STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Haven Health and Rehabilitation, LLC	2201 32nd Street Northport, AL 35476

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interviews, record review, and review of the facility's policy, the facility failed to ensure one (Resident #146) of two sampled residents reviewed for urinary catheter had a comprehensive care plan to direct staff how to care for the resident's suprapubic catheter. Findings included: Review of a facility policy titled, Person Centered Care Plans, with an effective date of 08/15/2018, indicated . Person centered plans of care are developed by the interdisciplinary team, to coordinate and communicate care approaches and goals of the resident/guest . The policy specified, .According to federal regulations, the facility develops a comprehensive person centered plan of care for each resident/guest that includes measurable objectives and timetables to meet a resident/guest(s) medical, nursing and mental/psychosocial needs that are identified in the comprehensive assessment . A review of Resident #146's Face Sheet revealed the facility admitted Resident #146 on 10/15/2021 with diagnoses that included Hemiplegia following Cerebral Infarction Affecting the Right Dominant Side and Urinary Retention. Review of the significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/23/2023, revealed Resident #146 had a Brief Interview for Mental Status (BIMS) score of seven, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had an indwelling urinary catheter. Review of Resident #146's comprehensive care plan, revealed there was not a care plan that directed staff how to care for Resident #146's suprapubic catheter. During an interview on 07/21/2023 at 01:06 PM, the MDS Coordinator confirmed Resident #146's care plan did not address the care of the resident's suprapubic catheter. During an interview on 07/23/2023 at 8:13 AM, the Director of Nursing stated the care of the suprapubic catheter should be included in the resident's care plan. During an interview on 07/23/2023 at 8:20 AM, the Administrator stated the expectation was catheter care be care planned.

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: 015186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Haven Health and Rehabilitation, LLC	2201 32nd Street Northport, AL 35476

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 3. A review of a Face Sheet revealed the facility admitted Resident #146 on 10/15/2021 with a diagnosis of Hemiplegia Following Cerebral Infraction Affecting the Right Dominant Side. The resident was receiving hospice care and services per the document. A significant change MDS, with an ARD of 06/23/2023, revealed Resident #146 had a BIMS score of seven, which indicated the resident had severely impaired cognition. The MDS indicated the resident required extensive assistance with dressing and personal hygiene tasks. Review of Resident #146's Care Plan, with a start date of 06/15/2023, revealed the resident required staff assistance with all ADLs due to impaired mobility. An intervention in the plan directed staff to provide nail care as needed. On 07/18/2023 at 10:10 AM, CNA #40 was observed providing a bed bath for Resident #146. The resident's toenails and fingernails were observed to be long and jagged, with a brown substance underneath the fingernails. The toenails on the resident's great toes were observed to be very thick; the toenails on the other four toes were long and curled around the tips of the toes. The CNA stated the resident's toenails and fingernails needed to be trimmed and the nurse would have to trim them. On 07/20/2023 at 10:25 AM, Resident #146 was observed receiving wound care from LPN #36. After the wound care was completed, LPN #36 stated the resident's fingernails and toenails were long and needed to be trimmed. LPN #36 said the resident was not seen by the podiatrist because the resident was receiving hospice services and stated she would have to talk to the Director of Nursing (DON) to see what could be done. On 07/20/2023 at 12:31 PM, CNA #41 was interviewed and stated the CNAs were responsible for the care of the residents' fingernails and toenails, unless a resident was a diabetic, noting then the nurses would provide the nail care. On 07/20/2023 at 12:34 PM, CNA #24 was interviewed. CNA #24 stated hospice staff had completed Resident #146's morning care and bed bath. CNA #24 observed the resident's fingernails and toenails and stated they needed to be cut and cleaned. CNA #24 reported hospice staff should have taken care of the resident's nail care that morning, but noted she would trim them. On 07/20/2023 at 12:40 PM, RN #1 was interviewed. The RN was asked about Resident #146's fingernails and toenails. She stated she had not inspected the resident's nails during skin assessments but now noted the nails needed to be cleaned and cut. During an interview on 07/22/2023 at 10:10 AM, LPN #14, a unit manager, stated a podiatrist came to the facility. LPN #14 said she did not think Resident #146 could have their toenails trimmed by the podiatrist because the resident was receiving hospice care. LPN #14 stated staff could tell the hospice nurse to provide nail care and hospice staff could trim the resident's fingernails, but not the toenails. During an observation on 07/23/2023 at 10:29 AM, Resident #146's toenails and fingernails remained long and jagged. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2023
NAME OF PROVIDER OR SUPPLIER: Glen Haven Health and Rehabilitation, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 2201 32nd Street Northport, AL 35476	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/23/2023 at 10:39 AM, the Assistant Director of Nursing (ADON) stated the podiatrist had visited the facility the previous day and trimmed some residents' toenails and was due to come back on 07/23/2023. The ADON reported Resident #146 had not received services due to being on hospice. The ADON said the facility staff usually provided nail care. On 07/23/2023 at 10:40 AM, LPN #14, unit manager, was interviewed and stated anyone who provided care for a resident should address the resident's nail care. On 07/24/2023 at 7:58 AM, the DON was interviewed. The DON stated Resident #146 was placed on a list for toenail trimming by the podiatrist. On 07/24/2023 at 8:00 AM, the Administrator stated her expectation was that a resident's nails would be trimmed as needed or the resident would see the podiatrist if needed. 2. A review of a Face Sheet for Resident #152 revealed the facility admitted the resident on 12/10/2021 with diagnoses that included Cellulitis of the Right Lower Limb, Dementia, and Adult Failure to Thrive. A review of a quarterly MDS, with an ARD of 06/07/2023, revealed Resident #152 had a BIMS score of 13, which indicated the resident had intact cognition. The MDS indicated Resident #152 required extensive assistance from staff for the completion of personal hygiene tasks. A review of Resident #152's Care Plan, with a start date of 12/10/2021, indicated the resident required assistance to complete ADLs. Interventions directed staff to provide assistance with nail care as needed. A review of Resident #152's Departmental Notes for the timeframe from 06/01/2023 through 07/19/2023 revealed no documentation of care refusals. An observation was made on 07/18/2023 at 10:51 AM of the great toenail on Resident #152's right foot. The toenail extended approximately an inch beyond the toe. Resident #152 stated during the observation that their toenails had not been cut in a long time and added the toenails on the left foot were so long they curved under the toe. An interview was held with Resident #152 on 07/20/2023 at 8:45 AM, and the resident stated their toenails had not been trimmed since admission to the facility. An observation was made of Resident #152's toenails on 07/20/2023 at 8:45 AM. The surveyor was accompanied by CNA #25. The CNA stated the resident's toenails were long and needed to be trimmed. The CNA validated the resident had a right great toenail that was approximately one inch in length, along with a left fourth toenail that was approximately one inch in length. Resident #152's other toenails, while long and curling, were not quite as long as the right great toenail and the fourth toenail of the left foot. CNA #25 stated the CNAs were responsible for cutting toenails, but today was her first day working with Resident #152. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Haven Health and Rehabilitation, LLC	2201 32nd Street Northport, AL 35476

