sodium, Lisinopril, Memantine, and Metoprolol Succinate Oral Capsule Extended Release (ER).<br><br>On 03/22/2025 at 9:42 AM the DON was interviewed. The DON said she was not notified that residents' medications were not administered on 01/21/2025. The DON said she had not been able to locate the January 2025 paper MARS. The DON said the possibility of things that could have occurred when residents did not receive their medications as ordered by the physician depended on the medication. The DON said if it was a blood pressure (BP) medication not given, the BP may go up or down, if insulin was not administered hypo- or hyperglycemia may occur.<br><br>On 03/25/2025 at 12:00 PM a follow-up interview was conducted with the DON who was asked, when should a nurse not administer medication as ordered and not notify the facility's DON or the person in charge that they were not able to administer medications. The DON responded never. The DON was asked, when should a nurse administer the pre-packaged medications and not document medications as administered. The DON responded, never.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | On 03/21/2025 at 10:23 AM an interview was conducted with the Administrator (ADM) who said he was notified the internet was not working, but not notified that staff were not administering medications as ordered. The ADM said he instructed staff to use the paper MARs. The ADM said he was not aware residents' medications had not been administered as ordered until the current survey.<br><br>**********<br><br>On 03/26/2025, the facility submitted an acceptable removal plan, which documented:<br><br>**********<br><br>1) Process: To ensure that in the event of a power/internet outage the most updated Medical Record Administration (MAR) will be available for nurses that provide care to the residents:<br><br>The medication administration Record (MAR) will be printed monthly by the Director of Nursing Assistant Director of Nursing or Unit Manager, by the 1st of each month. The paper MAR will be updated at the time the order is received or confirmed for all current resident and new admits by the RN/LPN who receives the order or confirms the new order for any medication changes including all new orders for new admits.<br><br>The updated MAR will be located by the nursing stations. All, 100% of LPNs and RNs were in-serviced and completed on March 26th, 2025. Inservice was to ensure nurses know where the paper MAR is located and to update it as soon as a new admission or whenever the physician changes an order in the MAR.<br><br>2) In services<br><br>On 3/20/2025 - 03/26/2025 the Director of Nursing and Assistant Director of Nursing began to educate all nurses, all physical therapy staff and administrative staff (receptionist, Admissions Coordinator, Staffing Coordinator and Human Resources) and provided the education with 1:1 in-service to LPN #14, RN #15, LPN #11, RN #20, and RN #16. The in-services included:<br><br>a) the policy titled Policy on Computer or Internet Downtime and EHR,<br><br>b) the standard of practice to:<br><br>i) administer medication,<br><br>ii) monitor blood glucose,<br><br>iii) the implementation of the prescribing physicians' orders<br><br>iv) the importance of documenting medication administration at the time of administration.<br><br>c) Inservice included calling the physician as well as notify the Director of Nursing or Designee if staff including nurses are unable to carry out a physician's order.<br><br>d) Inservice included how it led to neglect and the facility's Abuse Policy titled Abuse Policy.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | The in-service was completed on March 26th, 2025 for 21 of 21 nurses, 9/9 PT staff, 16/16 of administrative staff.<br><br>On 3/26/2025, 21 of 21 of the nursing staff were all educated by the Director of Nursing or Assistant Director of Nursing and 1:1 in-service to LPN #14, RN #15, LPN #11, RN #20, and RN #16. The in-service included that a printed MAR will be ready for the 1st of each month. A copy of the paper MAR will be kept at each nurses' station for use during downtime. Education included that RNs and LPNs who receives an order or confirms a new order for any medication changes including all new orders for new admits will update the paper medication administration records at the time the order is received or confirmed for all current resident and new admits.<br><br>The Administrator educated the Director of Nursing and the Assistant Director of Nursing on 03/26/2025 that both of them are responsible to print the paper MAR to be ready for the 1st of each month and will be placed by each of the nurse's station. A monthly MAR print out schedule was created for clarity. The education included that the DON and the ADON will confirm that an accurate MAR for all residents is printed and available for use in the event of a forecasted severe storm such as tropical depression, tropical storm, hurricane, or winter snow storm or other reason to expect downtime.<br><br>A mock drill was conducted on 3/21/25 for the nursing personnel on shift.<br><br>2) Assessment<br><br>Due to the failure of functionality of the router which caused the internet outage in the facility, the facility replaced the router on January 30th, 2025 through its internet provider.<br><br>On 3/26/25 The entire Medical Record Administration was reprinted in the event of outage and nurses were all educated that any medication changes or new admissions will need to be updated in the paper medical administration records.<br><br>All residents that had the potential of being affected by this deficient practice from January 21st 2025 to January 22nd 2025. A report was generated from the electronic medical records to see which residents could have been affected during 1/21/25 - 1/22/25.<br><br>There was a total of 56 of 56 residents were assessed by the medical director and completed on March 26th, 2025. No adverse effects were identified by the physician due to this deficient practice and no recommendations were made.