STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015115	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cordova Health and Rehabilitation, LLC	70 Highland Street West Cordova, AL 35550

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 0550 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and the facility's policy for Enhanced Dining; the facility failed to ensure residents' lunch meals were not left upon transport trays when served to residents in the dining room on Tuesday, 11/12/2024 and Wednesday, 11/13/2024. This affected 40 of 40 residents receiving meals in the facility's dining room. Findings include: The facility's policy for Enhanced Dining, dated 02/23/2011, included the following: PURPOSE: To improve resident/guest(s) quality of life by allowing them to enjoy dining in a non-institutional environment, when possible. STANDARD: To the extent possible, the facility should provide a dignified environment at mealtime, . PROCESS: To enhance the resident/guest(s) dining experience, and ultimately the resident/guest(s) appetite, the following strategies may be considered: . e. Use of china or attractive dishes, with elimination of food trays . Resident Identifier (RI) #14 was admitted to the facility on [DATE]. During a dining observation on 11/12/2024 at 11:34 AM, the facility's dining room was filled with 32 residents seated at tables with green linen tablecloths and centerpieces of either silk flowers or small pumpkins. The dining room was decorated for the Fall/[NAME] season, eight staff were present, and quiet conversations were ongoing. At 11:45 AM, the first cart of meal trays entered the dining room from the kitchen and service of lunch began. At 11:46 AM, nine staff members were serving lunch to the residents, table by table. All residents in the dining room were being served with the meal plate, silverware, and other food items remaining on the transport tray. Each meal tray was placed directly on the table in front of the resident. Plate lids and trash/wrappers were placed on a separate cart parked by the dishwashing room entrance. During a dining observation on 11/13/2024 at 11:32 AM, the facility's dining room was filled with 40 residents seated at tables with green linen tablecloths. Eleven staff members were present. The dining room was decorated for Fall/[NAME] and corresponding themed centerpieces were on the tables. Quiet conversations were ongoing among the residents and staff present. At 11:38 AM, thirteen staff (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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F 0550 Level of Harm - Potential for minimal harm Residents Affected - Many	were in the dining room and by 11:40 AM, the lunch meal service began with the arrival of the first cart from the kitchen. Again, all items were left on the transport tray. At 11:50 AM, one of the staff providing service was identified as the Restorative Nurse. On 11/13/2024 at 5:10 PM, the Registered Dietitian (RD) and the Dietary Manager were questioned if the residents or the Resident Council had been asked if it was okay to serve them meals on trays in the dining room. Neither the RD nor the Dietary Manager was aware of the residents being asked that question. The RD said it would make sense to take the items off the tray for a more enhanced dining experience. On 11/13/24 at 5:49 PM, an interview was conducted with RI #14, the Resident Council President. RI #14 said he/she had been Resident Council President for about five years. When asked if anyone had ever discussed the topic of leaving trays on the tables in the dining room, he/she said no. During an interview on 11/14/2024 at 11:22 AM, the Restorative Nurse said she assisted with meals in the dining room on Wednesday, 11/13/2024. When asked if taking the food items off the tray for service in the dining room had ever been discussed, the Restorative Nurse said no, we have always just set the tray down on the table. The Restorative Nurse further said she did not know if the residents had ever been asked if they were okay with their meals being left on the trays during dining room service. The Restorative Nurse was asked if you went to a restaurant with a tablecloth and centerpiece on the table, would you expect the server to place the service tray with your food on it onto the table before you. The Restorative Nurse shook her head no and said even in a fast-food restaurant, you take your food off the tray. During an interview on 11/14/2024 at 12:52 PM, the Dietary Manager was asked how could serving meals on trays in the dining room negatively affect residents. The Dietary Manager said they might not feel like they were at home. During an interview on 11/14/2024 at 1:11 PM, the RD was asked how could serving meals on trays in the dining room negatively affect residents. The RD said it could seem less homelike.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, the facility's policy for Sanitation Principles, and the United States (U.S.) Food and Drug Administration (FDA) 2022 Food Code; the facility failed to ensure one large return vent in the Dining Room and seven of thirteen exit vents on C and D halls were clean. The facility also failed to ensure one of two clocks on C Hall was working. In addition, the facility failed to ensure five of six vinyl covered chairs in the front lobby and front hallway did not have torn or cracked upholstery. This affected two of four halls and one of one dining room. Findings include: The facility's policy for Sanitation Principles, dated 08/10/2018, included the following: . PURPOSE: To prevent the spread of bacteria . STANDARD: . areas should be maintained in a clean and sanitary manner. PROCESS: . b. equipment should be kept clean, maintained in good repair, and should be free from breaks, corrosion, open seams, cracks . The U.S. FDA 2022 Food Code included the following: . 6-501.11 Repairing. PHYSICAL FACILITIES shall be maintained in good repair. 6-501.12 Cleaning, Frequency and Restrictions. (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. 6-501.14 Cleaning Ventilation Systems, Nuisance and Discharge Prohibition. (A) Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials. 1. Dining Room Vent Beginning at 11:34 AM on 11/12/2024, 32 residents were observed receiving lunch in the Dining Room. At 11:58 AM, a large wall vent, approximately 1.5 by 3 feet in size, was observed near the emergency exit door at the back of the Dining Room. The wall vent was badly corroded with rust at the bottom third of the vent and heavily covered with dust, which could be removed by touch. Beginning at 11:32 AM on 11/13/2024, 40 residents were observed receiving lunch in the Dining Room. At 12:09 PM, the large wall vent near the exit door of the Dining Room was still thickly layered with dust that could be removed by ones' finger. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/14/2024 at 11:42 AM, the Director of Maintenance was interviewed beside the large wall vent near the exit door in the Dining Room. The Director of Maintenance said the large wall vent was a return vent. The Director of Maintenance also said the substances on the vent's grill were rust, dirt, and dust. When asked the problem of rust, dirt, and dust on the vent grill, the Director of Maintenance said it could affect the performance of the ventilation system. Upon being asked if this was homelike, the Director of Maintenance said no. On 11/14/2024 at 12:52 PM, the Dietary Manager was interviewed. When asked about the large vent near the exit door in the Dining Room, the Dietary Manager said the substances on the vent's grill were paint, rust, and dust. Upon being asked if this helped to create a homelike environment, the Dietary Manager said no. On 11/14/2024 at 01:11 PM, the Registered Dietitian (RD) was interviewed. When asked about the large vent near the exit door in the Dining Room, the RD said the substances on the vent's grill were rust and grime. The RD further said there have been various things placed in front of that vent, so it has not been extremely visible to her. When asked the problem with having rust, dirt, and heavy dust on the vent's grill; the RD said possible cross contamination. Upon being asked if this helped to create a homelike environment, the RD said no, it does not help. 2. Hallway Vents On 11/14/2024 at 10:48 AM, three ceiling vents on C Hall (part of the front hall), between room [ROOM NUMBER] and the Social Services' office, were observed to have a build-up of a dark black substance beside each vent. There were six ceiling vents (of the same type) on C Hall. On 11/14/2024 at 10:50 AM, four ceiling vents on D Hall, between rooms [ROOM NUMBERS], were observed to have a build-up of a dark black substance beside each vent. There were seven ceiling vents (of the same type) on D Hall. On 11/14/2024 at 11:42 AM, the Director of Maintenance was interviewed. While observing the three ceiling vents on C Hall and then the four ceiling vents on D Hall, the Director of Maintenance said these were exit vents. The Director of Maintenance said the dark substance around the hallway ceiling vents was dust. The Director of Maintenance further said we have a lot of dust coming through the vent systems. When asked how this could affect the residents, the Director of Maintenance said allergies and respiratory issues. The Director of Maintenance additionally said Maintenance could do more cleaning of the vents. 3. Clock On 11/12/2024 at 10:25 AM, a clock on the archway wall in the front hallway on C Hall, between rooms [ROOM NUMBERS], was not working. The clock was stopped at 6:14. On 11/13/2024 at 11:28 AM, the clock on the archway wall in the front hallway on C Hall was still not working. The clock was stopped at 6:14. This was one of two clocks on C Hall. On 11/14/2024 at 10:56 AM, the clock on the archway wall in the front hallway on C Hall was still not working. The clock was stopped at 6:14. On 11/14/2024 at 11:42 AM, the Director of Maintenance was interviewed. When asked the problem with (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	having a clock on the front hall being out of order and reading 6:14, the Director of Maintenance said the residents would not get the correct time, if they were depending on that clock, to arrive at Activities on time. 4. Vinyl Upholstered Chairs On 11/12/2024 at 12:29 PM, two vinyl covered chairs in the front hallway by the conference room were both observed to have badly cracked seat cushions, so that the seat cushion surfaces were rough and not smooth. The larger of the two chairs was missing a large section of brown, vinyl upholstery on the right armrest, approximately half of the vinyl upholstery on the right arm rest was missing. On 11/14/2024 at 10:58 AM, a brown, vinyl covered chair in the seating area near the front door was observed. The chair was used by residents at the jigsaw puzzle table. The chair had a tear in the vinyl seat, which was partially covered with clear tape. On 11/14/2024 at 04:05 PM, one vinyl covered chair by the front entrance was observed to have a badly cracked seat cushion, so that the seat cushion surface was rough and not smooth. Another vinyl covered chair in the seating area near the front entrance was observed to be missing a section of brown, vinyl upholstery on the right armrest, approximately 1.5 by 3 inches in size. A total of six vinyl upholstered chairs were observed on the front hall of the facility. On 11/14/2024 at 11:42 AM, the Director of Maintenance was interviewed. Upon observing the vinyl upholstered chairs on the front hall of the facility, the Director of Maintenance said the torn seat cushions and the missing sections of upholstery could possibly result in injury and also in the transfer of fluids. The Director of Maintenance additionally said the chairs were not easily cleanable. The Director of Maintenance further said the residents could be affected by possible cross contamination because the chairs could not be properly cleaned. Upon being asked if this was homelike, the Director of Maintenance said no. This tag was cited as a result of investigation/complaint # AL00048132.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety 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 observation, interviews, record reviews, and the facility policy titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation, and review of a Facility Reported Incident (FRI) received by the Alabama Department of Public Health, the facility failed to provide adequate supervision and appropriate interventions to prevent sexual abuse perpetrated by Resident Identifier (RI) #325 against RI #82, a resident with known manipulative romantic behaviors, history of entering male residents' rooms, and history of consenting to sexual relationships. Multiple of the facility's staff were aware of RI #82's behaviors of entering male residents' rooms and manipulative romantic behaviors. The facility did not develop or implement interventions to address RI #82's repeated behaviors and ensure he/she was protected. The facility did not develop interventions to establish the level of supervision needed to ensure RI #82's safety. On 06/03/2024 staff heard a resident yelling no, no, let me go. Two staff members entered RI #325's room and found RI #82 on the floor beside RI #325's bed. RI #325 was observed on the bed with his/her pants down and penis exposed just inches away from RI #82's face. RI #325 was holding RI #82 by the hair of his/her head pushing RI #82's face toward his/her penis. RI #82 cried and told the staff broken, broken. RI #82 was transferred to the Emergency Department for examination for sexual assault. RI #82 was treated for a right sprained ankle. 