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

An interview was held with RN #15 on 07/20/2023 at 8:50 AM. RN #15 observed Resident #152's toenails and stated they needed to be clipped. RN #15 stated a podiatrist came to the facility, but the visits were sporadic. The RN stated that since Resident #152 did not have a diagnosis of diabetes, the staff could trim the resident's toenails and added she could give no reason why the toenails had not been trimmed.

An interview was held with LPN #7 on 07/20/2023 at 11:55 AM. LPN #7 stated there were residents on her assignment who refused care, but she did not identify Resident #152 as a resident who refused care. LPN #7 stated it was the responsibility of the podiatrist to trim resident toenails. LPN #7 stated she had not seen Resident #152's toenails in a while. LPN #7 added she was not sure if the nurses were allowed to clip the resident's toenails and added no one had reported that Resident #152's nails needed to be trimmed. LPN #7 observed Resident #152's toenails at that time and stated she had no idea the resident's nails were so long. LPN #7 stated that, if she had known, she would have asked the DON if she could cut the resident's toenails. LPN #7 stated she expected the CNAs to report to her when resident nails needed to be trimmed.

CNA #22 was interviewed on 07/21/2023 at 1:18 PM and stated she was the primary day shift nursing assistant for Resident #152. CNA #22 stated she had noticed that Resident #152's toenails were long and had reported the length of the toenails to LPN #7.

The DON was interviewed on 07/20/2023 at 12:05 PM and stated she expected the CNAs to report any toenails that required cutting to the nurse and added if a resident did not have diabetes the CNAs were able to cut their toenails. She added the nurses were also able to cut toenails. The DON observed Resident #152's toenails at that time and stated she would not have expected staff to allow the resident's toenails to get that long before they were trimmed.

Based on observations, interviews, record review, and facility policy review, the facility failed to provide timely nailcare for three (Residents #108, #152, and #146) of eight residents reviewed for activities of daily living (ADLs).

Findings included:

Review of a facility policy titled, Nail Care, dated 10/01/2010, indicated, .PURPOSE: Routine nail care helps reduce the potential for infection, prevents intrusion of the nail into the skin, prevents possible injuries and promotes a feeling of well-being for the resident. STANDARD: Nail care is a routine part of grooming each day. Foot care should be provided as a part of a tub or shower bath . Further review of the facility indicated, . It is recommended a Podiatrist provides foot care for residents with Diabetes or Peripheral Vascular Disease, and that a licensed nurse provide fingernail care for residents with those diagnoses .

