STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015217	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birmingham Nursing and Rehabilitation Ctr LLC	1000 Dugan Avenue Birmingham, AL 35214

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, review of a facility policy titled, ABUSE PREVENTION, review of Facility Reported Incidents (FRIs) received by the State Agency and review of the facility's investigative files, the facility failed to ensure residents in the facility were free from physical abuse perpetrated by other residents. The facility failed to protect (RI) #119's right to be free from physical abuse perpetrated by RI #78, a resident with a known history of Chronic Delusions, Psychosis, Restlessness, Agitation, and Dementia with Behavioral Disturbance. RI #78 was witnessed walking across the dining room and hit RI #119 in the right upper arm on 06/12/2025. The facility failed to assess and determine the level of staff supervision needed for RI #78, before and after the abuse, to prevent RI #78 from abusing others.Because the facility failed to assess and determine the level of supervision required for RI #78, address behaviors, and implement actions to prevent RI #78 from abusing other residents, on 09/15/2025 during the noon meal RI #78 was witnessed to get up from his/her chair; walk across the dining room and hit RI #13 in the left shoulder. Per the facility investigative file, five staff members who were present in the dining room during the abuse were not aware RI #78 approached and hit RI #13 until RI #13 yelled out. Another staff member, an Occupational Therapist (OT), who was present was the only staff member to witness what occurred. Staff interviewed said, a reasonable person in RI #13's situation would feel upset and confused. The facility failed to ensure the incidences of abuse perpetrated by RI #78 were reviewed and analyzed in a manner to determine causes and implement appropriate and effective corrective actions to prevent recurrence of abuse towards residents in the facility.This deficiency was cited as a result of the investigation of complaint/report numbers 462289 and 2619326 and had the potential to affect three of seven residents sampled for abuse. Findings Include: Cross - Reference F740 On 06/12/2025 at 11:35 AM the State Agency received a Facility Reported Incident (FRI) alleging physical abuse occurred when staff witnessed Resident Identifier (RI) #78 walk up to RI #119 and hit RI #119 in the right upper arm. RI #78 was admitted to the facility on [DATE] and had diagnoses to include Schizoaffective Disorder, Bipolar type, Dementia with Behavioral Disturbance, Restlessness, Agitation, and History of Mental and Behavioral Disorders. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RI #78's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/30/2025 documented a Brief Mental Status Score of 6 out of 15 which indicated severely impaired cognition. RI # 78's MDS documented RI #78 was resistive to care and wandered the facility one out of three days during the observation period. A review of RI #78's Level I determination dated 03/05/2021 documented the need for a Level II due to a serious Mental health diagnosis of Schizoaffective Disorder, Bipolar Disorder, and Psychotic Manic. RI #78's Level II determination dated 03/15/2021 recommended Psychiatric Follow up Care for Serious Mental Illness of Bipolar, Psychotic Manic, Schizoaffective Disorder (Symptoms Severe) which RI #78 had received since his/her initial evaluation from Integrative Behavioral Health on 02/04/2021. On 03/01/2021 RI #78's had a care plan initiated for a PASSRR Level 11 r/t (related to) serious mental illness, Bipolar, psychotic manic, schizoaffective disorder (symptoms severe). On 09/16/2024 RI #78's behavioral symptoms care plan was initiated of for focus areas of having a history of being verbally aggressive, cusses at staff, Dementia, Ineffective coping skills, Mental/Emotional Illness, poor impulse control. The care plan was last revised on 06/18/2025. On 09/16/2024 RI #78's care plan with a focus area of history of being physically aggressive, Dementia with behavior disturbance, schizoaffective disorder, bipolar disorder towards staff/other residents when agitated. The care plan was revised last on 06/18/2025. On 02/24/2024 RI #78 had a care plan initiated for focus areas of having delusions that he/she was working at the facility. RI #78's care plans did not contain any interventions to guide staff in the level of routine supervision RI #78 required to prevent him/her from abusing others. RI #119 was admitted to the facility on [DATE] and had diagnoses to include Schizophrenia, Chronic, Pain, Mood Disorder, and Intellectual Disabilities. RI #119's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/02/2025 documented a Brief Mental Status (BIMS) score of 13 out of 15 which indicated intact cognition. The facility investigative file contained a summary signed by the Administrator dated 06/19/2025 which documented: . I (ADM) was notified that (RI #78) had entered the dining room and had struck (RI #119) on the right upper forearm. (RI #78) stated that (RI #119) was in (his/her) business. (RI #78's) explanations then became inconsistent. The allegation that (RI #78) struck (RI #119) is substantiated. The facility investigative file contained a typed Witness Statement for RI #119 dated 06/12/2025 which included questions and answers as follows: . I was sitting at my table and (he/she) came up to me and said something about dipping in (his/her) business and then hit me on my arm. This arm. (Points to right upper arm. Upper arm examined.) . No I wasn't talking about (him/her). I wasn't doing anything. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/2025 at 3:45 PM an interview was conducted with RI #119 regarding the incident on the morning of 06/12/2025. RI #119 said he/she recalled the incident on 06/12/2025. When asked what occurred, RI #119 said that he/she was sitting in the usual spot in the dining room and RI #78 just came up and hit (him/her) in the shoulder unprovoked, it did not feel good. RI #119 said the hit hurt and that he/she had a sore arm for a while. The facility investigative file contained a typed Witness Statement for RI #78 dated 06/12/2025 which included questions and answers as follows: . I went in there and (he/she) was dipping in my business. My business. You know, just business. I just reached out and tapped (him/her) on (his/her) arm and told (him/her) to stop dipping in my business. Why would you even touch (him/her)? . Just a reflex. For dipping in my business. To tell (him/her) to stop. Contained within the facility's investigative file was a typed Witness Statement with the eyewitness, CNA #13, dated 06/12/2025, which documented the following questions and answers: . Did you observe an interaction between (RI #78) and (RI #119) this am? . Yes. (RI #78) walked in the dining room and walked up to (RI #119) and told (him/her) to stop dipping in (his/her) business and hit it. Opened hand with (his/her) right hand on (RI #119's) Left Shoulder. How did RI #119 react? . (He/she said OK you don't have to hit me. CNA #13 no longer works at the facility and the facility did not have a contact number. On 12/01/2025 at 3:35 PM an interview was conducted with CNA #7 who was familiar with RI #78's mood and behaviors. CNA #7 said RI #78 exhibited resistance to care often and that RI #78's mood/behaviors were unpredictable and would fluctuate daily. CNA #7 said she did not witness RI# 78 hit RI#119, but she was present when RI #78 hit RI #13 in the dining room on 09/15/2025. CNA #7 said one resident hitting another resident would be physical abuse and would make a person feel scared. When asked what level of supervision RI #78 would need to prevent him/her from hitting out at others, CNA #7 said, RI #78 would need someone all the time because RI #78's moods were always changing and unpredictable. On 12/01/2025 at 4:05 PM an interview was conducted with CNA #6 regarding the incident on 06/12/2025. When CNA #6 was asked if she had ever seen RI #78 hit anyone before, she stated no, but she had seen RI #78 get mad and curse at other residents. When asked what curse words RI #78 used, CNA #6 said called people the B word. CNA #6 said a resident hitting another resident is considered physical abuse. On 12/4/2025 at 12:53 PM an interview was conducted with the ADM regarding the abuse on 06/12/2025. The ADM said she was notified by LPN #14 of the of the allegation of physical abuse at 9:35 AM on 6/12/2025 that RI #119 was sitting in the dining room and RI #78 walked up and hit RI #119 in the right upper arm. The ADM said residents in the dining room were attended by staff for safety, residents were assessed for injury with none noted, notifications made, and RI #78 was placed on one-to-one supervision until sent out to the hospital for evaluation. When asked if the facility completed an assessment to determine the level of supervision needed after the incident, the ADM said there was no assessment, and RI #78 was placed on one-to-one supervision. The ADM said, RI #78 was determined to be appropriate for nursing home placement when the Level II was completed on admission. The ADM said the incident was investigated, taken to QAPI and the root cause analysis determined RI #78 was having pain related to medical issues. The ADM said the allegation that RI #78 struck RI #119 was substantiated based on her investigation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to assess and determine what level of staff supervision would be required for RI #78 to prevent further abuse of residents in the facility after the one-on-one supervision was discontinued on 06/17/2025. On 09/15/2025 at 1:55 PM the State Agency received a FRI alleging physical abuse occurred in the dining room when RI #13 said, OUCH and reported to staff that RI #78 had hit (him/her) on the left shoulder. RI #13 was admitted to the facility on [DATE] and had diagnoses to include Diabetes Mellitus with Diabetic Chronic Kidney Disease. RI #13's Quarterly MDS with an