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. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect, and Exploitation. On 11/18/2024 at 4:44 PM, the Administrator (ADM), Assistant Director of Nursing (ADON), the Corporate Nurse (CN), the Regional Administrator (RADM) and the Administrator in Training (AIT) were provided a copy of the Immediate Jeopardy (IJ) template and notified of the finding of substandard quality of care at the immediate jeopardy level in the area of Freedom from Abuse, Neglect, and Exploitation at F 600- Free from Abuse and Neglect. The IJ began on 06/03/2024 and continued until 11/20/2024 when the survey team verified onsite that corrective actions had been implemented. On 11/21/2024 the immediate jeopardy was removed, F 600 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. This affected RI #82, one of 11 residents sampled for abuse. This deficiency was cited as the result of the investigation of complaint/report #AL00048048. Findings include: Cross-Reference F 610. On 06/03/2024 at 8:16 PM, the State Agency received a complaint/report through the Online Incident Reporting System that reported: (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Category: Abuse - Sexual . Date and time of incident or alleged incident: 06/03/2024 . Time: 07:15 PM . Narrative summary of incident: It was reported that a male/female resident was heard yelling in resident (RI #325)'s room. Upon arrival, resident (RI #82) was observed on (his/her) back in the floor (fully clothed) and resident (RI #325) kneeling over (him/her) with (his/her) penis out . A review of a document titled Alabama Uniform Incident/Offense Dated 06/03/2024, documented: .Type of Incident or Offense .Sexual Misconduct . Narrative . The victim, RI #82, . stated he/she had gone to RI #325's room to have a conversation . once inside RI #82 stated that RI #325 kept putting his/her hands on him/her and pulled his/her pants down grabbing him/her around his/her private area. RI #82 stated that RI #325 pulled his/her hair and forced him/her into the floor at which time RI #325 . forcefully tried to insert his/her private part into RI #82's mouth . A review of facility policy titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation dated May 01, 2023 revealed: Purpose: . The facility's policy strictly prohibits the abuse, neglect, exploitation . The following are definitions of specific types of abuse: . 2. Sexual- Sexual abuse, is a non-consensual sexual contact of any type with a resident/guest and includes, but not limited to, sexual harassment, sexual coercion, or sexual assault. Sexual contact may be considered non-consensual: if the resident either appears to want the contact to occur but lacks the cognitive ability to consent: or does not want the contact to occur . Determination of capacity cannot necessarily be based on a diagnosis alone . Sexual contact can include touching of . breasts, genitalia, groin, inner thighs, or buttocks with intent to cause sexual satisfaction or excitement to either person. Sexual harassment can include sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature . III. Prevention Policies and Procedures . d) The facility will make all reasonable efforts to minimize instances of abuse, but in cases where such an instance occurs, the facility will use the event as an opportunity to develop new interventions in an attempt to prevent a re-occurrence . RI #82 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #82 had diagnosis of Hemiplegia and Hemiparesis Following Infarction Affecting Right Dominant Side, Aphasia Following Cerebral Infarction, and Depression. A review of RI #82's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	05/13/2024 documented that RI #82's Brief Interview for Mental Status (BIMS) score was 99 which indicated that he/she was unable to complete the interview. The MDS documented that RI #82 had short- and long-term memory problems. A review of facilities Departmental Notes for RI #82 revealed Social Service's notes that documented: A note dated 07/27/2022 signed by the Social Services Director (SSD) documented IDT (interdisciplinary team) met to review behaviors. Resident's roommate is accusing resident of bringing men into their room to have sex. Resident denies . A note dated 08/17/2022 signed by the SSD documented IDT met to review behaviors. Resident was caught going into other resident's rooms and going through their things. Resident also caught trying to go into other male resident's rooms. A note dated 09/28/2022 signed by the SSD documented IDT met to review behaviors. Resident going into other male resident's rooms. A note dated 10/06/2022 signed by the SSD documented Resident is seeking a relationship with another male resident . A note dated 01/04/2023 signed by the SSD documented IDT met to review behaviors. Resident presenting manipulating behaviors toward another male resident. Resident is in a mutually willing relationship with another male resident and will ask male resident for money, and male resident gives him/her money from his/her personal account. A note dated 01/25/2023 signed by the SSD documented IDT met to review behaviors. Resident is manipulating other male residents. Resident will state he/she is in a relationship with other willing male residents. Once male residents receive their money for the month she/he will manipulate male resident into giving him/her money. A note dated 02/23/2023 signed by the SSD documented IDT met to review behaviors. Resident is manipulating another male resident into giving him/her money . A note dated 05/10/2023 signed by the SSD documented IDT met to review behaviors. Resident going into other resident's rooms . A note dated 07/19/2023 signed by the SSD documented IDT met to review behaviors. Resident got into a verbal disagreement with another male resident due to no longer wanting to be socially involved with him/her. A note dated 07/26/2023 signed by the SSD documented IDT met to review behaviors. Resident also witnessed by staff kissing another male resident . A note dated 08/02/2023 signed by the SSD documented IDT met to review behaviors. Resident was viewed by staff being inappropriate with another male resident. A note dated 08/09/2023 signed by the SSD documented IDT met to review behaviors. Resident is approaching different men in the facility in an attempt to get money from them . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A note dated 08/16/2023 signed by the SSD documented IDT met to review behaviors. Resident was witnessed by staff being inappropriate with another male resident in a public area . A note dated 08/30/2023 signed by the SSD documented IDT met to review behaviors. Resident is approaching other male residents and asking them for money. A review of RI #82's comprehensive care plan indicated care plans were developed for: .Exhibits behaviors entering other resident's rooms without permission . start date of 08/17/2022 . Exhibits behaviors r/t (related to) resident manipulates male residents into believing he/she is romantically interested in them . start date 02/15/2023 . Sexual expressions r/t consensual desires with opposite sex . start date of 07/31/2023 . The comprehensive care plan did not include the level of supervision needed to ensure RI #82's safety or when and how RI #82 was to be monitored. RI #325 was admitted to the facility on [DATE] with diagnoses that included Vascular Dementia with Mood Disturbance. A review of RI #325's admission MDS with an ARD of 03/13/2024 documented that RI #325's BIMS score was 13 of 15 which indicated intact cognition. On 11/15/2024 at 9:45 AM an interview was conducted with the Social Service Director (SSD). The SSD said that RI #82 was care planned for sexually manipulating behaviors and going into other residents' rooms. The SSD said the IDT had discussed RI #82's manipulating behaviors, and the SSD had multiple conversations with RI #82 about the risks of going in and out of male residents' rooms. The SSD said she had observed RI #82 several times going into male residents' room and redirected RI #82 out of the room and educated him/her on the risks. The SSD said she saw RI #82 in RI #325's room at least two different occasions before the incident. The SSD said after RI #82 was noted entering male residents' rooms the facility did not develop or implement any interventions other than to monitor and continue to redirect him/her out of rooms when observed. On 11/18/2024 at 9:10 AM a follow-up interview was conducted with the SSD. The SSD said RI #82's behaviors of going into male residents' rooms was discussed during the IDT meeting multiple times. The SSD said the team decided to address the behavior by redirecting RI #82 and monitor more. The SSD said staff would know to monitor RI #82 by being aware to watch him/her and it was not documented anywhere. The SSD was asked, how would the staff be aware. The SSD replied, after the meeting the CNA that worked with RI #82 was notified to be aware of this behavior and to redirect him/her out of rooms. The SSD said nothing could have been done differently unless the facility provided RI #82 with one on one monitoring. The SSD said something bad could have happened as a result of RI #82's continued behaviors. On 11/15/2024 at 4:50 PM an interview was conducted with Nursing Assistant (NA) #18 who had worked with RI #82 for approximately six months and was familiar with his/her daily pattern. NA #18 said she had observed RI #82 in RI #325's room a few times prior to the incident that occurred on 06/03/2024. NA #18 said the two residents would visit in the room about 15 minutes, and she (NA) would be outside RI #325's doorway to monitor and ensure the safety and protection of RI #82. NA #18 said this (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was something she chose to do when on duty and not providing care for other residents. NA #18 said RI #82 walked around the facility daily in the afternoon. NA #18 said on 06/03/2024 RI #82 left his/her room around 6:45 PM and NA #18 assumed he/she was going to walk but she now thought he/she must have went to RI #325's room because the incident was witnessed soon after. On 11/13/2024 at 2:51 PM Licensed Practical Nurse (LPN) #12 was interviewed. LPN #12 said when walking down the hallway about 12 feet past RI #325's room, she heard a female voice saying no, no, let me go. LPN #12 said she was unclear which room the voice was coming from, or if it was a resident's television. LPN #12 said she was approximately two doors from RI #325's room when she heard the noise and motioned for Certified Nursing Assistant (CNA) #13 who was located further down the hallway to come help. LPN #12 said she entered the room first and CNA #13 followed her. LPN #12 said when they entered the room, they pulled the curtain open and RI #82 was on the floor and his/her right leg (affected side from prior stroke) was bent almost to the floor in an unnatural position. LPN #12 said RI #325 had his/her left hand on top of RI #82's head and was pushing RI #82's head toward his/her exposed penis. LPN #12 said RI #325 was not letting RI #82 loose. LPN #12 said RI #82 was crying and continued to say, no, no. LPN #12 said what she observed was mental and sexual abuse and a reasonable person in a similar situation as RI #82 would feel victimized. A review of RI #82's Departmental Notes revealed an entry dated 06/03/2024 at 9:33 PM by Registered Nurse (RN) #14. The note documented: At (approximately) 7pm . Charge nurse reported she heard No and Help me coming from another residents room . When she pulled the curtain, she seen (RI #82) on the floor . (RI #325) hands were in his/her hair, (RI #325) had his/her bottoms pulled down to his/her penis noted to be erect and inches away from (RI #82's) mouth . On 11/14/2024 at 12:13 PM an interview was conducted with RN #14 who said a staff called her on the phone after the incident occurred and reported that RI #325 had tried to get RI #82 to do sexual things to him/her and got aggressive but they intervened. RN #14 said she had seen the two residents sitting together in the gazebo or in social settings but that was all. RN #14 said this was the first time that she was aware that RI #82 had entered RI #325's room. On 11/13/2024 at 5:12 PM an interview was conducted with Medication Administration Certified (MAC) #21 who said she sat with RI #82 after the incident. MAC #21 said after the incident RI #82 was clearly upset and crying and said no more like he/she thought it was his/her fault. MAC #21 said she sat with RI #82 for 15 to 20 minutes and the ambulance arrived to transport RI #82 to the hospital. MAC #21 said RI #82 was still upset when he/she was on the stretcher and was saying I am sorry, no more, no more. On 11/16/2024 at 2:40 PM an interview was conducted with the ADON. When asked what protective measures were put in place to prevent potential abuse with RI #82, ADON said redirecting him/her out of male residents' rooms. The ADON said she redirected RI #82 out of male rooms several times previously and instructed him/her to visit in a public area. In addition to the facility redirecting RI #82, he/she was also educated, and the ADON said the Responsible Party (RP) was involved and spoke to RI #82 about not going into male residents' rooms. The ADON said the interventions of providing redirection and education were not effective and the facility could have placed staff on the hall for closer monitoring. During a follow up interview with the ADON on 11/17/2024 at 4:57 PM, she said a reasonable person (continued on next page)