1. A review of a Face Sheet indicated the facility admitted Resident #108 on 02/06/2020 and readmitted the resident on 05/19/2022 with diagnoses that included Dementia, Encephalopathy, Cerebral Infarction (stroke) with Left Sided Hemiplegia (weakness), Left Below the Knee Amputation (BKA), Right Above the Knee Amputation (AKA), and Type Two Diabetes Mellitus.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2023
NAME OF PROVIDER OR SUPPLIER Glen Haven Health and Rehabilitation, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2201 32nd Street Northport, AL 35476	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 06/28/2023, revealed Resident #108 had a Brief Interview for Mental Status (BIMS) score of three, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was totally dependent upon staff for dressing and personal hygiene. Review of Resident #108's Care Plan description, with a start date of 02/07/2020, revealed the resident required staff assistance with all ADLs related to decreased mobility, impaired cognition, impaired vision, left BKA, and right AKA. Interventions directed staff to assist with nail care. During observations on 07/18/2023 at 12:12 PM, 07/19/2023 at 1:20 PM, 07/20/2023 at 8:39 AM, 07/21/2023 at 9:15 AM, and 07/22/2023 at 10:46 AM, Resident #108's fingernails were long, extended past the fingertips, and curved back into the skin of the resident's fingers. Documentation of Resident #108's ADL care for July 2023 was requested from the facility on 07/25/2023 at 11:07 AM, and Registered Nurse (RN) #15 stated they did not have those documents available. During an interview on 07/22/2023 at 8:57 AM, RN #13 stated she was not sure how often nail care was supposed to be provided but thought it should be done as needed. During an interview on 07/22/2023 at 9:57 AM, Licensed Practical Nurse (LPN) #14 stated nail care should be provided when it needed to be done and the fingernails should not be allowed to get long enough that they were curving back into the skin of the fingers. During an interview on 07/22/2023 at 10:53 AM, Certified Nursing Assistant (CNA) #23 stated she had worked at the facility for 17 years. She stated nail care was to be provided on the evening shift at least once a week. She stated if a resident was diabetic a nurse should trim the nails. CNA #23 stated Resident #108's nails needed to be cut by the evening nurse since the resident was diabetic. She stated she told the day shift nurse that morning that Resident #108's nails needed to be trimmed so the nurse could pass it on to the evening nurse. During an interview on 07/22/2023 at 10:57 AM, after the Director of Nursing (DON) made an observation of Resident #108's fingernails, the DON stated the resident's nails were too long, needed to be trimmed, and she would make sure the nails were cut. She stated nail care should be provided as needed and the resident's nails should not have been allowed to get that long. She stated she was not able to say why the nail care was not provided. She stated it was the responsibility of the nurse on the hall where the resident resided to make sure nail care was performed. During an interview on 07/22/2023 at 3:21 PM, LPN #2 stated nail care should be provided as needed. She stated if the resident was diabetic, then the nurse would need to cut the nails; otherwise, a CNA should do it during the resident's bath. She stated any nurse could cut the resident's nails, and it was not assigned to a certain shift. She stated she was not aware Resident #108's nails needed to be cut. During an interview on 07/24/2023 at 9:09 AM, LPN #7 stated nail care was provided on Sundays on the evening shift by the CNAs unless the resident was diabetic, noting then the nurse was responsible. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Haven Health and Rehabilitation, LLC	2201 32nd Street Northport, AL 35476

