STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015101	A. Building B. Wing	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altoona Health & Rehab	6532 Walnut Grove Road Altoona, AL 35952

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, resident record review, review of an online report submitted to the State Survey Agency, review of the facility's abuse investigation, and review of a facility policy titled, ADMINISTRATIVE ABUSE, the facility failed to protect Resident Identifier (RI) #1's right to be free from physical abuse on 01/31/2023 when Employee Identifier (EI) #5 Licensed Practical Nurse (LPN), was witnessed pinching and slapping RI #1. Physical abuse was witnessed by EI #3 Registered Nurse (RN) and EI #4 RN. This deficient practice affected RI #1, one of three residents reviewed for abuse concerns. Findings include: On 02/01/2023 at 6:27 AM, the State Survey Agency received an initial report from the facility regarding an allegation that EI #5, LPN, physically abused RI #1. This report indicated EI #4, witnessed EI #5 pinch and then slap RI #1's arm/hand. A facility policy titled ADMINISTRATIVE ABUSE, with a revised date of 10/2017, documented: Policy Residents have the right to be free from abuse . Residents must not be subject to abuse by anyone, including, but not limited to; facility staff . IDENTIFICATION OF ABUSE . 1. The facility defines types of abuse as follows: . PHYSICAL ABUSE includes, but is not limited to, hitting, slapping, pinching and kicking. RI #1 was re-admitted to the facility on [DATE] with diagnoses to include Dementia. RI #1's significant change Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/26/2022 documented RI #1 had a Brief Interview for Mental Status (BIMS) score of six, which indicated RI #1 had severe cognitive impairment. A facility document titled VERIFICATION OF INVESTIGATION with an incident date of 01/31/2023 documented the following: (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

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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	. DETAILED DESCRIPTION OF INCIDENT . On Wednesday, February 1, 2023, at approximately 4:34 am, SSD (Social Service Director EI #2) was called by employee (EI #4) RN to report an allegation of physical abuse. The abuse happened on January 31, 2023 at approximately 10:00 pm. Resident (RI #1) was . in the front of the nurses station and had pulled his/her pants down. Employee (EI #4), RN, and employee (EI #3), RN, went to (RI #1) and took him/her to his/her room in an attempt to take him/her to the bathroom. Resident did not want to go to the bathroom or have his/her pants pulled up. (EI #4) . stepped to the doorway and asked for help. (EI #5), LPN, came to the room and stood at the door to observe the situation. Nurse, (EI #4) then stated that (RI #1) became combative and pinched and slapped at Nurse, (EI #5). Nurse, (EI #4) then stated that Nurse, (EI #5) pinched (RI #1) back and slapped his/her hand/arm and causing it to hit the wall. SUMMARY AND OUTCOME OF INVESTIGATION: . Tuesday, February 7, 2023 . After reviewing all pertinent information, the facility will conclude this investigation as substantiated. The eye-witnessed account from (EI #4), RN, is reliable evidence to support physical abuse occurred. The facility will terminate the employer-employee relationship with (EI #5) effective 02/07/23. The facility will communicate findings to the Alabama Board of Nursing . A handwritten statement from the facility's investigative file, signed by EI #4 RN documented the following: At approximately 10pm on 01/31/2023 resident (RI #1) attempted to get up from (his/her) gerichair while resident was in hallway by the nurse's station. This nurse, (EI #4), and Nurse (EI #3) attempted to redirect resident. Resident at this point pulled (his/her) pant/brief down. we went with resident to (his/her) resident bathroom to let resident have bathroom privileges. this nurse stepped to hallway and asked (EI #5) Nurse to help . thinking a familiar face would make resident feel more comfortable. (EI #5) stepped up and this nurse stepped back and (EI #5) forcefully and loudly called resident's name. (EI #5) attempted to redirect resident long enough to allow staff to pull up residents brief/pants. Once resident sat down (he/she) pinched (EI #5) so (EI #5) pinched (RI #1) back. Resident then slapped (EI #5) so (EI #5) slapped resident's hand/arm back and when this happened resident's hand hit the wall and it made a loud noise. A handwritten statement from the facility's investigative file, signed by EI #3 RN and dated 02/01/2023 documented the following: . This nurse was assisting resident to the restroom with (EI #4). Rsd (Resident) was agitated . refused to let us take (him/her) to restroom. (EI #5) walked in and helped us pull (his/her) pants back up. Rsd sat back down, this nurse walked thru bathroom to go around and finish helping rsd. Rsd was hitting . (EI #5) and (EI #5) tapped him/her on his/her right hand . An interview was conducted with EI #3 RN on 06/07/2023 at 9:05 AM. EI #3 was asked to recall the incident involving RI #1. EI #3 explained, RI #1 was at the nursing desk around 10:00 PM and pulled his/her pants down. EI #3 and EI #4 took RI #1 to his/her room and attempted to assist RI #1 to the bathroom. Once in the room RI #1 became agitated and refused to go in the bathroom. While attempting to care for RI #1, EI #5, LPN came in the room to assist. EI #3 stated she left the room for a moment and when she re-entered the room, she saw RI #1 slapping at EI #5. EI #3 saw EI #5 tap RI #1's hand. EI #3 said, RI #1 did not cry out or have any marks or bruises. EI #3 stated after the incident RI #1 consented to leave the room and was calm the rest of the night. EI #3 said, if abuse was observed it was supposed to be reported immediately to protect the resident. An interview was conducted with EI #4 on 06/07/2023 at 10:50 AM. EI #4 was asked to recall the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident involving RI #1 on 01/31/2023. EI #4 said, around 10:00 PM, RI #1 attempted to get up from his/her chair while in the hallway near the nurses desk. EI #4 said, she and EI #3 attempted to redirect RI #1, RI #1 pulled his/her pants down, then they took RI #1 to his/her room to use the bathroom. Once in the room RI #1 refused to allow EI #4 and EI #3 to assist him/her. EI #5 then came to the room to assist with redirecting RI #1. EI #4 said, she observed RI #1 pinch EI #5 and EI #5 then pinched RI #1. RI #1 then slapped EI #5 and EI #5 slapped RI #1's arm causing it to hit the wall. EI #4 stated she did not see any injury. EI #4 said, she did not say anything to EI #5 because she was in shock and felt intimidated by EI #5. EI #4 said, at that point she left the room to go take care of another resident. EI #4 said, shortly after the incident her shift ended and she left the facility a little after 10:30 PM without reporting the incident. EI #4 was asked why she did not report the incident. EI #4 replied, she was in shock. EI #4 said, the incident should have been reported to the abuse coordinator immediately to prevent it from happening again and to protect the resident. After leaving the building that night, EI #4 said, she called EI #6, RN, and left a message about the incident. EI #4 said, EI #6 did not immediately get the message but called her back around 4:00 AM on 02/01/2023. After talking to EI #6, EI #4 called the abuse coordinator EI #2 and reported the incident. An interview was completed with EI #5 on 06/07/2023 at 10:00 AM. EI #5 was asked about the incident involving RI #1. EI #5 said, she was asked to help EI #3 and EI #4 with RI #1 because RI #1 was confused and would not stand up or allow them to assist him/her to the bathroom. EI #5 said, after she, EI #3 and EI #4 pulled up RI #1's pants, RI #1 started hitting and pinching. EI #5 said, she grabbed RI #1's right wrist/arm to keep RI #1 from getting hurt. EI #5 said, she was trying to protect RI #1 when she grabbed RI #1's arm. EI #5 was asked why she was terminated from the facility. EI #5 replied, because of the abuse accusation involving RI #1. An interview was conducted with EI #1, Regional Administrator on 06/07/2023 at 1:00 PM. EI #1 was asked the outcome of the investigation related to physical abuse involving RI #1. EI # 1 said, the investigation was substantiated due to a believable eyewitness account of the incident. This deficient practice was cited as a result of the investigation of complaint/report number AL00043217. ********** The facility took immediate action to correct the noncompliance by: 1. Reported the incident to the Alabama Department of Public Health (ADPH) on 2/1/2023 and conducted an investigation. 