ARD of 09/04/2025 revealed a 12 out of 15 on the BIMS which indicates mild cognitive impairment. The facility investigative file contained a typed summary of the abuse signed by the ADM which documented: . During the lunch meal on 09/15/2025, (RI #13) stated that (RI #78) had hit (him/her) on the upper left arm. Staff heard (RI #13) say Ouch, I don't know your husband. The dining room was attended by 3 CNAs, DNS, Unit Manager, and an occupational therapist (OT). (RI #78) was immediately assisted form the dining room to (his/her) room for body audit and one:one supervision. An immediate investigation was started. The MD for both resident was notified. The Birmingham Police . was notified. (RI #78) was transferred to ER . and returned with no new orders. One:One supervision was maintained until 9/22/25. Upon investigation, it is noted that only 1 staff member saw the incident. The OT reported that she saw (RI #78) walking towards (RI #13) and told (him/her) something to the effect to get out of (his/her spouse's) face. Staff reports that (RI #78) had no symptoms of agitation as (he/she) approached (RI #13). OT reported that it looked like (RI #13) held (his/her) arm up in a defensive move and (RI #78) hit (RI #13) on the shoulder at the same time. Education for all staff was started on Preventative Measures – Resident to Resident Abuse. The Education was completed on 9/22/25. A QAPI (Quality Assurance Performance Improvement) meeting was held on 9/18/25. It is noted that (RI #78) was seen by . (behavioral health services) on 9/18/25 and medications were changed. (Behavioral health services) suggested (RI #78) remain on one:one supervision through the weekend. one:one was discontinued on 9/22/25 . The allegation of abuse of (RI #13) by (RI #78) is substantiated . On 12/01/2025 at 5:30 PM an interview was conducted with RI #13 regarding the incident on 09/15/2025. When RI #13 was asked what occurred, he/she said while eating lunch, RI# 78 came up from behind and poked him/her on the left arm and said to leave (his/her) man alone. RI #13 said he/she felt scared and confused as to why RI #78 would do this. RI #13 said the poke was not hard, but that it was very frightening because it was not expected. RI #13 said the staff intervened immediately and removed RI #78. Contained within the facility's investigative file was a typed interview with the eyewitness, Occupational Therapist (OT) #16, dated 09/15/2025, which documented the following questions and answers: . Were you working in the dining room at lunch today? . Yes.Did you observe and interaction between (RI #78) and (RI #13)? . Yes. (RI #78) got up from (his/her) chair at the table and walked over to (RI #13) and pushed or punched (his/her) shoulder. (He/she) said something along the lines of get out of my husbands face, something to that effect. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/2025 at 2:26 PM an interview was conducted with OT #16 regarding what she witnessed on 09/15/2025 in the dining room. OT #16 said that RI #78 was sitting in the back of the room at a table when RI #78 got up out of his/her chair and walked straight towards RI #13, and punched RI #13 on the shoulder, saying something along the lines of get out of my husband's face. OT #16 said she was seated to the left of the television, about 7 steps away from RI #13 and faced the back of the room, allowing her to see both RI #78 and RI #13. OT #16 said there were no indicators from RI #78 that it was about to occur (no cursing or yelling), but the actions appeared to be intentional and directed towards RI #13. OT #16 said RI #13 screamed and seemed upset and confused as to why RI #78 punched him/her in the shoulder. The OT said staff intervened immediately and provided separation. OT #16 said this would be categorized as physical abuse. When asked how a reasonable person may feel in this situation, OT #16 said upset and scared especially since the punch was unexpected. OT #16 said for this to be prevented, RI #78 would need supervision when out and about in the dining room or courtyard area where other residents are present. On 12/4/2025 at 12:53 PM an interview was conducted with the ADM regarding the incident on 09/15/2025. The ADM said she was notified at 11:55 PM on 09/15/2025 that RI #13 was heard to say OUCH, I do not know your husband and reported staff that RI #78 hit him/her on the left shoulder. ADM said there were no warning signs from RI #78, staff intervened, assessed residents and there were no injuries, and RI #78 was placed on one-to-one supervision. The Adm said the incident was investigated and taken to QAPI and the root cause analysis. The ADM said they determined the root cause to be environmental, including television noise, music and overall stimulation, and therefore implemented a quiet time during meals. The ADM said there have been no problems since this time. Based on her investigation, the ADM said the allegation of physical abuse that RI #78 hit RI #13 was substantiated.