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Cordova Health and Rehabilitation, LLC	70 Highland Street West Cordova, AL 35550

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	would feel in a similar situation as RI #82 would feel violated. On 11/18/2024 at 12:38 PM an interview was conducted with RI #82's responsible party (RP) via phone. RI #82's RP said what she gathered regarding the incident from speaking with RI #82 and what RI #82 told the police was that RI #325 invited RI #82 into his/her room. RI #82's RP said that RI #82 said that RI #325 asked him/her in, then pulled the curtain, and was trying to force him/her to perform oral sex on RI #325. RI #82's RP said RI #82 said RI #325 forced him/her down to the floor and hit him/her in the face he/she had a bruise. RI #82's RP said RI #325 was definitely forceful because RI #82 had injury to his/her right leg. RI #82's RP said the facility could prevented the abuse if they had someone at end of the hall supervising. ********** On 11/20/2024, the facility submitted an acceptable removal plan, which documented: F 600 Removal Plan 11/20/24 1. Immediate action(s) taken for the resident(s) found to have been potentially affected include: A. On 11/18/2024 RI #82 was placed back on 1:1 observation at 5:31 pm. RI #82 will not be left unsupervised until deemed safe by facility medical director. The facility will communicate to the medical director after there is no behaviors that increase her vulnerability for sexual abuse. B. RI #82 care plans were reviewed and revised by MDS coordinator on 11/18/2024 to include 1:1 supervision. C. RI #325 was placed on 1:1 supervision on 6/3/2024 until discharged to hospital then discharged home to family. Resident has not returned to the facility. D. On 6/3/2024 at 8:40 pm RI #82 was assessed by RN Unit Manager and noted to have right ankle pain. 2. Identification of other residents having the potential to be affected: A. This had the potential to affect all residents that resided in the facility. B. On 11/18/2024 management nursing staff completed a facility audit to identify any other residents with known manipulative romantic behaviors, history of consenting to sexual relationships with other residents and history of entering male residents' rooms without supervision. None were identified. 3. Actions taken/systems to be put into place to reduce the risk of future occurrences include: A. On 11/18/2024 the Regional Administrator provided 1:1 in-service education to Administrator and DON regarding the abuse policy, distressed behavior management program and identification and notification of new or worsening behaviors that increase residents' vulnerability to sexual abuse. The facilities abuse policy has always included that all residents have the right to be free from sexual abuse/abuse, identification of sexual abuse/abuse, and immediately protecting resident when sexual abuse/abuse is suspected. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	B. On 11/18/2024 education was initiated by Staff Development Nurse with 110 out of 112 facility staff (1 LPN and 1 CNA on FMLA) regarding abuse policy to include protecting residents from sexual abuse and identifying behaviors that increase residents vulnerability to sexual abuse, by use of notification of new or worsening behaviors from NM.II-24B (exhibit 2) the form will be reviewed in the morning to reduce the risk of abuse. No staff will be allowed to work unless they have been in serviced. CNA's will communicate behaviors to the nurse, the nurse will implement immediate appropriate intervention will document on the electronic medication administration (EMAR) record under resident task. The Director of Nursing or the assistant director of nursing will review resident task history each business day during morning meeting to ensure the appropriate intervention to maintain the safety of the resident. MDS coordinator will then update resident care plans to reflect the new behavior of the resident with the appropriate care plan. To start on 11/20/24. The facilities abuse policy has always included that all residents have the right to be free from abuse/sexual abuse is suspected. New hires will continue to be educated on the abuse policy to include identifying sexual abuse and protecting residents when suspected sexual abuse occurs. C. On 11/18/2024 Emergency QAPI meeting was held with all key personnel (Administrator, Director of Nursing, Department Heads, Regional Administrator and Regional Nurse Consultant). QAPI meeting discussed residents are kept safe from all types of abuse/sexual abuse and neglect. This was done by educating staff on who to report abuse to, when to report abuse and what to report. D. There are no residents known to the facility to be demonstrating with known manipulative romantic behaviors, history of consenting to sexual relationships with other resident, and history of entering male residents' rooms without supervision besides resident RI #82. Any sexually inappropriate behavior will be reported immediately to the Administrator or DON. The facility will immediately initiate the abuse protocol to include immediate protection of residents, notification of local police, MD/CRNP, ADPH and responsible parties followed by complete investigation. Facility requests for IJ removal plan to be effective on 11/20/2024. this plan was written by Regional Nurse Consultant and Administrator. ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 11/20/2024.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, documents titled Online Incident Reporting System Report and a facility policy titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation the facility failed to report allegations related to physical and verbal abuse within 2 hours to the state agency on 04/09/2024, 07/03/2024 and 10/27/2024. This affected Resident Identifiers (RI) #27, #43 and #91. This deficient practice affected three of eleven residents sampled for abuse. Findings Include: A review of a policy titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation with an effective date of May 01, 2023, documented the following: .b) Investigation and Reporting Steps .All allegations of abuse and instances that result in serious bodily injury must be reported with 2 hours. 