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/24/2023 at 9:24 AM, the DON stated nailcare should be provided as needed, and the CNAs should be checking the residents' nails during the bath. The DON said any staff member could provide nail care unless the resident was diabetic or on a blood thinner, and then a nurse should provide the nail care. The DON stated she did not know why Resident #108's nails were so long. During an interview on 07/24/2023 at 9:58 AM, the Administrator stated nail care should be provided when it was needed. She stated if the resident was diabetic, the nurse or podiatrist should provide the nail care. She stated RNs were responsible for ensuring nail care was provided. During an interview on 07/25/2023 at 9:27 AM, the Administrator reiterated that nail care should be provided as needed. She stated Resident #108's fingernails should have been cut before they got so long. She stated the staff would need to be reeducated to provide nail care when it was needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2023
NAME OF PROVIDER OR SUPPLIER Glen Haven Health and Rehabilitation, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2201 32nd Street Northport, AL 35476	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to check the pacemaker function as ordered for discharged Resident #428, Resident #11, and Resident #93, three of seven sampled residents identified by the facility as having a pacemaker. Resident #428 had a physician's order to check the function of their pacemaker (a small electronic device, implanted in the chest to regulate the heart's rhythm) every month. The facility did not have evidence to indicate the resident's pacemaker was checked monthly as ordered by the physician from April of 2021 until after discharge on [DATE]. On [DATE], Resident #428 was found unresponsive, pale in color, with a heart rate of 38 beats per minutes (a normal resting heart rate range for adults range from 60 to 100 beats per minute). The resident was transferred to the local hospital for further evaluation. At the hospital, Resident #428 was profoundly bradycardic (heart rate slower than 60 beats per minute) and his/her pacemaker not functioning properly. Resident #11 and Resident #93 also had physician's orders to check the function of their pacemaker. Interviews with facility staff revealed these resident's pacemaker was not checked as ordered by the physician. 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 to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25 (Quality of Care) at a scope and severity of K. On [DATE] at 1:00 PM, the Administrator, Regional Administrator, Regional Nurse Consultant, and the Director of Nursing (DON) were provided the IJ template and notified of the findings at substandard quality of care at the immediate jeopardy level in the area of Quality of Care at F684-Quality of Care. The IJ began on [DATE] and continued until [DATE] when survey team verified onsite that corrective actions had been implemented. On [DATE] the immediate jeopardy was removed, F684 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. Findings included: Cross Reference F867 QAPI/QAA Improvement Activities and F726 Competent Nursing Staff. 1. A review of Resident #428's Face Sheet revealed the facility admitted the resident on [DATE]. Resident #428 had diagnoses that included Atrial Fibrillation (an abnormal rhythm of the heart) and Presence of a Cardiac Pacemaker. Resident #428 was discharged on [DATE]. A review of Resident #428's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], indicated the resident had a Brief Interview for Mental Status (BIMS) score of four, which indicated Resident #428 had severe cognitive impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2023
NAME OF PROVIDER OR SUPPLIER: Glen Haven Health and Rehabilitation, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 2201 32nd Street Northport, AL 35476	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident #428's Care Plan(s), with a review date of [DATE], indicated the resident had a potential for alteration in their cardiac function related to a pacemaker. The goal was for no complications related to the pacemaker as evidenced by a heart rate within normal limits. Interventions directed staff to check the pacemaker per schedule. A review of Resident #428's Physician Orders, for [DATE], indicated an order dated [DATE] to check the resident's pacemaker every month. A review of Resident #428's Departmental Notes, dated [DATE] - [DATE], revealed no evidence the resident's pacemaker was checked. A review of Resident #428's Departmental Notes, dated [DATE] at 2:39 PM, indicated the resident was found sitting on the side of their bed with their eyes closed and breathing through his/her mouth. The resident did not respond to sternal (chest) rub, was pale in color and had a heart rate of 38 beats per minute (normal range is 60 beats to 100 beats per minute). Per the note, the resident was transferred to the hospital for further evaluation. A review of the hospital Emergency Department Note, dated [DATE], indicated Resident #428's chief complaint as arrhythmia (abnormal heart rhythm)/palpitations (the perceived abnormality of the heartbeat characterized by hard, fast, or irregular beats). Per the note, the resident's heart rate was 37 bpm. The Medical Decision Making (MDM) indicated, Resident #428 arrived at the hospital profoundly bradycardic. The MDM further specified, a doctor evaluated the resident and found the resident's pacemaker did not function properly. A telephone interview was held with a family member (FM) of Resident #428 on [DATE] at while a resident of the facility. The FM stated on [DATE], the facility called and informed them Resident #428 had been found unconscious and would be sent to the hospital. The FM said when they arrived at the hospital, the resident's heart rate was 30 beats per minute and the resident immediately received a new pacemaker due to one of the pacemaker's leads not functioning. The FM stated the resident expired about a week after she was hospitalized and during that time developed blood clots in her legs and lungs. In an interview on [DATE] at 8:10 AM, Registered Nurse (RN) #15/Unit Manager, stated a resident's pacemaker was ordered by the physician to be checked either once a month or every three months. RN #15 stated checking a resident's pacemaker was the responsibility of the assigned nurse or the unit manager. RN #15 stated she expected the resident's pacemaker check to be recorded in the nurse's note. RN #15 reviewed the orders for Resident #428 and stated since the resident's order had a specific date of the 8th of the month and a time, the order should have been transferred to the MAR for the 8th of every month on the 7-3 shift. RN #15 reviewed Resident #428's Medication Administration Record (MAR) and the nurse's (departmental) notes for [DATE], [DATE], and [DATE] and stated she was unable to find any information that indicated the resident's pacemaker had been checked. Licensed Practical Nurse (LPN) #14 was interviewed on [DATE] at 10:17 AM. She stated she worked with Resident #428 as the resident's primary nurse at least five days a week for six years. LPN #14 stated she did not check Resident #428's pacemaker function. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2023
NAME OF PROVIDER OR SUPPLIER: Glen Haven Health and Rehabilitation, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 2201 32nd Street Northport, AL 35476	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 1:20 PM the Director of Nursing (DON) stated she was unable to find any information in Resident #428's medical record to support the facility completed pacemaker checks for the resident. A telephone interview was conducted on [DATE] at 4:30 PM with the Device RN from Resident #428's cardiologist office. The RN stated he expected all physician orders to check pacemakers to be followed. He stated it was not acceptable for the facility to not check Resident #428's pacemaker after the last cardiology visit in April of 2021 and until the [DATE] hospitalization. The RN stated a pacemaker malfunction could be detected during a pacemaker check. The Device RN also stated, any traumatic event or fall could damage or break a pacemaker wire and result in an immediate problem with the pacemaker. He stated there were no documented falls for Resident #428, so one would believe the wires on the resident's pacemaker were worn. The RN stated a resident could maintain a normal pulse range and still have a worn pacemaker lead or a malfunctioning pacemaker. Per the RN, it was possible if Resident #428 had regular pacemaker checks the malfunction could have been detected and Resident #428's emergent pacemaker replacement and accompanying problems could have been avoided. In a follow-up interview on [DATE] at 8:00 AM, the DON stated the facility did not have a policy on pacemakers. The DON reported she was not aware the resident's pacemaker was not checked as ordered. The DON explained she could not answer why the resident's pacemaker was not checked as ordered and care planned. Per the DON, the last time the resident's pacemaker was checked was in [DATE], when the resident's family took to resident to see the cardiologist (a doctor who specialized in treating diseases of the cardiovascular system, mainly the heart and blood vessels). In another interview on [DATE] at 9:20 AM, the DON stated she expected staff to follow through on all physician's orders. The DON stated was unable to recall any details about Resident #428's transfer to the hospital on [DATE]. The Administrator was interviewed on [DATE] at 9:59 AM, the Administrator stated she expected physician's orders to be followed. During an interview on [DATE] at 10:36 AM, Resident #428's primary physician stated he expected physician's orders to be followed. 