

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  015109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/22/2024
NAME OF PROVIDER OR SUPPLIER  Civic Center Health and Rehabilitation, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 22nd Street North Birmingham, AL 35234	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, resident record review, review of an Employee file, and review of a facility policy titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation, the facility failed to ensure an allegation of exploitation was reported to the State Agency after the Administrator/Abuse Coordinator was made aware on 10/18/2023 of Licensed Practical Nurse (LPN) #13 taking money from Resident Identifier (RI) #27 on multiple occasions.</p> <p>This deficient practice affected RI #27, one of nineteen sampled residents and one of five residents investigated for abuse.</p> <p>Findings include:</p> <p>This tag was cited as a result of the investigation of complaint/report number AL00047241. The State Agency received the complaint on 03/15/2024 with the allegation that LPN #13 was terminated from the facility in the fall of 2023 because LPN #13 borrowed \$500.00 from RI #27.</p> <p>Review of a facility policy titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation with an effective date of 02/08/2018 revealed:</p> <p>. E. Exploitation is taking advantage of a resident/guest for personal gain through use of manipulation, intimidation, threats, or coercion. An example is monetary assistance provided to staff after informing resident/guest that they are in a financial crisis, gifts to staff by resident/guest(s) based on staff persuasion.</p> <p>VI. a) The facility will report all instances of alleged or suspected abuse, including . exploitation and misappropriation of resident/guest property in the following manner:</p> <p>b) Investigation and Reporting Steps .</p> <p>The Administrator/Designee will report to the State Agency . per regulations.</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  015109	Facility ID:  015109  If continuation sheet Page 1 of 5

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of LPN #13's employee file revealed a facility form titled CONFERENCE REPORT dated 10/18/2023. The report documented a violation as follows: . Type A Violation #20: Engaging in fraudulent Activity by violating our Corporate Compliance Policy and Procedure: (LPN #13) . on multiple occasions took money from the resident . This activity was overheard by another Resident, the roommate and reported the activity to the Administrator. When the Resident . was questioned (he/she) acknowledged (he/she) would give her the money that was in (his/her) billfold when (he/she) was asked. (He/She) stated this occurred on multiple occasions. HR was notified and informed of the situation, they were in agreement with termination.</p> <p>RI #27 was admitted to the facility on [DATE] and a readmit date of 09/10/2018.</p> <p>On 03/22/2024 at 12:50 PM an interview was conducted with the Abuse Coordinator (AC)/Administrator (ADM). The ADM said, she had talked to RI #27 and was told that LPN #13 would ask for money and RI #27 would give her money. The ADM stated, the incident had not been reported to the State Agency but LPN #13 was terminated. The ADM stated, the situation should have been reported to the State Agency because it was regulatory and there was a concern of it not being reported.</p> <p>On 03/22/2024 at 04:00 PM an interview was conducted with RI #27. RI #27 stated, he/she would give money to LPN #13 when she needed it. RI #27 stated, he/she would only give LPN #13 a little money at a time, like \$30.00, and LPN #13 had a bad home life and needed money to come to work.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, resident record review, and review of a facility policy titled Incidents and Accidents the facility failed to ensure Resident Identifier (RI) #81 and RI #26 was not left alone after being dropped off unaccompanied at a local health clinic on 01/25/2024.</p> <p>This affected 2 of 4 residents sampled for accident concerns.</p> <p>Findings include:</p> <p>On 01/25/2024 at 12:42 PM, the State Survey Agency received an initial report from the facility via the Online Incident Reporting System regarding an allegation of possible abuse-neglect that occurred on 01/25/2024 at approximately 10:30 AM. According to this initial report, RI #81 was transported to a local hospital medical clinic on 01/25/2024 at 7:15 AM unattended. The driver escorted RI #81 into the clinic and returned to the facility at approximately 7:35 AM to pick up RI #26 for an appointment at the same clinic. When the driver to with clinic he saw RI #81 standing outside the clinic in the rain.</p> <p>A facility policy titled Incidents and Accidents with an effective date of 11/10/2014 documented: . The resident/guest environment remains as free of accident hazards as is possible, . An incident is an occurrence that may not be consistent with the routine operation of the facility or the routine care of a particular resident/guest.</p> <p>RI #81 was admitted to the facility on [DATE].</p> <p>RI #81's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/05/2023, documented a Brief Interview of Mental Status (BIMS) score of 12, indicating moderate cognitive impairment.</p> <p>RI #26 was re-admitted to the facility on [DATE].</p> <p>RI #26's quarterly MDS assessment with an ARD of 10/26/2023 documented RI #26 had both long and short term memory problems and moderately impaired cognition.