2. Reported an incident of possible physical abuse to local police department on 2/1/2023. 3. Completed an in-service with all staff on the abuse policy from 2/1/2023 - 2/3/2023. 4. Completed one on one education with Registered Nurse (EI #3) on 2/1/2023. 5. Completed one on one education with Registered Nurse (EI #4) on 2/3/2023. 6. Quality Assurance (QA) meeting held on 2/1/2023 to create plan of correction (POC). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Weekly abuse monitoring form initiated by Social Services/Abuse Coordinator. The weekly monitoring begin on 02/01/23 for a period of 6 weeks, or longer if deemed necessary by the QA committee. Start date 2/1/2023 - Ongoing. After review of documentation supporting the corrective actions, including in-service records, employee files, education records, and interviews with staff, the survey team verified the facility had implemented corrective actions from 02/01/2023 through 02/03/2023 and had an ongoing monitoring system in place; thus, past non-compliance was cited.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, interviews, review of an online report submitted to the State Survey Agency, review of the facility's investigation file, and review of a facility policy titled ADMINISTRATIVE ABUSE, the facility failed to ensure staff implemented one of the seven components of the abuse policy. Employee Identifier (EI) #3 Registered Nurse (RN) and EI #4 RN failed to immediately report physical abuse to the abuse coordinator after they witnessed EI #5 Licensed Practical Nurse (LPN) physically abuse Resident Identifier (RI) #1 on 01/31/2023, in accordance with the facility policy. This affected RI #1 one of three residents sampled for abuse. Cross reference F600. Findings include: On 02/01/2023 at 6:27 AM, the State Survey Agency received an initial report from the facility regarding an allegation that EI #5, LPN, physically abused RI #1. This report indicated EI #4, witnessed EI #5 pinch and then slap RI #1's arm/hand. A facility policy titled, ADMINISTRATIVE ABUSE with a revised date of 10/2017 documented Policy: Residents have the right to be free from abuse . Residents must not be subject to abuse by anyone, including, but not limited to; facility staff . The facility defines types of abuse as follows: .PHYSICAL ABUSE includes, but is not limited to, hitting, slapping, pinching and kicking. REPORTING/RESPONSE OF ABUSE . Facility personnel are to report allegations or suspected abuse . immediately to the Administrator, or facility appointed designee. RI #1 was re-admitted to the facility on [DATE] with diagnoses to include: Dementia. RI #1's significant change Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/26/2022 documented the resident had a Brief Interview for Mental Status (BIMS) score of six which indicated RI #1 had severe cognitive impairment. A facility document titled VERIFICATION OF INVESTIGATION with an incident date of 01/31/2023 documented the following: . DETAILED DESCRIPTION OF INCIDENT . On Wednesday, February 1, 2023, at approximately 4:34 am, SSD (Social Service Director EI #2) was called by employee (EI #4) RN to report an allegation of physical abuse. The abuse happened on January 31, 2023 at approximately 10:00 pm. Employee (EI #4), RN, and employee (EI #3), RN, went to (RI #1) and took (him/her) to (his/her) room in an attempt to take (him/her) to the bathroom. (EI #4) . stepped to the doorway and asked for help. (EI #5), LPN, came to the room and stood at the door to observe the situation. Nurse, (EI #4) then stated that (RI #1) became combative and pinched and slapped at Nurse, (EI #5). Nurse, (EI #4) then stated that Nurse, (EI #5) pinched (RI #1) back and slapped (his/her) hand/arm and causing it to hit the wall. SUMMARY AND OUTCOME OF INVESTIGATION: . (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tuesday, February 7, 2023 . After reviewing all pertinent information, the facility will conclude this investigation as substantiated. The eye-witnessed account from (EI #4), RN, is reliable evidence to support physical abuse occurred. Review of the facility's timeline of events revealed the following: On 01/31/2023 at 10:00 PM EI #4 witnessed EI #5 physically abuse RI #1. On 01/31/2023 at 11:13 PM EI #4 placed a call to EI #6 RN, Assistant Director of Nursing (ADON). On 02/1/2023 at 4:11 AM EI #6 became aware of numerous missed calls from EI #4, returned her call, and she