STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015075	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summerford Health and Rehab, LLC	4087 Highway 31 Southwest Falkville, AL 35622

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 - 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 record reviews, interviews, the facility's incident report, the facility's investigation titled, INVESTIGATION TEMPLATE, and the facility's policy titled, Abuse Prevention Program, the facility failed to protect Resident #403's right to be free from physical abuse by having inadequate staff to supervise residents. On 01/09/2023 at approximately 3:45 AM, Certified Nurse Assistant (CNA) #32 responded to Resident #403's room and observed him/her lying in bed with blood coming from a laceration to the face. Upon investigation, it was determined that residents were left unsupervised on the secured (locked) unit and staff failed to prevent Resident #404 from repeatedly striking Resident #403 with his/her cane. This resulted in actual harm to Resident #403, who sustained laceration to left forehead with hematoma, laceration to right forehead, skin tear to left ear, [NAME]/redness to left cheek, top right side mouth swollen with laceration and chipped front tooth, [NAME] to right outer thigh, bruising to left and upper arm, welps to left upper and lower arm, skin tear with bring to left thumb, bruises on top of bilateral hands, [NAME] on right side of mid back, welps on right shoulder and upper arm, and left knee swollen with discoloration that required transport to a local hospital for evaluation and treatment. This affected Resident #403, one of five residents sampled for abuse. Findings included: Cross Reference F 725 The facility's policy titled, Abuse Prevention Program dated 10/27/2022, documented: Policy Statement Our residents have the right to be free from abuse . This includes . physical abuse . Definitions 1. Abuse, is defined at §483.5 as the willful infliction of injury, deliberate act . with resulting physical harm, pain or mental anguish . It includes . physical abuse . Abusers can be . residents . A review of an admission Sheet indicated Resident #403 was admitted on [DATE], and readmitted on (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: 015075	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024
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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 - Actual harm Residents Affected - Few	[DATE], with diagnoses that included Dementia and Sleep Disorder. The admission Minimum Data Set (MDS), dated [DATE], revealed Resident #403 had a Brief Interview for Mental Status (BIMS) score of three of 15, which indicated the resident had severe cognitive impairment. The resident required total assistance with all Activities of Daily Living (ADLs). The MDS indicated Resident #403 did not have any behaviors directed at others. A review of Resident #403's care plan, developed on 01/13/2023, after being struck several times by Resident #404, indicated that the resident had a risk of decreasing psychosocial well-being related to recent trauma as evidenced by voicing remembrance of the event. A review of an admission Sheet indicated the facility admitted Resident #404 on 03/25/2021, with diagnoses that included Vascular Dementia with Agitation and Insomnia. Resident #404's MDS dated [DATE], indicated he/she had a BIMS score of 11 of 15, which indicated the resident had moderate cognitive impairment. The resident required limited assistance with all Activities of Daily Living and exhibited no behaviors toward others. On 01/09/2023, the facility reported an incident to the Alabama Department of Public Health (ADPH) Online Incident Reporting System regarding an incident that occurred 01/09/2023. The facility's initial report documented that at 3:45 AM a Certified Nurse Assistant (CNA) heard someone talking and upon entering Resident #403's room she observed Resident #403 lying in bed with injuries. The report revealed the resident had been transported to a local hospital at approximately 5:10 AM for evaluation and treatment. The report indicated it was undetermined at that time how the injuries occurred. Resident #403's Emergency Department (ED) Physician Documentation, dated 01/09/2023, revealed Resident #403 presented to the ED after being assaulted by a demented roommate. The resident was struck in the face multiple times with a cane. The ED report revealed the resident had ecchymosis (bruises) to the left side of the face, a laceration to the left eyebrow, soft tissue swelling over the right upper lip, and soft tissue contusion of the superior left forehead. The laceration to the left eyebrow was described as 2.5 centimeters in length and the depth as superficial, which required approximation with steri-strips. A review of the facility's investigation titled, INVESTIGATION TEMPLATE dated 01/16/2023, revealed the details of the facility's investigation related to the injuries inflicted upon Resident #403 on 01/09/2023. The report documented: . Description of the Allegation: On 1/9/2023 (CNA #32) heard someone talking and entered (Resident #403's) . room she (CNA #32) noted patient to be lying bed with injuries to (his/her) head, face, arms and legs. (CNA #32) noted another resident to be in the room sitting in a chair talking to (Resident #403). Resident was immediately assessed . Bruising and redness noted to forearms and legs. Lacerations noted to forehead and left arm. Bleeding was not to mouth upon initial assessment . Resident (#403) was discharged to the hospital at approximately 5:10 AM . Description of any assessment and injury. Initial assessment completed 1/9/23 prior to d/c (discharge) to hospital: Bruising and redness (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	noted to forearms and legs. Lacerations noted to forehead and left arm. Bleeding noted to mouth. Assessment done 