2. A review of Resident #11's Face Sheet indicated the facility admitted the resident on [DATE] with diagnoses that included Thoracic Aortic Aneurysm, Chronic Systolic (Congestive) Heart Failure, Hypertensive Heart Disease, and a Cardiac Pacemaker. A review of Resident #11's quarterly MDS, with an ARD of [DATE], indicated Resident #11 had a Brief Interview for Mental Status BIMS score of 14, which indicated the resident was cognitively intact. A review of Resident #11's Care Plan (s) with a start date of [DATE] and a review date of [DATE], indicated the resident had an alteration in cardiac function related to a pacemaker. Interventions directed staff to check the pacemaker per schedule. A review of Resident #11's Physician Orders, for [DATE], indicated an order dated [DATE] to check the resident's pacemaker every three months in June, September, December, and March. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2023
NAME OF PROVIDER OR SUPPLIER Glen Haven Health and Rehabilitation, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2201 32nd Street Northport, AL 35476	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 9:13 AM, Resident #11 stated it had been a while since their pacemaker was checked. RN #15/Unit Manager stated she was unsure when the resident's pacemaker was checked. 3. A review of Resident #93's Face Sheet revealed the facility admitted the resident on [DATE] with diagnoses of Vascular Dementia and Encounter for Checking and Testing of Cardiac Pacemaker Pulse Generator. A review of Resident #93's quarterly MDS, with an ARD of [DATE], revealed Resident #93 had a BIMS score of three, which indicated the resident had severe cognitive impairment. A review of Resident #93's Care Plan(s), with a start date of [DATE], revealed the resident had potential for alteration in cardiac function related to a pacemaker. Care plan interventions directed the staff to the resident's pacemaker per schedule. A review of Resident #93's Physician Orders, for [DATE] revealed an order dated [DATE] to check the resident's pacemaker every month. A review of Resident #93's Departmental Notes, from [DATE] to [DATE] revealed no evidence of documentation denoting the resident's pacemaker was checked. During an interview on [DATE] at 7:37 AM, LPN #8 revealed when Resident #93 was admitted to the facility in [DATE] the resident did not have a cardiologist and Resident #93 had not had a cardiologist since admission. LPN #8 further revealed she had never checked the pacemaker and thought the Registered Nurses checked the pacemaker but could not find any documentation the pacemaker had ever been checked. During an interview on [DATE] at 4:31 PM, Licensed Practical Nurse LPN #2 revealed she knew Resident #93 had a pacemaker, but she had never checked the function of the resident's pacemaker. In an interview on [DATE] at 2:48 PM, LPN #7, Unit Manager, stated she was not aware Resident #93 had a pacemaker. LPN #7 continued to say that there was not a task to check the pacemaker on the resident's MAR so she would not know to check it. During an interview on [DATE] at 4:35 PM, RN #3 stated she had never checked the function of a resident's pacemaker. On [DATE] at 2:50 pm a follow-up interview was conducted with LPN #14, Unit Coordinator. LPN #14 said the facility did not have a way to check residents' pacemakers. LPN #14 stated the only way staff would know that the resident needed a pacemaker check was if the cardiologist had called to schedule the check. During an interview on [DATE] at 2:55 PM, the Assistant Director of Nursing (ADON) stated she never noticed the resident's pacemaker was not checked every month. The ADON said she did not know why the order for a pacemaker to be checked every month did not come up on the MAR as a task. The nurses on the floor could not see the order and did not know to check the pacemaker monthly. The ADON said there was an issue with the pacemaker checks orders not being added to the MAR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2023
NAME OF PROVIDER OR SUPPLIER: Glen Haven Health and Rehabilitation, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 2201 32nd Street Northport, AL 35476	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a follow-up interview on [DATE] at 9:11 AM, the DON stated the facility had quarterly care plan meetings in which staff reviewed the resident's physician's orders and care plan. Per the DON, in these meetings, nursing staff should have identified the physician's orders were not being completed. In an interview on [DATE] at 10:10 AM, the Administrator revealed the electronic MAR was not showing the physician's order to check the pacemaker monthly. The Administrator stated quarterly meetings are held with staff from all disciplines and during the meeting monthly orders should be checked to assure the orders were being implemented. The Administrator said staff missed that the pacemaker was not being checked and acknowledged the facility missed the fact Resident #93's pacemaker was not checked monthly. ** On [DATE] the facility submitted the following acceptable Removal Plan: 1. Registered Nurse Unit Managers, Director of Nursing and/or Assistant Director of Nursing notified the cardiologist/physician for the [three] residents identified to verify orders for monitoring of pacemaker checks and specific equipment needed. Registered Nurse Unit Managers initiated contact with three equipment companies on [DATE] to obtain pacemaker monitoring device. The necessary equipment has been ordered for eight residents whose pacemakers cannot be checked remotely. If the equipment does not arrive, Registered Nurse Unit Manager or Director of Nursing or Assistant Director of Nursing/Designee, will contact the specific pacemaker device company to complete an onsite pacemaker check. All pacemakers were checked between [DATE] - [DATE]. All were found to be in good working order. The physician indicated to check the resident's pacemaker function again, monthly, or quarterly, as indicated per physician orders based on the residents' specific needs. 2. To ensure all pacemakers were checked as ordered while awaiting the ordered equipment, the Administrator contacted a Medtronic pacemaker representative via phone on [DATE], and the representative made a facility visit to check pacemakers for 10 residents whose pacemakers cannot be checked remotely on [DATE]. The remaining three residents had their pacemakers checked onsite, with the results sent to the facility on [DATE]. The Administrator verified all residents with pacemakers had their devices checked, either onsite or remotely, on [DATE]. No concerns were identified with the pacemakers or the residents during the checks. 3. Registered Nurse Unit Managers reviewed the medical record and identified nine additional residents within the facility with pacemakers, for a total of 13 current residents with pacemakers. This review was completed by the Registered Nurse Unit Managers on [DATE]. 4. The facility has developed and implemented, on [DATE], a pacemaker policy related to the checking of pacemakers and documenting the pacemaker checks on the resident's medication administration record to ensure pacemakers are monitored at prescribed frequency. 5. Licensed nurses will be responsible for completion of the pacemaker checks per the care plan, documenting the pacemaker checks on the medication administration record per the care plan and the Registered Nurse Unit Manager or Director of Nursing or Assistant Director of Nursing/Designee will verify the checks have been completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Haven Health and Rehabilitation, LLC	2201 32nd Street Northport, AL 35476