informed him of the allegation of physical abuse. On 02/01/2023 at 4:34 AM EI #4 contacted EI #2 Social Services Director/Abuse Coordinator, to report the allegation of abuse, as instructed by EI #6. On 02/01/2023 at 5:45 AM EI #6 arrived at the facility and notified EI #5 of the allegation of abuse, placed her on administrative leave and escorted her from the facility. An interview was conducted with Employee Identifier (EI) #3, Registered Nurse (RN) on 06/07/2023 at 9:05 AM. EI #3 explained, while attempting to care for RI #1, EI #5, LPN came in the room to assist. EI #3 stated she left the room for a moment and when she came back in the room she saw RI #1 slapping at EI #5. EI #3 then saw EI #5 tap RI #1's hand. EI #3 said if abuse was observed it was supposed to be reported immediately to protect the resident. EI #3 said she did not realize what she witnessed was abuse. An interview was conducted with EI #4 on 06/07/2023 at 10:50 AM. EI #4 was asked to recall the incident involving RI #1 on 01/31/2023. EI #4 said around 10:00 PM EI #4 and EI #3 took RI #1 to his/her room to use the bathroom. Once in the room RI #1 refused. EI #5 then came in the room to assist. EI #4 said she observed RI #1 pinch EI #5 and EI #5 then pinched RI #1. RI #1 then slapped EI #5 and EI #5 slapped RI #1's arm causing it to hit the wall. EI #4 said, she did not report this incident prior to leaving the building around 10:30 PM. EI #4 was asked why she did not report the incident, to which she replied, she was in shock. EI #4 said the incident should have been reported to the abuse coordinator immediately to protect the resident. After leaving the building EI #4 said she called EI #6, RN, and left a message about the incident. EI #4 said EI #6 did not immediately get the message but called her back around 4:00 AM on 02/01/2023. After talking to EI #6, EI #4 called the Abuse Coordinator EI #2 and reported the incident. An interview was conducted with EI #2, Abuse Coordinator on 06/07/2023 at 11:34 AM. EI #2 said she was the person staff should report abuse to. She stated staff were told who to call during training and her name and number was posted in the facility. EI #2 said, if staff witnessed abuse they should make sure the resident was safe and report the abuse immediately. When asked why EI #4 did not report the abuse she witnessed involving RI #1, EI #2 said she was not sure, but EI #4 was trained to report abuse immediately. EI #2 said EI #4 reported the abuse after she left the building and when she was notified she began the investigation. A follow up interview was conducted with EI #2 on 06/08/2023 at 11:53 AM. EI #2 said the abuse (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy instructed staff to report abuse immediately to the administrator or designee. EI #2 stated she was the designee in the facility. EI #2 was asked if EI #4 followed the abuse policy when she witnessed abuse involving RI #1. EI #2 said no, she did not follow the policy. EI #2 further stated the problem with not reporting immediately was the resident was not protected from further possible abuse. This deficient practice was cited as a result of the investigation of complaint/report number AL00043217. ********** The facility took immediate action to correct the noncompliance by: 1. Reported the incident to the Alabama Department of Public Health (ADPH) on 2/1/2023 and conducted an investigation. 2. Reported an incident of possible physical abuse to local police department on 2/1/2023. 3. Completed an in-service with all staff on the abuse policy from 2/1/2023 - 2/3/2023. 4. Completed one on one education with Registered Nurse (EI #3) on 2/1/2023. 5. Completed one on one education with Registered Nurse (EI #4) on 2/3/2023. 6. Quality Assurance (QA) meeting held on 2/1/2023 to create plan of correction (POC). 7. Weekly abuse monitoring form initiated by Social Services/Abuse Coordinator. The weekly monitoring begin on 02/01/23 for a period of 6 weeks, or longer if deemed necessary by the QA committee. Start date 2/1/2023 - Ongoing. After review of documentation supporting the corrective actions, including in-service records, employee files, education records, and interviews with staff, the survey team verified the facility had implemented corrective actions from 02/01/2023 through 02/03/2023 and had an ongoing monitoring system in place; thus, past non-compliance was cited.