1. A review of a document titled Online Incident Reporting System Report documented RI #91 reported an allegation of verbal abuse regarding RI #27 threatening RI #91 on 04/09/2024 and the facility notified the State Agency on 04/10/2024 at 1:02: PM. The report indicated that RI #27 was placed on 1:1 on 04/09/2024 until transferred for psychiatric evaluation on 04/10/2024. RI #91 was admitted to the facility on [DATE] with diagnoses to include Alzheimer's Disease, Dementia and Type 2 Diabetes Mellitus with Hyperglycemia. RI #27 was readmitted to the facility on [DATE] with diagnoses to include Human Immunodeficiency Virus, Chronic Obstructive Pulmonary Disease, Type Two Diabetes Mellitus with Diabetic Nephropathy and Vascular Dementia An interview was conducted with the ADM on 11/15/2024 at 5:23 PM. The ADM stated he became aware of the allegation of verbal abuse involving RI #91 and RI #27 on 04/10/2024. The ADM was asked why the incident was not reported on 04/09/2024. He responded that if the incident was witnessed/occurred on 04/09/2024 it should have been reported to the State agency on 04/09/2024. This was cited as a result of investigation of complaint/report number AL00047516. 2. A review of a document titled Online Incident Reporting System Report documented RI #43 reported an allegation of verbal abuse on 10/27/2024 and the facility notified the State Agency on 10/28/2024 at 9:38 PM. The allegation was that CNA #20 cursed at RI #43. The report indicated CNA #20 was immediately removed from the room and suspended pending investigation. RI #43 was admitted to the facility on [DATE] with diagnoses to include Dementia, Major Depressive Disorder, Alcohol Abuse and Adjustment Disorder with Depressed Mood. An interview was conducted with the Assistant Director of Nursing (ADON) on 11/16/2024 at 10:56 AM. The ADON stated it was reported to her on 10/27/2024 at 12:20 AM and she reported it to the State Agency on 10/28/2024 at 09:30 AM. She further said abuse was to be reported in two hours and it was (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not reported within the two-hour timeframe, and it should have been. The ADON said the allegation was reported late to the State Agency because she did not have a key to the ADM's office to access the computer codes and that the ADM was out of the country. She further said that when it was reported to the ADM it was late reporting. The ADON further stated the allegation was not substantiated due to lack of evidence. An interview was conducted with the ADM on 11/16/2024 at 11:21 AM. The ADM stated he it was reported to him on 10/27/2024 at 12:20 AM and was reported to the State Agency on 10/28/2024 at 9:39 AM. He further said it was not reported within the two-hour timeframe and he reported it when he became aware. This deficiency was cited as the result of the investigation of complaint /report number AL00049463.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of facility policies titled, Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation, and Incidents and Accidents, the facility failed to thoroughly investigate an incident of abuse to prevent further occurrences. After staff witnessed an incident of sexual abuse on 06/03/2024 involving RI #82 and RI #325, the Director of Nursing (DON) reported the 06/03/2024 incident to the Administrator (ADM). There was no evidence the investigation included interviews with either resident involved. The investigation failed to identify that the facility's failure to provide supervision to RI #82, a resident with a known history of romantically manipulative behaviors and history entering male resident rooms without supervision. Because the facility's investigation failed to identify potential contributing factors, the facility was unable to develop and implement any new measures or actions to prevent recurrence. 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. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect, and Exploitation. On 11/18/2024 at 4:44 PM, the Administrator (ADM), Assistant Director of Nursing (ADON), the Corporate Nurse (CN), the Regional Administrator (RADM), and the Administrator in Training (AIT) were provided a copy of the Immediate Jeopardy (IJ) template and notified of the finding of substandard quality of care at the immediate jeopardy level in the area of Freedom from Abuse, Neglect, and Exploitation at F 610-Investigate/Prevent/Correct Alleged Violations. The IJ began on 06/03/2024 and continued until 11/20/2024 when the survey team verified onsite that corrective actions had been implemented. On 11/21/2024 the immediate jeopardy was removed, F 610 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. These failures affected RI #82 and RI #325. This deficiency was cited as the result of the investigation of complaint /report #AL00048048. Findings include: Cross-Reference F 600. Review of the facility's abuse policy titled, Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation, with an effective date of 05/01/2023, revealed the following: . PURPOSE: This policy is concerned with all incidents . involving residents. The facility will investigate and document all incidents . involving residents . The investigation protocol for incidents . is set forth in Section VI of this Policy . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	For purpose of this Policy, the following terms shall have the following meanings: A. Abuse. The definition of abuse encompasses a broad scope of behavior . Any act considered abusive towards an alert oriented resident should also be considered abusive to the cognitively impaired or nonresponsive . The following are definitions of specific types of abuse: . 2. Sexual- Sexual abuse, is a non-consensual sexual contact of any type with a resident and includes, but not limited to, sexual harassment, sexual coercion, or sexual assault. Sexual contact may be considered non-consensual: if the resident either appears to want the contact to occur but lacks the cognitive ability to consent: or does not want the contact to occur. Determination of capacity cannot necessarily be based on a diagnosis alone . Sexual contact can include touching of . inner thighs, or buttocks with intent to cause sexual satisfaction or excitement to either person. Sexual harassment can include sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature . III. Prevention Policies and Procedures . d.) The facility will make all reasonable efforts to minimize instances of abuse, but in case where such an instance occurs, the facility will use the event as an opportunity to develop new interventions in an attempt to prevent a reoccurrence . IV. Identification of Resident Incidents . a) The facility's employees . may become aware of resident/guest incidents . The facility will investigate all incidents or allegations regardless of how the facility became aware of the incident or the source of the allegation . VI. Investigations and Facility Response to Incidents . b) Investigation . Steps Notify the Administrator of any unusual situation in the facility, whether reportable or not immediately . Immediately consider and put into place interventions to protect the resident . involved . and other facility resident . The Administrator is responsible for conducting a thorough investigation and obtaining witness statements. A complete and thorough investigation must be conducted on all incidents . whether reportable or not . to determine the cause of the . incident. The outcomes of the investigation must also determine whether or not the incident was abusive or neglectful in nature. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	If reportable to the State Agency, the facility will make an investigation report within five (5) working days to the State Agency. This report will be in writing and will contain: .9. What the facility did to immediately correct the problem. 10. Actions taken by the facility following the investigation. A facility policy titled, Incidents and Accidents, with an effective date of 05/01/2023, revealed the following: . STANDARD: An incident is an occurrence that may not be consistent with the routine operation of the facility . PROCESS: . II. Documentation . b) An Incident/Accident report should be completed. c) Develop a brief investigation plan including obvious interviewees, questions to be asked and information to be gathered . RI #82 was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. A review of RI #82's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/13/2024 revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident was unable to complete the interview and noted RI #82 to have short- and long-term memory problems. RI #325 was admitted to the facility on [DATE] with a diagnosis of Vascular Dementia, with Mood Disturbance. A review of RI #325's admission MDS with an ARD of 03/13/2024 revealed a BIMS score of 13 of 15 which indicated intact cognition. A review of facilities Departmental Notes revealed incidents with RI # 82 on 08/17/2022, 09/28/2022, 01/25/2023, 07/31/2023, 02/23/2024, 08/02/2023, and 08/16/2023 where the Interdisciplinary Team (IDT) met to review RI #82's sexual behaviors to include: manipulating male residents, exhibiting inappropriate behaviors with male resident in public, and expressing desire to be intimate with a male resident. The facility did not investigate, develop interventions, or implement protective measures to address repeated behaviors. A review of the facility's investigative file revealed a document titled VERIFICATION OF INVESTIGATION with DATE OF INCIDENT of 06/03/2024 documented: . DETAILED DESCRIPTION OF INCIDENT/ALLEGATION: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	It was reported by (Licensed Practical Nurse (LPN) #12) that she heard yelling coming from the room of (RI #325). (LPN #12) and (Certified Nursing Assistant (CNA) #13) entered the room, and observed the curtain pulled blocking the view of his/her bed. Once they pulled the curtain, they saw RI #325 lying . with his/her penis exposed and RI #82 in the floor beside the bed with his/her face near (RI #325's) penis and his/her hand behind his/her head. Note neither eyewitness confirm there was any actual sexual contact between the two. RESIDENT INTERVIEW SUMMARY: RI #325 did not provide any comments to charge nurse immediately following the interaction. Nurse noted resident was masturbating in his/her room at the time she tried to interview . RI #82 was questioned on 6-4-2024 but due to her severe cognitive impairments, she was unable to provide any reliable information that would contribute to the outcome of this investigation. PROVIDE SUMMARY AND OUTCOME OF INVESTIGATION: Outcome: On 06/03/2024 (RI #325) was observed in his/her room, lying on his/her side with his/her penis exposed and his/her hand behind the head of (RI #82) by (LPN #12) and (CNA #13). (RI #82) was observed on the floor beside the bed, on one knee and the other out to his/her side. It is unknown how or why (RI #82) was in (RI #325's) room although resident does ambulate throughout the facility independently. It was reported by the two eyewitnesses that (RI #325) seemed to be attempting to have (RI #82) perform oral sex on him/her. (RI #325) reportedly had his/her hand behind his/her head but neither witness could confirm any actual sexual contact took place as (RI #82) was fully dressed. Given the testimony of the eyewitnesses, it is the opinion of this investigator that an allegation of sexual abuse is inconclusive. However, it was discovered that (RI #325) had his/her hand on the back of (RI #82's) head, and he/she was noted to have a sprained ankle upon returning from the hospital. Therefore, it is the opinion of this investigator that an allegation of physical abuse is substantiated. IDENTIFY APPROPRIATE RECOMMENDATIONS / INTERVENTIONS FOR EACH CAUSAL OR CONTRIBUTING FACTOR LISTED: CAUSAL / CONTRIBUTING FACTORS AND OBSERVATION (May include information from witness interviews, medical record review ., etc.) Factor 1: dx (diagnosis) of vascular dementia. SPECIFY RECOMMENDATIONS /INTERVENTIONS TAKEN TO PREVENT REOCCURENCE . (RI #325) discharged to family from hospital. SIGNATURE OF ADMINISTRATOR . (ADM's name) . WITNESS INFORMATION: IDENTIFY ALL INDIVIDUALS WHO MAY HAVE PERTINENT KNOWLEDGE EITHER PRIOR TO, DURING, OR AFTER ALLEGED EVENT . There was no information entered on this portion of the document that included space for name of witness and summary of testimony. Further review of the facility's investigative filed revealed handwritten statements from LPN #12 and CNA #13. LPN #12's statement was dated 06/06/2024 and indicated she saw RI #325's penis exposed and he/she had RI #82 by the hair and was pushing his/her face to his/her exposed penis. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA #13's statement was not dated and indicated she saw RI #82 bent over RI #325 while RI #325's pants were down. The investigative file did not include additional interviews or statements from staff or residents. On 11/14/2024 at 10:11 AM, an interview was conducted with the ADM who said it was in his opinion that the allegation of sexual abuse was inconclusive, and the allegation of physical abuse was substantiated. The ADM said he came to the determination that sexual abuse was inconclusive because RI #82 was fully clothed and there was not intercourse. The ADM added, there could have been something orally but it could not be determined based on interviews. The ADM said he was not aware either resident had any previous sexual behaviors. The ADM said the root cause was determined to be to discourage residents from going to other resident's rooms. The ADM added, it was important to keep in mind that RI #82 was in RI #325's room, and he could not rule out whether RI #82 initiated something sexual. The ADM said RI #82's family decided to press charges. 