<br><br>2) Quality Assurance<br><br>An ad-hoc Quality Assurance meeting which included the entire IDT team ( Director of Nursing, Administrator, Rehab Director, Business Office Manager, Social Worker Director, Governing Body, Medical Director, Business Office Manager, Assistant Director of Nursing, Staffing Coordinator, Unit Manager, Dietary Director, Admissions Director) was conducted on March 25, 2025 in response to F600, F658, F580, and F760 to discuss the deficient practice and plan of correction. The nurses that were responsible were immediately educated about the in-proper practice that led to F600, F658, F580, and F760 and on the Policy on Computer or Internet Downtime and EHR access. The QA team discussed the needed in services/education for LPN #14, RN #15, LPN #11, RN #20, and RN #16.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | This plan was completed on March 26th, 2025.<br><br>**********<br><br>After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 03/26/2025. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055<br><br>Based on observations, interview, and resident record review, the facility failed to ensure care was provided in a manner to prevent skin breakdown. The facility failed to ensure a care planned preventive measure to prevent skin breakdown was implemented for Resident Identifier (RI) #43, a resident with a potential for impaired skin integrity, when unpadded oxygen (O2) tubing was observed behind RI #43's ears.<br><br>This was observed on 03/18/2025 and 03/19/2025, and had the potential to affect RI #43, one of 18 sampled residents.<br><br>Findings Include:<br><br>RI #43 was admitted to the facility on [DATE].<br><br>RI #43's care plan with a need of POTENTIAL FOR IMPAIRED SKIN INTEGRITY had an approach initiated 07/23/2024 for licensed staff to . PAD TUBING AROUND EARS WHEN O2 IS IN USE .<br><br>On 03/18/2025 at 10:48 AM, the surveyor observed RI #43's O2 in use set at two liters per minutes by way of a nasal cannula/concentrator. There was no padding on the tubing behind RI #43's ears.<br><br>On 03/18/2025 at 12:18 PM, the tubing behind RI #43's ears remained without padding.<br><br>On 03/19/2025 at 8:35 AM, RI #43's O2 continued at two liters per minute and the tubing behind RI #43's ears remained unpadded.<br><br>On 03/19/2025 at 8:53 AM, the surveyor conducted an interview with Licensed Practical Nurse (LPN) #25. LPN #25 said she did not see padding on the tubing behind RI #43's ears and the tubing should be padded. LPN #25 said it would be important to ensure the tubing behind RI #43's ears was padded to prevent skin breakdown. |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide medically-related social services to help each resident achieve the highest possible quality of life.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47408<br><br>Based on interviews, review of the facility Online Incident Report (FRI), review of Resident Identifier (RI) #15's medical records, and review of a facility policy titled, Abuse Policy, the facility failed to provide appropriate social services to meet RI #15's needs after Certified Nurse Assistant (CNA) #10 verbally abuse RI #15 on 01/30/2025.<br><br>The facility's Social Services Director (SSD) was not aware the abuse policy instructed her to monitor residents' reactions to an incident of abuse and she was not aware that RI #15 had been verbally abused by a CNA.<br><br>This deficient practice affected RI #15; one of three residents sampled for abuse.<br><br>This deficiency was cited as a result of the investigation of complaint/report number AL00050214.<br><br>Findings Include:<br><br>Review of a facility policy titled, Abuse Policy, updated 08/2022, revealed the following:<br><br>. Upon receiving information concerning report of abuse, the Director of Nursing Services will request that a representative of the Social Services Department monitor the resident's reactions to and statements regarding the incident and his/her involvement in the investigation.<br><br>On 01/30/2025, the State Agency received a Facility Reported Incident that alleged that CNA #10 verbally abused RI #15 when RI #15 reported CNA #10 called him/her a stupid motherfucker. This initial report indicated RI #15 would be seen by a mental health nurse.<br><br>RI #15 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Cerebral Infarction, Hemiplegia and Hemiparesis, Lack of Coordination and Muscle Weakness, and Cellulitis of Left and Right Lower Limb.<br><br>(continued on next page) |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on 03/22/2025 at 12:35 PM with the Social Services Director (SSD). The SSD said, she had that position since January 6, 2025, and her job duties included assessing residents, attending care plan meetings, care planning, grievances, arranging services, and coordinating services with doctors and other outside services. When asked about RI #15, the SSD said, she just learned of RI #15's abuse during the survey a few days ago. The SSD said, she had not yet assessed RI #15. The SSD said, she had not been informed a Mental Health Nurse was to evaluate RI #15. The SSD said, she should have been made aware. When provided a copy of the abuse policy the SSD identified number 11 under the response section as a SSD task as follows: Upon receiving information concerning a report of abuse, the Director of Nursing Services will request that a representative of the Social Services Department monitor the resident's reactions to and statements regarding the incident and his/her involvement in the investigation. The SSD also identified the following in the Abuse Policy: Protection/Investigation: . 