1/9/23 upon return from hospital: Laceration to left forehead with hematoma, laceration to right forehead, skin tear to left ear, [NAME]/redness to left cheek, top right side mouth swollen with laceration and chipped front tooth, [NAME] to right outer thigh, bruising to left and upper arm, welps to left upper and lower arm, skin tear with bring to left thumb, bruises on top of bilateral hands, [NAME] on right side of mid back, welps on right shoulder and upper arm, left knee swollen with discoloration . Investigation Summary . (LPN #15) stated at approximately 3:45 AM, (CNA #32) came to get me and told me that (Resident #403) had blood on the bed, pillow, mouth, arm and leg. (LPN #15) stated when she (LPN #15) got into the room . (Resident #403's) lips were swollen, (he/she) had blood in (his/her) mouth, (his/her) left ear was bleeding . skin tear with hematoma on left side of (his/her) forehead, skin tear to left forearm, skin tear to right forearm, left knee was bruised, [NAME] marks on upper and outer left and right . thigh . (LPN #15) noted (Resident #404) to be sitting on the side of the bed . and the handle of (Resident #404's) cane . between the bed and night stand . (Resident #403) was re-interviewed on 1/12/23 . When asked if anyone had hurt him/her (Resident #403) stated Yeah, someone hurt me from behind. They beat the fire out of me. They took a stick and just come in and beat the fire out of me when I was trying to sleep . When asked to describe the person (Resident #403) stated (He/She) shared a room with me. (He/She) was white. (He/She) was rough looking. Several staff reported (Resident #404) would at time use (his/her) cane to tap ground in front of another resident or on another resident's wheelchair as a means to get their attention to get them out of (his/her way). One staff member reported they observed (Resident #404) to raise (his/her) cane at another resident, however, would not say anything threatening to the other patient just for them to move . Upon completing of the investigation, it remains evident that (Resident #403) was physically abused. the cane belonged to (Resident #404) .was found broken by (Resident #404) in (his/her) bed under the covers upon initial assessment of the resident room. (Resident #404) revealed the cane when asked by staff where (his/her) cane was. (Resident #404) had the means and ability to commit this offense and due to evidence, we have reason to believe (Resident #404) to have committed the offense. On 09/14/2023 at 4:56 PM, an interview was conducted with CNA #32. The CNA stated that on 01/09/2024 around 8:00 PM Resident #403 was in bed rolling around in bed and calling out. She stated she heard Resident #404 tell Resident #403 to shut the hell up. She stated Resident #404 had not seemed aggressive or agitated. She stated after the resident told the other resident to shut up; she did not tell anyone, but she should have told someone. She stated she left the unit to go help on another hall and no additional staff were on the secured unit. She stated they were low staffed always and it was her first time working on the unit. On 09/12/2023 at 10:45 AM, CNA #32 stated that on 01/09/2023 there was one CNA assigned to the secured unit and one LPN. She stated Resident #403 would yell out a lot. She stated that around 2:30 AM she left the secured unit to work on another unit because she had been assigned some residents on another unit. The CNA stated that when she returned to the locked unit, she observed that blood was on Resident #403. She stated part of Resident #404's cane was on the floor beside Resident #403's bed and the rest of the cane was in Resident #404's bed. She stated Resident #47 was in the residents' room, but the resident was not cognitively intact and was not able to provide any information. CNA (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	#32 said that Resident #47 stated there was singing in the room, and he/she had come to join them. On 09/11/2023 at 6:45 AM, LPN #15 stated on 01/09/2023 she was assigned to two halls and was back and forth between them. She stated the resident would make moaning noises and yell out. She indicated she was not on the unit when the incident occurred; she was floating between the two units. She stated the handle of Resident #404's cane was found on the floor near the head of Resident #403's bed; it had some red spots on it. The rest of the cane was broken and was found in Resident #404's bed. The LPN stated Resident #47 was in the resident's room but was not cognitively intact. LPN #15 interviewed Resident #47 who stated there was singing in the room, so he/she came in to join them. The LPN stated she interviewed both residents, but Resident #403 did not say anything and Resident #404 stated they did not know anything. She stated Resident #403 was transferred to a local hospital and later that day Resident #404 was transferred to a local psychiatric hospital. On 09/13/2023 at 3:16 PM, the Director of Nurses (DON) stated her expectation was that the residents on the locked unit should never be left without a staff member present on the unit and there should be enough staff to adequately supervise the residents. The DON stated that the victim Resident #403 had been placed on another unit when he/she returned from the hospital. Resident #404 was placed in a private room on the unit when he/she returned from the local psychiatric hospital. On 09/13/2023 at 5:07 PM, the Administrator (ADM) stated CNA #32 began to suspect that Resident #404 had assaulted the roommate, Resident #403, when the broken cane was discovered on the floor next to the bed. She stated Resident #404 was able to transfer and ambulate without staff assistance, but Resident #403 was totally dependent on staff for all ADLs. She stated Resident #47 was not cognitively intact and was not able to provide any information. This was cited as a result of complaint/report # AL00042935.