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, review of Facility Reported Incidents (FRI), review of the facility investigative files, review of a facility policy titled Abuse Prevention and review of a facility policy titled Behavior Management and Psychopharmacological Medication Monitoring Protocol, the facility failed to provide adequate supervision and ensure appropriate interventions were developed to manage RI #78's psychosis/delusional behaviors and ensure safety of residents in the facility. Because RI #78, a resident with a known history of chronic delusions/psychosis/restlessness/agitation, was not adequately supervised by staff, RI #78 hit RI #119 in the left shoulder on 06/12/25 and hit RI #13 on the left shoulder on 09/15/2025. This was discovered during investigations of abuse. Staff at the facility described RI #78's behaviors as unpredictable, difficult to pinpoint triggers, and to keep RI #78 from abusing other residents it would require supervision of RI #78 when out and about in the presence of other residents.This deficient practice affected RI #78 one of five residents sampled for behavioral health services. Findings Included:Cross Reference F600 A facility policy titled ABUSE PREVENTION dated 01/2025 documented the following: . PREVENTION: .5. Examples of steps that the facility may put in place immediately to prevent further potential abuse includes, but are not limited to, staffing changes, increased supervision, protection from retaliation, and follow-up counseling for the resident(s) . A facility policy titled Behavior Management and Psychopharmacological Medication Monitoring Protocol with an date of revision of 3/2018 documented: . PURPOSE: Residents with behaviors that are displayed routinely, that effect the resident's psychosocial well- being or that of other residents, or behaviors that can have potential for harm to self or others will be assessed with the development of a behavior program.DEFINITIONS: . Behavioral Interventions are individualized non -pharm logical approaches to care that are provided as part of a supportive physical and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities as well as maintaining or improving a resident's mental, physical or psychosocial well-being.PROCEDURE: .2. Established resident with new onset of adverse behaviors:d) The Interdisciplinary Care Team (IDT) will update the care plan to include the problem behavior, goals, and approaches. RI #78 was admitted to the facility on [DATE] and had diagnoses to include Schizoaffective Disorder, Bipolar type, Dementia with Behavioral Disturbance, Restless and Agitation and Personal History of Other Mental and Behavioral Disorders. RI #78's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/30/2025 documented a Brief Mental Status Score of 6 out of 15 which indicated impaired cognition. RI #78's MDS documented resistance to care and wandering the facility one out of three days during the observation period. RI #78's MDS documented receipt of Antipsychotic medication. A review of RI #78's Level I determination dated 03/05/2021 documented the need for a Level II due to Diagnosis of Mental Illness; Mental Disorder of Schizoaffective Disorder, Bipolar Disorder, Psychotic, Manic. RI #78's Level II determination dated 03/15/2021 recommended Psychiatric Follow up Care for Serious Mental Illness of Bipolar, Psychotic Manic, Schizoaffective Disorder (Symptoms Severe) which RI #78 had received since his/her initial evaluation from Integrative Behavioral Health on 02/04/2021.On 03/01/2021 RI #78 had a care plan initiated for a focus area of PASRR Level II related to serious mental illness, Bipolar, psychotic manic, schizoaffective disorder (symptoms severe).On 09/16/2024 RI #78 had a behavioral symptoms care plan initiated for a focus area of history of being verbally aggressive cusses at staff, Dementia, Ineffective coping skills, Mental/Emotional illness, poor impulse control; history of being physically aggressive, Dementia with behavior disturbance, Schizoaffective disorder, Bipolar Disorder towards staff and other residents when agitated. Care Plan Interventions included: Administer medications as ordered; Analysis of key times, places, circumstances, triggers, and what de- escalates behavior and document; Assess resident's coping skills and support system; Assess resident' understanding of the situation. On 09/16/2024 RI #78's behavioral symptoms care plan was initiated for a focus area of having a history of being physically aggressive towards staff/other residents when agitated related to Dementia with behavioral disturbances and Schizoaffective Disorder, Bipolar Disorder. Interventions on the care plan include; Administer medications as ordered; Analyze of key times, places, circumstances, triggers, and what de- escalates behavior and document; Assess and anticipate resident needs, Modify Environment; Adjust room temperature to comfortable level, Reduce Noise, Dim lights, place familiar objects in the room, keep door closed; Monitor/ document/report any signs or symptoms of resident posing a danger to self or others