3. Follow-up counseling for the resident(s), if warranted. When asked what was the process she followed once she was made aware of alleged abuse. The SSD stated, she would want to know about the allegation, she would speak to the victim, let them know she had been informed, listen to them, and see what assistance they may need and if required, counseling. The SSD said, she would reach out to the Psychiatric Nurse and make sure the resident was alright. The SSD said, if the resident wanted to talk to her, she would let them know their conversations were confidential and she would let them know she would be speaking to her supervisor and Administrator. The SSD said, she would let them know they could talk to her at any time. The SSD said, the concern of not performing monitoring and assessment after an allegation of abuse, was a lack of communication, the resident not knowing their options, they might think the SSD did not do anything about it, the resident could be reluctant to talk to the SSD in the future, and the resident would not have received their needed counseling. The SSD said, she did not see any notes about Mental Health Nurse visit or evaluation, and she had not received a referral from the DON or Administrator regarding RI #15.<br><br>During an interview with the Director of Nursing (DON) on 03/22/2025 at 5:51 PM, the DON reviewed the abuse policy. The DON stated, the policy instructed upon receiving information concerning a report of abuse the Director of Nursing Services will request that a representative of the Social Services Department monitor the resident's reactions regarding the incident. The DON was asked if she contacted the SSD to evaluate RI #15 and or have the SSD contact the Mental Health Nurse to evaluate RI #15 after the verbal abuse allegation. The DON stated, Licensed Practical Nurse (LPN) #11 was responsible for notifying the SSD. The DON stated there was no documentation that had been done. The DON stated, not notifying the SSD and Psychiatric nurse of the alleged abuse of RI #15 could have caused RI #15 emotional distress regarding the situation.<br><br>During an interview on 03/20/2025 at 11:28 AM, the Administrator (ADM) stated he became aware of the abuse allegation involving CNA #10 and RI #15 on 01/30/2025 at 11:20 AM. The ADM stated, he interviewed RI #15 and RI #15 told him CNA #10 called him/her a stupid motherfucker and that he/she was afraid of CNA #10. The ADM stated, a mental health evaluation was to be performed by the psychiatric nurse practitioner on her next visit to see RI #15.<br><br>During a follow up interview with the ADM on 03/21/2025 at 5:38 PM, the ADM said the mental health nurse or psychiatric nurse practitioner had not evaluated RI #15 after the abuse allegation. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055<br><br>Based on interviews and resident record review, the facility failed to ensure Resident Identifier (RI) #52's Cyclobenzaprine (Flexeril) medication was retrieved from RI #308's home, for proper storage and/or disposal, after the medication was accidentally sent home with RI #308 on 01/29/2025.<br><br>This deficient practice affected RI #52, one of 18 sampled residents.<br><br>This deficiency was cited as a result of the investigation of complaint/report #AL00050173.<br><br>Findings Include:<br><br>RI #308 was admitted to the facility 01/09/2025 and discharged on [DATE].<br><br>RI #52 was admitted to the facility on [DATE].<br><br>RI #52's Order Summary Report (Physician Orders) revealed RI #52 was prescribed Flexeril (Cyclobenzaprine HCL (Hydrochloric)) Oral Tablet 5 MG (milligrams) by mouth three times a day for muscle spasms for 14 days. This order had a start date of 01/16/2025.<br><br>On 03/19/2025 at 9:54 AM, a telephone interview was conducted with RI #308's family member. RI #308's family member said RI #52's Flexeril medication had been sent home with RI #308 when RI #308 was discharged from the facility. The family member said she still had RI #52's medications at home with her.<br><br>On 03/19/2025 at 8:45 PM, the surveyor conducted a telephone interview with Registered Nurse (RN) #13. RN #13 said she accidentally sent RI #52's medication home with RI #308. RN #13 said she did not know if facility had the medications back from RI #308's family member or not.<br><br>On 03/20/2025 at 11:00 AM, an interview was conducted with the Director of Nursing (DON). The DON said she was informed by RI #308's family member that they had another resident's medications, they had spelled it out, and it was Flexeril. The DON said a resident should never be sent home with another resident's medication.<br><br>On 03/26/2025 at 3:42 PM, a telephone interview was conducted with the facility's Pharmacist. The Pharmacist said to dispose of medicaitons properly and safely, the facility used a service to pick up medicines if they were not narcotics. When asked could the facility dispose of a residents medications if they went home with another resident and were never returned, the pharmacist said no. When asked what guidance she would have given facility staff if a resident's medications were accidentally sent home with another resident, the Pharmacist said to try to retrieve the medicine from the family and bring them back to the facility. |

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|---|---|---|---|
| | 015463 | A. Building<br>B. Wing | 03/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Knollwood Healthcare | 3151-A Knollwood Drive<br>Mobile, AL 36693 |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055<br><br>Based on interviews, record review, and review of a facility policy titled Administering Medications the facility failed to ensure residents were free of significant medication errors when licensed nursing staff failed to administer medications including insulin and other significant medications.<br><br>Specifically, on 01/21/2025 during a forecasted snowstorm the facility lost internet connection sometime after lunch which resulted in inability to access residents Electronic Health Record (EHR)/Electronic Medication Administration Record (eMAR) until the evening of 01/22/2025.<br><br>Resident Identifier (RI) #12, RI #15, RI #30, and RI #308 were not administered significant medications from 01/21/2025 at 5:00 PM until 01/22/2025 at 9:00 PM.<br><br>It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death. The Immediate Jeopardy (IJ) was cited in reference to 483.45 Pharmacy Services.<br><br>On 03/25/2025 at 4:15 PM, the Administrator (ADM), the DON, the Assistant Director of Nursing (ADON), and Executive Director of Operations were provided a copy of the IJ template and notified of the finding of immediate jeopardy substandard quality of care in the area of Pharmacy Services at F 760-Residents are Free of Significant Med Errors.