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F 0725

Level of Harm - Actual harm

Residents Affected - Few

Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on record reviews, interviews, document reviews, and policy review, the facility failed to ensure sufficient staff were available to provide supervision for residents on the facility's secured unit during the night shift. On 01/09/2023 at approximately 2:30 AM, staff left residents on the [NAME] Haven Unit (a locked, secured unit where 24 residents resided) unsupervised to take care of residents on other units because there was an insufficient number of staff. While the locked/secured unit was unsupervised, Resident #404 struck their roommate, Resident #403, with a cane which resulted in a facial laceration, facial bruising and swelling, and multiple other injuries to the resident's body.

This failure affected one of nine units in the facility.

Findings included:

A review of the facility's Staffing policy revised October 2017 revealed .Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. Policy Interpretation and Implementation 1. Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services. 2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care .

A review of the facility's 2023 Facility Assessment updated 08/10/2023, indicated in Section 3.1 . Our general staffing plan to ensure sufficient staff to meet the needs of the residents at any given time . Per the Facility Assessment, the direct care staff (licensed and certified) were . 1:6 resident ratio days (total licensed or certified) 1:8 resident ratio evenings 1:10 resident ratio nights This includes RN [Registered Nurse] Supervisors, Restorative Nurse, LPNs [Licensed Practical Nurses] and CNAs [Certified Nursing Assistants] providing direct care . A review of Section 3.2 titled Staffing plan, indicated . Our staffing plan to meet the needs of the resident population. Staff needed for care for our resident census/population: Licensed or Registered Nurses providing direct care . 3-5 on nights . Nurses Aides . 7-9 on nights . Section 3.3 Individual staff assignment, revealed . How we determine and review individual staff assignments for coordination and continuity of care for residents within and across staff assignment. We compare our overall census and/or resident acuity needs to determine if we need to adjust staffing. Acuity needs change often, so we may adjust schedule assignments each shift. Charge Nurse or Registered Nurses on call may adapt staffing based on our internal communication tools, such as our verbal shift change report, or team talks .

A review of the facility schedule for Sunday 01/08/2023 for the 11:00 PM to 7:00 AM shift, revealed LPN #15 was scheduled to work the 1st North Unit and the [NAME] Haven Unit. The schedule indicated one CNA (CNA #32) was scheduled to work the [NAME] Haven Unit, one CNA was scheduled on the 1st North Unit, one CNA was scheduled for the Far North Unit, and the word split was written on the schedule for the Northeast (NE) Unit. According to the schedule, there were nine total staff members (three LPNs and five CNAs) for the 11:00 PM to 7:00 AM shift that began on 01/08/2023.