</p> <p>An interview was conducted with RI #81 on 03/18/2024 at 4:49 PM. RI #81 stated, she arrived at the clinic on 01/25/2024, and was the first one there. RI #81 said, the secretary at the clinic stated they did not open until 8:00 AM, so RI #81 explored the building upstairs before going outside and then waited outside for the driver. RI #81 continued, when he arrived with another resident, they went inside for the appointment. RI #81 added, once inside, an employee of the facility joined the appointment, and they were transported back to the facility afterwards.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/19/2024 at 2:46 PM, an interview was conducted with the Transport Driver. He said, on 01/25/2024, he accompanied RI #81 to the clinic for an appointment. He opened the door for RI #81 and RI #81 proceeded to the front desk where to sign in. After that, the driver said, he returned to the facility and picked up RI #26 for an appointment at the same clinic. Upon his return, he noticed RI #81 was walking outside in the misting rain. He observed RI #81's clothes were damp from standing in the rain. The driver then escorted both residents into the clinic for their appointments.</p> <p>On 03/20/2024 at 11:25 AM, an interview was conducted with Certified Nursing Assistant (CNA) #14. CNA #14 reported that she had arrived at work on 01/25/2024 around 8:00 AM and she was informed there was no staff present for RI #81 and RI #26 at their scheduled appointment. CNA #14 said, she then proceeded to the clinic and stayed with the residents until the driver arrived to transport both residents back to the facility, and she followed in her own vehicle. CNA #14 said, that her duty during resident appointments was to ensure their safety and prevent them from wandering off.</p> <p>On 03/20/2024 at 12:13 PM CNA #9 was asked about residents going out for appointments. CNA #9 said, she arranges staff schedules to accompany residents to medical appointments. She recalled an incident on 01/25/2024, when a CNA was supposed to accompany RI #81 and RI #26 to their appointment but called off. CNA #9 discovered that the residents had gone to the appointment unaccompanied when she arrived at around 8:00 AM. CNA #9 said, she then assigned another staff member to go with the residents. When questioned about why the residents were sent without a staff member, she attributed it to bad weather causing and staff calling out.</p> <p>On 3/20/2024 at 12:43 PM, an interview was conducted with the charge nurse, a Registered Nurse (RN) #15. During the interview, RN #15 said, on 01/25/2024, when he arrived at work, the transportation driver was present to pick up RI #81 and RI #26. According to him, the driver initially left with RI #81 and later returned for RI #26. He stated, no employee accompanied RI #81 when they left, and there was no employee following behind the transport van. The RN supervisor said, it was the facility's policy to have staff accompany residents to their appointments. RN #15 said, he assumed he CNA was to accompany residents at the appointment and he did not know she had called out.</p> <p>On 03/20/2024 at 2:57 PM an interview was conducted with the Administrator. She said, sending staff with residents to appointments had always been a practice to ensure continuity of care. She said the facility had no written policy regarding this but sending staff with residents to appointments had been consistently implemented by the facility. The administrator explained that the reason RI #81 and RI #26 were sent without a staff member on 01/25/2024 was due to the confusion with the call offs. When asked how the process has changed since this incident, she said, it was the same but they were more cautious.</p> <p>This deficiency was cited as a result of complaint/report number AL00046869.</p> <p>*****</p> <p>The facility took immediate actions to correct the non-compliance and prevent reoccurrence by:</p> <p>- On 01/25/2024, the facility became aware of a resident being left at an appointment by there selves at a local hospital clinic. The resident did walk out of the lobby and outside in the misting rain. The resident stood outside until the driver returned with a second resident. Both residents were then walked into the clinic</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- A report was made to the Alabama Department of Public Health on 01/25/2024.</p> <p>- On 01/25/2024 an In-service began with License Nurses, and the Lead CNA who sets up staff to go on appointments with instructions for any time a resident leaves the facility for an appointment staff is always to accompany the resident and residents should never go to an appointment unaccompanied by a staff member. Completed 01/25/2024.</p> <p>- Monitoring began on 01/25/2024 at stand down regarding resident appointments and staff attending. Monitoring continued for four weeks with no issues. The facility continues to monitor resident appointments during AM and PM meetings; Monday - Friday.</p> <p>- Compliance has been met with no further concerns identified.</p> <p>*****</p> <p>After review of documentation supporting the above corrective actions, including the facility's investigation file, and in-service/education records, the survey team verified the facility implemented corrective actions including monitoring that began 01/25/2024, thus F689 was cited at past non-compliance.</p>