<br><br>The IJ began on 01/21/2025 and continued until 03/26/2025 when the facility implemented corrective action to remove the immediacy. On 03/27/2025 the immediate jeopardy was removed, F760 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.<br><br>This deficient practice affected RI #12, 15, 30 and 308, four of four residents reviewed for significant medication errors.<br><br>This deficiency was cited as the result of the investigation of complaint/report number AL00050173.<br><br>Findings Include:<br><br>Cross-Reference F580, F600, and F658.<br><br>Review of the facility's policy titled, Administering Medications, with a revised date of 04/2019, revealed the following:<br><br>Policy Statement<br><br>Medications are administered in a safe and timely manner, and as prescribed.<br><br>Policy Interpretation and Implementation .<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | 4. Medications are administered in accordance with prescriber orders, including any required time frame .<br><br>7. Medications are administered within one (1) hour of their prescribed time .<br><br>22. The individual administering the medication initials the resident's MAR . after giving each medication .<br><br>RI #12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis to include Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease and Hyperglycemia. RI #12 resided on the Third Flood of the facility.<br><br>RI #12's January 2025 Order Summary Report (Physicians Orders) revealed RI #12 had orders for: sliding scale Insulin Aspart Injection Solution subcutaneous four times a for hyperglycemia related to Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease; and 6 units of Novolin N FlexPen Subcutaneous Suspension Pen-Injection subcutaneously at bedtime related to Type 2 Diabetes Mellitus with Other Specific Complication.<br><br>A review of RI #12's January 2025 eMAR revealed RI #12's Insulin Aspart injection per sliding scale was not administered on 01/21/2025 at 5:00 PM, 01/21/2025 at 9:00 PM, 01/22/2025 at 7:30 AM, 01/22/2025 at 11:30 AM, 01/22/2025 at 5:00 PM, and 01/22/2025 at 9:00 PM. The eMAR further revealed Novolin N 6 units was not administered to RI #12 on 01/21/2025 at 9:00 PM and 01/22/2025 at 9:00 PM.<br><br>On 03/22/2025 at 5:47 PM an interview was conducted with RN #16. During the interview RN #16 said she worked on the Third Floor on the 2 PM to 10 PM and 10 PM to 6 AM shift on 01/21/2025. RN #16 said if anyone required blood glucose monitoring such as a sliding scale, she could not have administered it, because the facility did not have the paper MAR or eMAR while the internet was down. RN #16 said she could administer residents with scheduled doses of insulin because she knew which residents were routine.<br><br>On 03/20/2025 at 4:49 PM an interview was conducted with Licensed Practical Nurse (LPN) #18 who reported she worked on the Third Floor on the 6 AM to 2 PM and 2 PM to 10 PM shifts on 01/22/2025. She reported when the facility lost internet that she connected to a hotspot and passed medications as ordered.<br><br>RI #15 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Type 2 Diabetes Mellitus, Localization-Related (Focal) (Partial) Symptomatic Epilepsy, and Essential (Primary) Hypertension. RI #15 resided on the Second Floor of the facility.<br><br>RI #15's January 2025 Physicians Orders revealed RI #15 had orders for Carvedilol 25 mg two times a day related to Hypertension, Hydralazine 50 mg two times a day related to Hypertension, Insulin Glargine 30 units subcutaneous in the evening related to Diabetes, Lacosamide 50 mg two times a day related to Seizures, and Insulin Lispro per sliding scale before meals related to Diabetes.<br><br>A review of RI #15's January 2025 eMAR revealed RI #15's was not administered:<br><br>Hydralazine 50 milligram (mg) 01/21/2025 at 5:00 PM, 01/22/2025 at 8:00 AM, and 01/22/2025 at 5:00 PM;<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Lacosamide 50 mg on 01/21/2025 at 5:00 PM, 01/22/2025 at 8:00 AM, and 01/22/2025 at 5:00 PM;<br><br>Carvedilol 25 mg on 01/21/2025 at 8:00 PM, 01/22/2025 at 8:00, and 01/22/2025 at 8:00 PM;<br><br>Glargine Insulin 30 units on 01/21/2025 at 5:00 PM and 01/22/2205 at 5:00 PM; and<br><br>Insulin Lispro sliding scale on 01/21/2025 at 4:00 PM, 01/22/2025 at 7:30 AM, 01/22/2025 at 11:00 AM and 01/22/2025 at 4:00 PM.<br><br>RI #30 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Type 2 Diabetes Mellitus with Diabetic Neuropathy, Chronic Diastolic (Congestive) Heart Failure, Essential Hypertension, Atherosclerotic Heart Disease of Native Coronary Artery, and Long Term (Current) Use of Insulin. RI #30 resided on the Second Floor.<br><br>RI #30's January 2025 Physicians Orders revealed RI #30 had orders for blood glucose monitoring twice a day related to Type 2 Diabetes, Carvedilol 12.5 mg every morning and at bedtime for Beta Blockers, Furosemide 40 mg two times a day for Diuretics, Novolog 8 units before meals related to Type 2 Diabetes, and Rivaroxaban 2.5 mg two times a day for Anticoagulants.<br><br>A review of RI #30's January 2025 eMAR revealed RI #30 was not administered:<br><br>Lasix 40 mg 01/21/2025 at 5:00 PM, 01/22/2025 at 8:00 AM, 01/22/2025 at 5:00 PM;<br><br>Rivaroxaban 2.5 mg 01/21/2025 at 5:00 PM, 01/22/2025 at 8:00 AM, 01/22/2025 at 5:00 PM;<br><br>Coreg 12.5 mg 01/21/2025 at 8:00 PM, 01/22/2025 at 8:00 AM, 01/22/2025 at 8:00 PM;<br><br>Novolog 8 units on 01/21/2025 at 4:00 PM, 01/21/2025 at 9:00 PM, 01/22/2025 at 7:30 AM, 01/22/2025 at 11:00 AM, 01/22/2025 at 4:00 PM, and 01/22/2025 at 9:00 PM.<br><br>RI #30's January 2025 eMAR also indicated his/her blood glucose was not monitored on 01/21/2025 at 5:00 PM, 01/22/2025 at 8:00 AM, or on 01/22/2025 at 5:00 PM.<br><br>RI #308 was admitted to the facility on [DATE] and discharged on [DATE]. RI #308 had diagnoses that included Epilepsy, Unspecified, Conversion Disorder with Seizures or Convulsions and Localization-Related (Focal) (Partial) Symptomatic Epilepsy and Epileptic Syndrome with Complex Partial Seizures. RI #308 resided on the Second Floor.