A review of an undated, unlabeled, handwritten note provided by the Administrator indicated on 01/08/2023, during the 11:00 PM to 7:00 AM shift, there were nine total staff that worked in the facility and not 10 to 14 staff as required per the 2023 Facility Assessment.

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F 0725 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's Daily Census report dated 01/08/2023, indicated the [NAME] Haven Unit/secured unit had a census of 24 residents, resulting in a resident to staff ratio of 1:12, not 1:10 per the 2023 Facility Assessment for the evening shift. A review of Resident #403's admission Record revealed the facility admitted the resident on 10/22/2022 with diagnoses that included dementia, generalized anxiety, adjustment disorder with depressed mood, and sleep disorder. A review of Resident #403's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 10/26/2022, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. A review of Resident #404's admission Record revealed the facility admitted the resident on 03/25/2021. Per the admission Record, Resident #404's diagnoses included vascular dementia with agitation, anxiety disorder, and insomnia. A review of Resident #404's annual MDS, with an ARD of 02/01/2023 revealed the resident had a BIMS score of 8, which indicated the resident had moderate cognitive impairment. A review of the facility's Investigation Template dated 01/16/2023 revealed on 01/09/2023 at approximately 3:45 AM, when CNA #32 entered Resident #403 and Resident #404's room she observed blood all over Resident #403 and Resident #404 sat on their bed facing Resident #403's bed. CNA #32 observed the top of Resident #404's walking cane on the floor next to Resident #403's bed by the nightstand. CNA #32 asked Resident #404 whether the resident knew what happened and whether the resident had hit Resident #403. Per the Investigation Template, Resident #404 denied hitting the resident. The CNA reported the incident to LPN #15. When LPN #15 got to the room, she noted Resident #403's lips were swollen, there was blood in the resident's mouth, a skin tear and bleeding to the left ear, a skin tear to the left hand between the first and second digits, a skin tear with a hematoma on the left side of the forehead, a skin tear to the left forearm, a skin tear to the right forearm, the left knee was bruised, [NAME] (a raised area caused by a blow) marks to the upper and outer left thigh and right upper thigh, several dark purple bruises to the left forearm, and the left pupil was pinpoint and not as reactive (indicative of possible neurological injury). LPN #15 reported she saw the handle of Resident #404's walking cane on the floor at the head of Resident #403's bed on the left side between the bed and the nightstand. The LPN reported when she asked Resident #404 what happened, the resident stated they did not know. According to the facility's Investigation Template, Resident #403 reported Yeah, someone hurt me from behind. They beat the fire out of me. They took a stick and just come in and beat the fire out of me when I was trying to sleep. That is one reason I am afraid to go to sleep. Continued review of the Investigative Template revealed the facility determined Resident #403 was physically abused. Resident #403's recount of the incident described the alleged offender, stated the alleged offender shared a room with them, and they were beaten with a stick. By reason of deduction the cane that belonged to Resident #404 was found broken in the resident's bed under the covers. The facility determined Resident #404 had the means and the ability to commit this offense and due to evidence, the facility had reason to believe Resident #404 committed the offense. A review of Resident #403's Emergency Department [ED]-Physician Documentation dated 01/09/2023 revealed the resident reported to the ED after being assaulted by their roommate (Resident #404). Per (continued on next page)

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F 0725

Level of Harm - Actual harm

Residents Affected - Few

the report, the resident was hit in their face with a cane multiple times. The ED report revealed the resident had ecchymosis (bruises) to the left side of the face, a laceration to the left eyebrow, soft tissue swelling over the right upper lip, and soft tissue contusion of the superior left forehead. The laceration to the left eyebrow was described as 2.5 (two and one-half) centimeters in length and the depth as superficial, which required approximation with Steri-strips.

During an interview on 09/12/2023 at 10:45 AM, CNA #32 stated on the night of 01/08/2023 to 01/09/2023 she was assigned to the secured unit with one LPN. She stated at approximately 2:30 AM, she left the secured unit to help on the NE unit. CNA #32 stated there was no CNA assigned to cover the NE unit; subsequently, all the CNAs covered that unit in addition to their assigned units. CNA #32 stated when she returned to the secured unit, she observed blood on Resident #403. CNA #32 stated she did not remember how long she was off the unit. According to CNA #32, part of Resident #404's cane was observed on the floor beside Resident #403's bed and the rest of the cane was in Resident #404's bed.