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. The Director of Nursing, Assistant Director of Nursing, and Registered Nurse Unit Managers will be educated on [DATE] by the Regional Nurse Consultant/designee regarding following physician orders related to monitoring of pacemaker checks and obtaining necessary equipment when needed. 7. All licensed staff, to include contract nurses, will be educated by the Director of Nursing/designee regarding following physician orders related to monitoring of pacemaker checks and necessary equipment needed. This education will be initiated on [DATE]. This education will be provided to staff prior to their next scheduled shift. In addition, education will be added to new licensed staff orientation. As of [DATE] at 5:00 PM, 14 of 21 LPNs and 12 of 16 RNs have received the education. Licensed nurses working the night shift and weekends will be educated by the Director of Nursing or Assistant Director of Nursing or Registered Nurse Unit Managers/Designee prior to their next shift. 8. New admissions/readmissions will be reviewed daily, seven days a week by the Registered Nurse Unit Manager or Director of Nursing or Assistant Director of Nursing/Designee, to ensure Physician orders are initiated for residents with pacemakers to include how to perform specific device pacemaker checks and ensure necessary equipment is available. After review, any resident admitted with pacemaker will have orders obtained for monitoring and needed equipment. 9. Based on the actions listed above the completion date of this plan is [DATE]. The immediacy of the IJ was removed on [DATE]. ******************** On [DATE], after reviewing the facility's information provided in their Removal Plan and verifying the immediate actions had been implemented, the scope/severity level of F684 was lowered to E, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2023
NAME OF PROVIDER OR SUPPLIER Glen Haven Health and Rehabilitation, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2201 32nd Street Northport, AL 35476	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interviews, record review, and facility policy review, the facility failed to ensure urinary catheter tubing was secured in a manner to prevent trauma to the urethra for one (Resident #31) of four sampled residents reviewed for urinary catheter. Findings included: Review of a facility policy titled, Urinary Catheter Care, with an effective date of 11/10/2014, indicated, . Secure the catheter with a leg band or loop to the bed sheet in a comfortable position for the resident/guest . A review of Resident #31's Face Sheet indicated the facility admitted Resident #31 on 06/23/2023, with diagnoses that included Retention of Urine. Review of the admission Minimum Data Set (MDS), with an Assessment Review Date (ARD) of 06/29/2023, revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS indicated the resident had an indwelling urinary catheter. Review of Resident #31's Care Plan(s), with a start date of 06/24/2023, indicated the resident had an indwelling urinary catheter related to a diagnosis of urinary retention. Interventions directed staff to use a leg strap to secure the resident's catheter tubing. During an observation on 07/25/2023 at 11:17 AM, Resident #31 was observed seated in a wheelchair with their urinary catheter collection bag positioned on the side. The resident's catheter tubing was not secured using a leg strap or another device. Certified Nursing Assistant (CNA) #18 confirmed the resident's catheter tubing was not secured. According to CNA #18, it was the nurses' responsibility to apply the leg strap that secured the resident's catheter tubing. During an interview on 07/23/2023 at 8:15 AM, the Director of Nursing stated it was her expectation that all indwelling urinary catheters and suprapubic catheter be secured with a leg strap or a stat lock.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2023
NAME OF PROVIDER OR SUPPLIER Glen Haven Health and Rehabilitation, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2201 32nd Street Northport, AL 35476	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on document review and interviews, the facility failed to train their nurses on how to perform a pacemaker check or have any documentation that a competency skill check was done to determine if nurses possessed the knowledge/skills to perform a pacemaker check. This failure had the potential to affect all 13 residents who resided in the facility identified as having a pacemaker. Findings included: Cross Reference F867 QAPI/QAA Improvement Activities and F684 Quality of Care. On 07/24/2023 at 10:26 AM, the Administrator presented the survey team with a list that indicated 13 residents, who resided in the facility, had a pacemaker (a small electronic device, usually placed in the chest to help regulate slow electrical problems with the heart). Resident #11 and Resident #93 both had a Physician Order to check their pacemaker and care planned intervention to check their pacemaker. A review of the Licensed Nurse Skills Competency Evaluation, revised 06/05/2018, did not indicate there was a skill check on how to perform a pacemaker check. Licensed Practical Nurse (LPN) #14 was interviewed on 07/22/2023 at 10:17 AM. She stated she had not received any training or validation of her competency skills to perform a pacemaker check since 2015. During an interview on 07/20/2023 at 4:31 PM, LPN #2 stated she had never received in-service on checking pacemakers. In an interview on 07/21/2023 at 2:48 PM, LPN #7, said there was never an in-service on how to check the pacemaker. During an interview on 07/20/2023 at 8:10 AM Registered Nurse (RN) #15/Unit Manager stated pacemakers were to be checked by physician's orders RN #15 stated checking pacemakers was the responsibility of the assigned nurse or the unit manager. In a follow-up interview on 07/21/2023 at 4:18 PM, RN #15 stated she only found out that week that she was responsible for checking the pacemakers. RN #15 said she had not received training on how to check the function of the pacemakers that were in use for the facility's residents. RN #15 stated she was aware how to check the function of a pacemaker from previous work experience, but no one at the facility had performed a competency skill check to ensure she checked a resident's pacemaker accurately. In an interview on 07/21/2023 at 8:00 AM, the Director of Nursing (DON) reported the facility did not have a policy on pacemakers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015186	A. Building B. Wing	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Haven Health and Rehabilitation, LLC	2201 32nd Street Northport, AL 35476