<br><br>RI #308's January 2025 Physicians Orders revealed RI #308 had orders for Clobazam 10 mg two times a day for Anticonvulsants, Lacosamide 50 mg two times a day for Anticonvulsants, Lamotrigine 100 mg two times a day for Anticonvulsants, Oxcarbazepine 300 mg two times a day for Anticonvulsant, and Topiramate 300 mg two times a day for Anticonvulsant.<br><br>A review of RI #308's January 2025 eMAR revealed RI #308 was not administered his/her:<br><br>Clobazam 10 mg on 01/21/2025 at 5:00 PM, 01/22/2025 at 8:00 AM, and 01/22/2025 at 5:00 PM;<br><br>Lacosamide 50 mg on 01/21/2025 at 5:00 PM, 01/22/2025 at 8:00 AM, and 01/22/2025 at 5:00 PM;<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Lamotrigine 100 mg on 01/21/2025 at 5:00 PM, 01/22/2025 at 8:00 AM, and 01/22/2025 at 5:00 PM;<br><br>Oxcarbazepine 300 mg on 01/21/2025 at 5:00 PM, 01/22/2025 at 8:00 AM, and 01/22/2025 at 5:00 PM;<br><br>Topiramate 300 mg on 01/21/2025 at 5:00 PM, 01/22/2025 at 8:00 AM, and 01/22/2025 at 5:00 PM.<br><br>On 03/25/2025 at 11:05 AM an interview was conducted with RI #308 who said he/she was scheduled to receive medications for seizures twice a day. RI #308 said there was a few shifts that he/she did not receive any of his/her medications.<br><br>On 03/21/2025 at 11:58 AM an interview was conducted with Registered Nurse (RN) #15. RN #15 reported she worked a double shift from 6 AM to 10 PM on 01/21/2025 on the Second Floor. RN #15 said something happened during the evening shift on 01/21/2025 and she was unable to pass any medications because she did not have access to residents' eMAR.<br><br>On 03/22/2025 at 1:43 PM an interview was conducted with LPN #14 who reported she worked a double shift from 6 AM to 10 PM on 01/21/2025 on the Second Floor and was assigned to RI #15's rooms for medication passes. LPN #14 reported that RN #15 was assigned to RI #30 and RI #308's medication passes. LPN #14 said the facility's internet stopped functioning around 2 PM on 01/21/2025. LPN #14 said she was unable to access residents' eMAR. RN #15 said she did not administer medications or monitor resident blood glucose because the internet was down. LPN #14 said she did not know who needed their blood glucose checked off the top of her head, so she did not check.<br><br>On 03/25/2025 at 1:32 PM, a telephone interview was conducted with the Medical Director (MD) and RI #12, 308, 40 and 15's physician. Regarding RI #12's missed medications the MD said, the likelihood of harm was that resident's blood sugars could go up if a resident did not receive their scheduled insulin and their blood sugars were not monitored as ordered. The MD said other things that could result from a person not receiving their insulin and not having their blood sugars checked as ordered would be short term DKA (Diabetic Ketoacidosis) and being placed on an insulin drip if blood sugars were too high. Regarding RI #308's missed medications, the MD said there was a likelihood of reoccurrence of seizures if a resident did not receive their seizure medications as ordered. Regarding RI #40's missed medications, the MD said a person with a history of diabetes, hypertension and stroke, and congestive heart failure not receiving their scheduled medications as ordered could cause their blood sugars to go up, fluid retention, and reoccurrence of heart failure. Regarding RI #15's missed medications the MD was asked, what was likely to occur if a resident did not receive their insulin, blood pressure, and seizure medications as ordered. The MD said there could be a reoccurrence of seizures, elevated blood pressures, and a person's blood sugars could go up.<br><br>**********<br><br>On 03/26/2025, the facility submitted an acceptable removal plan, which documented:<br><br>**********<br><br>1) Process: To ensure that in the event of a power/internet outage the most updated Medical Record Administration (MAR) will be available for nurses that provide care to the residents:<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | The medication administration Record (MAR) will be printed monthly by the Director of Nursing Assistant Director of Nursing or Unit Manager, by the 1st of each month. The paper MAR will be updated at the time the order is received or confirmed for all current resident and new admits by the RN/LPN who receives the order or confirms the new order for any medication changes including all new orders for new admits.<br><br>The updated MAR will be located by the nursing stations. All, 100% of LPNs and RNs were in-serviced and completed on March 26th, 2025. Inservice was to ensure nurses know where the paper MAR is located and to update it as soon as a new admission or whenever the physician changes an order in the MAR.<br><br>2) In services<br><br>On 3/20/2025 - 03/26/2025 the Director of Nursing and Assistant Director of Nursing began to educate all nurses, all physical therapy staff and administrative staff (receptionist, Admissions Coordinator, Staffing Coordinator and Human Resources) and provided the education with 1:1 in-service to LPN #14, RN #15, LPN #11, RN #20, and RN #16. The in-services included:<br><br>a) the policy titled Policy on Computer or Internet Downtime and EHR,<br><br>b) the standard of practice to:<br><br>i) administer medication,<br><br>ii) monitor blood glucose,<br><br>iii) the implementation of the prescribing physicians' orders<br><br>iv) the importance of documenting medication administration at the time of administration.<br><br>c) Inservice included calling the physician as well as notify the Director of Nursing or Designee if staff including nurses are unable to carry out a physician's order.<br><br>d) Inservice included how it led to neglect and the facility's Abuse Policy titled Abuse Policy.<br><br>The in-service was completed on March 26th, 2025 for 21 of 21 nurses, 9/9 PT staff, 16/16 of administrative staff.<br><br>On 3/26/2025, 21 of 21 of the nursing staff were all educated by the Director of Nursing or Assistant Director of Nursing and 1:1 in-service to LPN #14, RN #15, LPN #11, RN #20, and RN #16. The in-service included that a printed MAR will be ready for the 1st of each month. A copy of the paper MAR will be kept at each nurses' station for use during downtime. Education included that RNs and LPNs who receives an order or confirms a new order for any medication changes including all new orders for new admits will update the paper medication administration records at the time the order is received or confirmed for all current resident and new admits.