In a follow-up interview on 09/14/2023 at 8:38 AM, CNA #32 stated the night of 01/08/2023 was the first time she had been assigned to the secured unit and she was also assigned to provide care for two residents on the NE unit. She stated the NE charge nurse (LPN #34) instructed her to do rounds on the NE unit at 2:30 AM and 4:30 AM. She stated she was aware she was expected to arrange coverage when she left the secured unit; however, there were not enough CNAs to cover the unit. The CNA stated she could not remember whether she contacted the charge nurse when she left to go to the NE unit. She stated there was no other staff member on the unit when she left the unit. CNA #32 said she was off the secured unit about 25 to 30 minutes. According to CNA #32, when she left the unit to notify LPN #15 of Resident #403's injuries, the nurse was in the medication room on the North unit, just outside the doors to the secured unit.

During an interview on 09/12/2023 at 6:45 AM, LPN #15 reported she was assigned to work the night shift that started on 01/08/2023. LPN #15 stated she was assigned to cover two units, one of which was the secured unit, and during the shift she was back and forth between the two units. She stated it was normal for staff to be assigned to float between two floors. She stated she was not present on the secured unit when the incident occurred between Resident #403 and Resident #404 because she floated between two units. LPN #15 stated as she assessed Resident #403's injuries she observed part of Resident #404's cane on the floor beside Resident #403's bed and the cane had red spots on it. Per LPN #15, the rest of the cane was found broken in Resident #404's bed. She stated she interviewed both residents, but no information was provided.

During an interview on 09/14/2023 at 10:00 AM, CNA #33 stated she had gone to the secured unit during the night shift on the morning of 01/09/2023 to get CNA #32 to help her lift a resident. She stated when she entered the secured unit, there were no other staff members present. She stated the NE Unit did not have a CNA assigned for the night shift so all CNAs in the building were assigned to care for residents on that unit.

During an interview on 09/14/2023 at 10:30 AM, LPN #34 stated CNA #32 had three or four residents on the NE unit assigned to her during the night shift of 01/08/2023. According to the LPN, CNA #32 would have spent 25 to 30 minutes caring for the assigned residents on the NE Unit. She stated there was no CNA for the NE Unit so all CNAs in the building were assigned residents on that unit. She stated it was common for all CNAs to help cover the entire building. According to LPN #34, the CNA was expected to come to the NE Unit every two hours to check on their assigned residents. LPN #34 stated most of the units could be viewed/supervised from the nurses' station. However, the secured unit

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F 0725 Level of Harm - Actual harm Residents Affected - Few	could not be visualized from the nurses' station because of the locked/solid doors. LPN #34 stated the locked unit should not be left unsupervised. In an interview on 09/13/2023 at 3:16 PM, the Director of Nursing (DON) stated the facility had trouble staffing at times. Per the DON, her expectation was that the residents on the secured unit should never be left without a staff member present on the unit and there should be enough staff to adequately supervise and care for the residents. The DON added that if only one CNA and one nurse were assigned to the secured unit, and they were both covering another hall, they should switch out so that one of them would always be on the secured unit. She stated normally they would schedule staff so that the CNA assigned to the locked unit would not be required to help on the other units. She stated she did not remember whether the residents had been left alone while the CNA assigned to the locked unit helped on another unit. She stated she would expect for the CNA and the LPN to trade places, so someone supervised the residents. According to the DON, she did not know whether the residents had been left alone. During an interview on 09/13/2023 at 5:07 PM, the Administrator stated it was common for the CNAs to leave the secured unit and assist on another unit. The administrator stated they did not have a policy for floating and she did not know how the CNAs decided when to leave their units to float another hall. There was no policy for staffing for the locked unit. In a follow-up interview on 09/14/2023 at 9:38 AM, the Administrator stated sometimes the facility had trouble getting enough staff. She stated she could not say the secured unit was supervised or unsupervised at all times. According to the Administrator, no one had reported to her the secured unit had been left unsupervised. This deficient practice was cited as a result of the investigation of complaint/report #AL00042935.