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/21/2023 at 3:18 PM, the DON the stated she did not remember the cardiac training provided to the nurses included how to check pacemakers. The DON reviewed the skills check list and confirmed there was nothing about pacemakers on the skills check list. The DON confirmed there were different types of checks for different types of pacemakers. The DON stated she expected the unit managers to make sure the pacemakers were checked as ordered. The DON stated RN #15 and RN #26, Unit Managers, had not been trained on the testing of the different types of pacemakers in the facility. During an interview on 07/21/2023 at 4:02 PM, the Administrator stated she expected the nurses who were responsible for checking pacemakers to be trained on the different types of pacemakers. The Administrator stated she had not seen anything about how to check a pacemaker on the skills checklist for the nurses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Haven Health and Rehabilitation, LLC	2201 32nd Street Northport, AL 35476

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility policy, the facility's Quality Assurance Performance Improvement (QAPI) committee failed to thoroughly review all factors related to Resident #428 emergent discharge to the hospital on [DATE]. The facility QAPI committee further failed to develop and implement corrective action. Resident #428 had a physician's order to check the function of their pacemaker (a small electronic device, usually placed in the chest to help regulate slow electrical problems with the heart) every month. The facility did not have evidence to indicate the resident's pacemaker was checked as ordered by the physician after [DATE]. On [DATE], Resident #428 was found unresponsive, pale in color, with a heart rate of 38 beats per minutes (a normal resting heart rate range for adults range from 60 to 100 beats per minute). The resident was transferred to the local hospital for further evaluation and found the resident's pacemaker did not function properly. Following Resident #428's emergent discharge QAPI committee failed to identify his/her pacemaker had not been checked as ordered. Resident #11 and Resident #93 were found to have a pacemaker, orders to check the pacemakers, and no evidence the pacemakers were being checked as ordered. This failure to investigate and implement corrective actions to ensure resident's pacemakers were checked as ordered had the potential to affect the remaining six sampled residents who had a pacemaker and currently resided in the facility. 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 to residents. The Immediate Jeopardy was related to State Operations Manual, Appendix PP, 483.75 (Quality Assurance and Performance Improvement) at a scope and severity of K. On [DATE] at 1:00 PM, the Administrator, Regional Administrator, Regional Nurse Consultant, and the Director of Nursing (DON) were informed of the Immediate Jeopardy (IJ) situation. On [DATE] at 1:00 PM, the Administrator, Regional Administrator, Regional Nurse Consultant, and the Director of Nursing (DON) were provided the IJ template and notified of the findings at the immediate jeopardy level in the area of Quality Assurance and Performance Improvement at F867-QAPI/QAA Improvement Activities. The IJ began on [DATE] and continued until [DATE] when the survey team verified onsite that corrective actions had been implemented. On [DATE] the immediate jeopardy was removed, F867 remained at 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. Findings included: Cross Reference F684 Quality of Care and F726 Competent Nursing Staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2023
NAME OF PROVIDER OR SUPPLIER: Glen Haven Health and Rehabilitation, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 2201 32nd Street Northport, AL 35476	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a facility policy titled, Quality Assurance/Quality Assurance Performance Improvement, effected [DATE], indicated Policy: Our purpose is to provide excellent quality resident/guest services. Quality is defined as meeting or exceeding the needs, expectations and requirements of the resident/guest cost effectively while maintaining good resident/guest outcomes and perceptions of resident/guest care . The policy specified, .QAPI Plan address: a. Clinical Care - Monitor existing QM [quality measures] results, [corporation name] infonet monitors for . incident reports, infection reports, discharges . Per the policy, . Administration is responsible and accountable for developing, leading and closely monitoring of QAPI program . A review of Resident #428's Face Sheet revealed the facility admitted the resident on [DATE] with diagnoses that included Atrial Fibrillation and Presence of a Cardiac Pacemaker. Resident #428 was discharged on [DATE]. A review of Resident #428's Care Plan(s), with a review date of [DATE], revealed interventions that directed staff to check the pacemaker per schedule. A review of Resident #428's Physician Orders, revealed an order dated [DATE] to check the resident's pacemaker every month. A review of Resident #428's Departmental Notes, dated [DATE] - [DATE], revealed no evidence of documentation denoting the resident's pacemaker was checked. A review of Resident #428's Departmental Notes, dated [DATE] at 2:39 PM, indicated Resident #428 was unresponsive and had a heart rate of 38 beats per minute (normal range is 60 beats to 100 beats per minute). Per the note, the resident was transferred to the hospital for further evaluation. A review of the hospital Emergency Department Note, dated [DATE], indicated Resident #428's had a heart rate of 37. The Medical Decision Making (MDM) indicated; Resident #428 arrived at the hospital profoundly bradycardic. The MDM further specified, a doctor evaluated the resident and found the resident's pacemaker did not function properly. A review of Resident #428's Departmental Notes, dated [DATE] 12:03 AM, indicated Registered Nurse (RN) #52 received an update from the hospital the hospital regarding Resident #428's condition and was notified the resident had a diagnosis to include pacemaker lead failure. Per the note, the hospital staff notified the