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | The Administrator educated the Director of Nursing and the Assistant Director of Nursing on 03/26/2025 that both of them are responsible to print the paper MAR to be ready for the 1st of each month and will be placed by each of the nurse's station. A monthly MAR print out schedule was created for clarity. The education included that the DON and the ADON will confirm that an accurate MAR for all residents is printed and available for use in the event of a forecasted severe storm such as tropical depression, tropical storm, hurricane, or winter snow storm or other reason to expect downtime.<br><br>A mock drill was conducted on 3/21/25 for the nursing personnel on shift.<br><br>2) Assessment<br><br>Due to the failure of functionality of the router which caused the internet outage in the facility, the facility replaced the router on January 30th, 2025 through its internet provider.<br><br>On 3/26/25 The entire Medical Record Administration was reprinted in the event of outage and nurses were all educated that any medication changes or new admissions will need to be updated in the paper medical administration records.<br><br>All residents that had the potential of being affected by this deficient practice from January 21st 2025 to January 22nd 2025. A report was generated from the electronic medical records to see which residents could have been affected during 1/21/25 - 1/22/25.<br><br>There was a total of 56 of 56 residents were assessed by the medical director and completed on March 26th, 2025. No adverse effects were identified by the physician due to this deficient practice and no recommendations were made.<br><br>2) Quality Assurance<br><br>An ad-hoc Quality Assurance meeting which included the entire IDT team ( Director of Nursing, Administrator, Rehab Director, Business Office Manager, Social Worker Director, Governing Body, Medical Director, Business Office Manager, Assistant Director of Nursing, Staffing Coordinator, Unit Manager, Dietary Director, Admissions Director) was conducted on March 25, 2025 in response to F600, F658, F580, and F760 to discuss the deficient practice and plan of correction. The nurses that were responsible were immediately educated about the in-proper practice that led to F600, F658, F580, and F760 and on the Policy on Computer or Internet Downtime and EHR access. The QA team discussed the needed in services/education for LPN #14, RN #15, LPN #11, RN #20, and RN #16.<br><br>This plan was completed on March 26th, 2025.<br><br>**********<br><br>After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 03/26/2025. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>34019<br><br>Based on observations, interviews and a review of the facility policie's titled, DATING AND LABELING POLICY, ICE MACHINE SANITATION POLICY, And HAND WASHING POLICY. The facility failed to ensure:<br><br>1) food items in the freezer and cooler was labeled and dated;<br><br>2) the ice machine was free of a black substance;<br><br>3) a staff did not work on the dirty and clean side of the dish room without changing gloves and aprons.<br><br>This had the potential to affect 53 of 53 residents who received meals from the kitchen.<br><br>Finding Includes:<br><br>1) A review of a policy titled, DATING AND LABELING POLICY, with no date revealed: POLICY: All foods are to be labeled and dated appropriately to ensure food safety regulations are followed. PROCEDURE: . Once opened, the label must be updated with the current date and a use by date . (including date opened) .<br><br>On 03/18/2025 at 8:39 AM, an during the initial tour of a large clear bag of okra and about six chicken fingers in a bag were observed in the freezer with no open or use by the date. Corn beef was observed in the cooler with no open or use by date.<br><br>On 03/20/2025 at 12:43 PM, an interview was conducted with the Food Service Director (FSD). The FSD stated that corn beef in the cooler did not have an open and a use by date on it. She stated that the chicken tenders and okra in the freezer did not have an open or use by date on it. She stated staff should label and date food items before putting them back in the freezer or cooler. She continued to say it should be labeled with an opened and use by date on the item. She stated that the food items should have the name of the item on it. On the label it should be the date, the name of the item, the opened date or prepared date, the use by date, and the initial of the person who put it in the freezer. The FSD stated that food should be labeled and dated to keep in within the time line of safe food. She stated that the person who opened the food was responsible for dating and labeling it. The FSD stated that food that was not dated and label could cause food borne illness. The FSD stated that food was supposed to be labeled and dated.<br><br>2) A review of a facility's policy titled, ICE MACHINE SANITATION POLICY, with no date revealed: POLICY: kitchen staff will wash, rinse and sanitize the ice making machine .<br><br>On 03/18/2025 at 8:39 AM, black substance was observed on the ice guard and lid on the inside of the ice machine in the kitchen.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 03/20/2025 at 12:52 PM, an interview was conducted with the FSD. The FSD was asked what was on the lid and guard on the inside of the ice machine. She stated that it was dirty with debris. She was asked why was it there and she said the machine had not been serviced. The FSD said she was responsible for making sure the ice machine was clean on the inside. The FSD stated that it was important that the ice machine was clean on the inside to make sure no bacteria or infection disease got into the ice that was served to the residents. The FSD said the ice machine lid and guard was cleaned monthly.<br><br>3) A review of an undated facility policy titled, HAND WASHING POLICY . revealed: . When to Wash Hands . Before and in between switching tasks.<br><br>On 03/20/2025 at 8:59 AM, during an observation in dishware washing in the kitchen, one staff taking dirty trays and plates out of a cart and another staff was at the dish machine rinsing dishes. Dietary Aide (DA) #23 was on the dirty side of the dish room wearing gloves and an apron. She was rinsing off dishes, washing plates, trays, and plates covers. Her apron was touching dirty trays. She pulled dish ware out of the dish machine on the clean side of the dish room without changing the dirty apron or gloves. She removed dish ware on the clean side from the dish machine with the same gloves she used on the dirty side of the dish room. She was touching clean dishes, cups, plate covers, trays. She did not change her gloves or apron when she moved from the dirty side to the clean side to put clean items up. She was working both sides of the dish room. At the same time, DA #24 was observed not wearing gloves. He was on the dirty side washing out glasses to be placed in the dish machine. He left the dirty side with the same apron on and began putting up dishes on the clean side. DA #24 carried plate covers and plates out of the clean side of the dish room. The clean dishes were touching his apron as he put up the dishes.<br><br>On 03/20/2025 at 9:12 AM, an interview was conducted with DA #23 who said she did she use the same gloves on the dirty and clean side of the dish room. She was asked why did she use the same gloves on the dirty side and clean side of the dish room. She stated she was a new employee. She stated that she worked both side of the dish room when someone was out. DA #23 said she did not change her apron from the dirty side to the clean side of the dish room. DA #23 stated that when she finished washing the dishes she should have changed her gloves. DA #23 was asked why should kitchen staff not work on the clean and dirty side of the dish room with the same gloves and apron. DA #23 stated because of cross-contamination<br><br>03/20/2025 at 12:31 PM, an interview was conducted with DA #24 who said he did not change his apron before went to the clean side after he rinsed out dishes on the dirty side. DA #24 stated he did not change the apron because he was so busy he did not think about it.<br><br>On 03/20/2025 at 12:52 PM, an interview was conducted with the FSD. The FSD was asked why did the dietary aide work on the clean side and dirty side of the dish room. The FSD stated the person on the dirty side work both side because the new people were slow. The FSD said she was responsible for training kitchen staff on infection control in the kitchen. The FSD said it was cross-contamination when staff was worked on the clean and dirty side of the dish room with the same gloves and apron. The FSD said residents could get sick from the cross-contamination. |

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|---|---|---|---|
| | 015463 | A. Building<br>B. Wing | 03/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Knollwood Healthcare | 3151-A Knollwood Drive<br>Mobile, AL 36693 |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>47408<br><br>Based on interviews, record review, review of facility policies titled Abuse Policy and Quality Assurance Performance Improvement Process, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee reviewed and analyzed an allegation of abuse in a manner to determine causes and implement appropriate corrective actions to prevent recurrence.<br><br>The committee failed to identify concerns with reporting and investigation for an allegation of abuse reported to the State Agency (SA) on 01/30/2025.<br><br>This deficient practice affected RI #15, one of 18 sampled residents.<br><br>This deficiency was cited as a result of the investigation of complaint/report number AL00050214.<br><br>Findings include:<br><br>Cross-reference F600, F609, F610, and F943.<br><br>The facility's policy titled Abuse Policy, updated 8-2022 documented: . Response:<br><br>The facility ensures that any incidents of substantiated abuse are reported and analyzed and the appropriate corrective, remedial or disciplinary action occurs, in accordance with applicable local state or federal law .<br><br>7. When an incident of resident abuse of resident abuse is suspected or confirmed, the incident must be immediately reported to facility management regardless of the time lapse since the incident occurred.<br><br>Cause Identification.<br><br>1. The staff with the physicians input (as needed) will investigate alleged occurrence of abuse . to clarify what happened and identify the possible causes.<br><br>The facility policy titled Quality Assurance and Process Improvement (QAPI) Committee updated 08/04/2022 documented: Purpose: The QAPI committee will monitor systematic, comprehensive, data driven, proactive approach to performance management and improvement that focuses on indicators of the outcome of care and quality of life.<br><br>1. The QAPI oversees the quality and effectiveness of living center operations and systems to meet the needs of the customers; to monitor and analyze facility key performances indicators .<br><br>10. The QAA Committee to determine if . abuse allegations are:<br><br>Thoroughly investigated.<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Whether the resident is protected.<br><br>Whether an analysis was conducted as to why the situation occurred .<br><br>The facility Quality Assurance and Performance Improvement (QAPI) Meeting for 02/21/2025, documented the facility reviewed a Reportable Incidents for RI #15 who was verbally abused by a CNA. The QAPI documentation indicated that investigations were started, abuse in-services were conducted, the resident was fine, and the CNA was terminated.