RN, Resident #428 had received a new pacemaker. A telephone interview was held with a family member (FM) of Resident #428 on [DATE] at 9:20 AM. The FM stated the entire time Resident #428 lived in the facility, they had no knowledge of the resident's pacemaker was checked. The FM stated the resident expired about a week after she was hospitalized and during that time developed blood clots in her legs and lungs. During an interview on [DATE] at 2:55 PM, the Assistant Director of Nursing (ADON) stated she never noticed the resident's pacemaker was not checked every month. The ADON said she did not know why the order for a pacemaker to be checked every month did not come up on the MAR (Medication Administration Record) as a task. The nurses on the floor could not see the order and did not know to check the pacemaker monthly. The ADON said there was an issue with the pacemaker checks orders not being added to the MAR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2023
NAME OF PROVIDER OR SUPPLIER Glen Haven Health and Rehabilitation, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2201 32nd Street Northport, AL 35476	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 1:20 PM the Director of Nursing (DON) stated she was unable to find any information in Resident #428's medical record to support the facility completed pacemaker checks for the resident. A telephone interview was conducted on [DATE] at 4:30 PM with the Device RN from Resident #428's cardiologist office. Per the RN, it was possible if Resident #428 had regular pacemaker checks the malfunction could have been detected and Resident #428's emergent pacemaker replacement and accompanying problems could have been avoided. In an interview on [DATE] at 8:00 AM, the DON reported she was not aware the resident's pacemaker was not checked as ordered. The DON explained she could not answer why the resident's pacemaker was not checked as ordered and care planned. Per the DON, the last time the resident's pacemaker was checked was in [DATE], when the resident's family took to resident to see the cardiologist (a doctor who specialized in treating diseases of the cardiovascular system, mainly the heart and blood vessels). The DON reported the facility did not have a policy on pacemakers. In a follow-up interview on [DATE] at 2:57 PM, the Administrator stated residents who were discharged /transferred were discussed in the facility's morning meetings to determine the reason for discharge/transfer. She stated the QAPI committee discussed specifics about each resident discharge/transfer. The Administrator indicated she was not the administrator at the time and the DON might have the QAPI review of Resident #428's transfer to the hospital. On [DATE] at 3:18 PM, the DON stated Resident #428's discharge was reviewed, but she was unable to recall anything that was discussed about the resident's discharge. The DON stated residents' discharges were reviewed each Monday, and the information discussed included an attempt to determine if the resident's discharge could have been prevented. The DON stated they tried to determine root cause and if the transfer could have prevented. The DON stated there were no changes implemented as a result of Resident #428's emergent transfer to the hospital. On [DATE] at 4:02 PM, the Administrator stated pacemakers were not discussed in the facility's QAPI meetings. *** On [DATE] at 10:22 AM, a Removal Plan was submitted by the facility and accepted by the state survey agency. The Removal Plan read as follows: 1. Those likely to suffer are the facility residents with the potential for any adverse reaction due to the failure to meet, discuss, and institute the collection of data and monitoring of other residents and processes. An emergency Quality Assurance and Performance Improvement (QAPI) meeting was held on [DATE] to address failure to meet, discuss, and institute collection of data and monitoring of other residents and processes related to an adverse event involving Resident #428 and failure to have a policy in place or defined process for pacemakers or checking pacemakers. It was determined that the root cause related to no pacemaker policy. The policy was developed and implemented on [DATE]. Those in attendance included the Regional Administrator, Regional Nurse Consultant, Regional Quality Assurance Nurse, Administrator, Director of Nursing, and Medical Director. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015186	A. Building B. Wing	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Haven Health and Rehabilitation, LLC	2201 32nd Street Northport, AL 35476

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. The Quality Assurance Committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, and Infection Control Preventionist) were reeducated on [DATE] by the Regional Director on policy and procedures of the QAPI meeting for consistent monitoring of QAPI programs to include Diagnostics, Event Reporting, Customer Relations, Policy and Procedure Review/Approval, Compliance/Regulatory, Rehospitalization, Other items Reviewed, Facility Assessment Results/Revisions/Annual Review, Action Plans, Survey Related Monitoring, Performance Improvement Project (PIP), and Emergency QAPI meeting minutes to ensure adverse events and quality deficiencies are identified, corrected, and monitored. 3. The Quality Assurance Committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, and Infection Control Preventionist) will monthly review the QAPI program to ensure quality deficiencies and adverse events are corrected and monitored. Findings will be submitted monthly, for three months, to the Regional Administrator, Regional Nurse Consultant, and Regional Quality Assurance Nurse for review and revision. Any concerns identified will be immediately addressed and education will be provided. 4. Based on the actions listed above, the completion date of this plan is [DATE]. The immediacy of the IJ was removed on [DATE]. *************************** On [DATE], after reviewing the facility's information provided in their Removal Plan and verifying the immediate actions had been implemented, the scope/severity level of F867 was lowered to E, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.