<br><br>The QAPI committee failed to identify and develop an action plan for the late reporting of the FRI which was not reported to the SA within the two-hour time frame for abuse. The QAPI committed failed to identify and develop an action plan for failure to conduct a thorough investigation and root cause analysis. The QAPI committee failed to identify all contributing factors of the verbal abuse against RI #15 including the CNA stating that she was tired and frustrated after working a double shift the previous day. The QAPI committee failed to identify any contributing factors associated with staff who may be burned out, tired, or frustrated after working double shifts.<br><br>On 03/21/2025 at 5:38 PM the ADM was asked about QAPI and root cause analysis, the ADM said, root cause analysis was not done for the incident of staff on resident verbal abuse involving RI #15. When asked about the QAPI committee review and action plan, the ADM said, he did not know they were to write out a plan.<br><br>During an interview with ADM on 03/22/2025 at 2:17 PM he stated, they reviewed the incident and investigation in Quality Assurance and Performance Improvement (QAPI) and felt like they handled it appropriately. According to QAPI meeting conducted 02/21/2025: Resident is fine. Abuse In-services conducted. CNA has been terminated . |

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| F 0943<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.<br><br>47408<br><br>Based on interviews, record review, and review of a Facility Reported Incident (FRI), the facility failed to provide and have evidence of abuse prevention training to staff to identify and address factors that may precipitate abuse/neglect/exploitation, to include signs of staff burnout, frustration, and stress. On 01/30/2025 Certified Nursing Assistant (CNA) #10 verbally abused Resident Identifier (RI #15) while providing care. CNA #10 voiced she was tired from working a double shift the day before.<br><br>Further, the facility had failed to provide the Social Serviced Director (SSD) with training on the abuse policy and the SSD did not know to monitor RI #15 after incident of staff on resident verbal abuse.<br><br>This affected RI #15 one of 18 sampled residents.<br><br>Findings include:<br><br>Cross-reference F600 and F745.<br><br>On 01/30/2025, the State Agency received a FRI alleging CNA #10 verbally abused RI #15.<br><br>Contained within the facility's investigative file was a handwritten statement signed by CNA #10 dated 01/30/2025 which documented she was tired and frustrated at the time RI #15 was verbally abused, as follows:<br><br>I (CNA #10's name) went to (RI #15's) room to change (him/her) to get (him/her) up for activities . I said a few words like I was tired from . doing a double on the previous shift from the day before and I wasn't directly saying it to (RI #15) just whisper it under my breath due to the frustration .<br><br>During an interview with the Administrator (ADM) on 03/21/2025 at 5:38 PM the ADM was asked about CNA #10's abuse training/orientation. The ADM said, the training for Abuse prevention, recognizing, and reporting abuse was done online. When asked what actions had been implemented by the facility to address staff on resident abuse, the ADM stated monthly in-services on abuse. When asked what type of supervision or monitoring was in place for staff who worked double shifts or extras hours, to make sure they were not burned out, frustrated, or too tired, ADM stated, they did not have a plan in place. The ADM said, overtime and abuse were discussed in (town) meetings monthly. The ADM was asked what type of training the staff received related to burnout or frustration after working increased hours and he stated there was no training or process for staff to express concerns.<br><br>An interview was conducted on 03/22/2025 at 12:35 PM with Social Services Director (SSD). The SSD said, she had that position since January 6, 2025. The SSD said she had not received training on the facility's abuse policy.<br><br>(continued on next page) |

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| F 0943<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with the Director of Nursing (DON) on 03/22/2025 at 5:51 PM, the DON was asked who was responsible for orientation of SSD on abuse upon hire. She stated it could be any of management, but the Administrator would be responsible since he was the abuse coordinator. The DON was asked where there would be evidence that SSD was instructed on abuse training; she stated, it should be in the personnel file.<br><br>On 03/23/2025 at 12:40 PM the Personnel File was received for SSD from the Administrator, for review. When asked if the SSD was present, he stated, no but he could get her to come to facility as soon as possible.<br><br>On 03/23/2025 at 1:20 PM the SSD arrived at the facility and an interview was conducted. The SSD was shown the abuse policy training titled Abuse Inservice Highlights with the SSD initials on each section and the SSD signature along with the date 01/08/2025. The SSD was asked if the initials and signature on the Abuse Policy were hers and she stated, yes. When asked who witnessed the signature, the SSD stated it was the Human Resources (HR) Director. The SSD was asked, when she signed the policy, to which she replied, this morning, 03/23/2025. The SSD was asked to verify the date on the Abuse training from her personnel folder and she stated 01/08/2025. When asked about the date, the SSD said, she asked what date to put on there and they said 01/08/2025, they told me to back date it.<br><br>On 03/23/2025 at 5:45 PM an interview was conducted with the Human Resources Director (HR). The signed Abuse Inservice Highlights for the SSD was shown to the HR. When asked when it was signed and dated, the HR stated they both signed the policy on today. The HR said, it was assigned to the SSD on 01/06/2025 for online training but she did not complete the task. The HR was asked who instructed her to contact the SSD and she stated, the ADM contacted her on 03/22/2025 and stated he needed the SSD's personnel file and particularly needed her abuse training. The HR said, when she arrived, she saw the SSD had not signed off on her Abuse Training. The HR said, the SSD did not read and sign the abuse policy until today, which was the mandatory nursing training which included abuse training and residents' rights.<br><br>51942 |