11/15/2024 at 3:28 PM a follow-up interview was conducted with the ADM. The ADM said the facility's investigation could not determine if RI #82 had been invited into RI #325's room because RI #325 had already been transferred to the hospital and did not return and RI #82 was not a credible or reliable source due to his/her cognitive impairment in his dealings with RI #82 due to aphasia. The ADM said he was not aware that RI #82 had a history of entering RI #325's room. On 11/17/2024 at 4:45 PM, another follow-up interview was conducted with the ADM. The ADM was asked was he able to conduct a thorough investigation. The ADM responded, yes, except for not talking to RI #82 due to him/her being hard to understand and the ADM could not make out what was being said. The ADM said he was unable to interview RI #325 because RI #325 did not return to the facility. A review of a document titled Alabama Uniform Incident/Offense Dated 06/03/2024, documented: .Type of Incident or Offense . Sexual Misconduct . Narrative . The victim, RI #82, . stated he/she had gone to RI #325's room to have a conversation . once inside RI #82 stated that RI #325 kept putting his/her hands on him/her and pulled his/her pants down grabbing him/her around his/her private area. RI #82 stated that RI #325 pulled his/her hair and forced him/her into the floor at which time RI #325 . forcefully tried to insert his/her private part into RI #82's mouth . ********** On 11/20/2024, the facility submitted an acceptable removal plan, which documented: F610 Removal Plan 11/20/24 1. Immediate action(s) taken for the resident(s) found to have been potentially affected include: A. Regional Administrator and Regional Nurse Consultant provided 1:1 in-service education to Administrator, DON and ADON regarding Abuse/Sexual Abuse policies implemented, including conducting a thorough investigation, to include contributing factors to the occurrence and take appropriate corrective action based on investigation results and contributing factors, completion of Abuse Questionnaire (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NM.II-20exh.A (exhibit 1 see attached) and collecting and retaining resident statements to determine a clear time of occurrence of events and that all staff responding appropriately per the abuse policy; identification of prospective residents who may pose a risk of sexual abuse to other residents due to their behaviors and planning for management of those behaviors. This was completed on 11-18-24. B. Director of Nursing re-interviewed RI #82 on 11/18/2024. RI #325 was unable to be interviewed by facility staff due to RI #325 discharge to the hospital on 6/3/24, then discharged to home from the hospital on 6/6/2024. 2. Identification of other residents having the potential to be affected: A. This had the potential to affect all residents. Regional nurse consultant and Regional Administrator reviewed for all previous investigations from 6-3-2024 through 11-28-2024. None were identified that the Regional Administrator or Regional Nurse Consultant disagreed with the investigation outcome. This was completed on 11-18-24. 3. Actions taken/systems to be put into place to reduce the risk of future occurrences include: A. QAPI completed on 11-18-24 with administrator for understanding the administrator's responsibility regarding facility policies being implemented and followed. Regional Administrator will sign off on facility reportable investigations to include sexual abuse investigations for compliance to the facilities abuse/sexual abuse policy, QAPI policy, behavior monitoring policy and notification policy are implemented/conducted according to the policy. B. The Administrator was educated by the regional nurse consultant to utilize the Verification of Investigation (VOI) form to conduct a consistent and thorough investigation of alleged abuse. The VOI includes detained description of events/allegation, BIMS score, Resident interview summary, immediate resident protection initiated, and the related. See attached. C. Facility requests for IJ removal plan to be effective on 11-20-24. ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 11/20/2024.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to ensure Resident Identifier (RI) #2's completed Minimum Data Set (MDS) assessments was transmitted to the CMS system. This affected RI #2, one of 22 sampled residents whose MDS assessments were reviewed. Findings include: Review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2024, revealed the following: CHAPTER 5: SUBMISSION .OF THE MDS ASSESSMENTS Transmitting Data: Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. . Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days) . RI #2 was admitted to the facility on [DATE]. On 11/14/2024 at 11:30 AM, record review revealed RI #'s 2's 09/23/2024 annual MDS assessment was not transmitted to CMS after it was completed on 10/07/2024. The MDS Coordinator, was interviewed on 11/14/2024 at 1:59 PM. During the interview, she indicated that she had completed the MDS for RI #2, which was dated 09/23/2024. She said the assessment was started on 09/23/2024 and completed on 10/07/2024. The MDS coordinator said that the MDS was not transmitted to CMS after it was completed on 10/07/2024. When asked why the MDS should be transmitted she said to ensure accuracy and to provide accurate information to CMS.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and the Centers for Medicare & Medicaid Services (CMS)Center) Long- Term Care Resident Assessment Instrument 3.0 Manual, the facility failed to 1) ensure Resident Identified (RI) #60's Annual Minimum Data Set (MDS) assessment dated [DATE] section A1500 was coded accurately to reflect RI #60's Preadmission Screening and Resident Review (PASRR) Level II. 2) ensure RI #82's Annual MDS assessment dated [DATE] section A1500 was coded accurately to reflect RI #82's PASRR Level II. This deficient practice affected two of 22 sampled residents whose MDS was reviewed. Findings include: Review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2024, revealed the following: A1500: Preadmission Screening and Resident Review (PASRR) . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition 1) RI #60 was admitted to the facility on [DATE] with a diagnosis of Generalized Anxiety Disorder, Post-Traumatic Stress Disorder, Chronic, Developmental Disorder. A review of RI #60's Annual MDS dated [DATE] documented: . A1500 Preadmission Screening and Resident Review (PASRR) . Is the resident currently considered by the state level II PASRR . was marked 0 indicating No. A review of RI #60's PASRR Level II Service Determination dated 11/27/2018 documented: . Section I: Diagnosis . X marked for Serious Mental Illness (MI) specify: PTSD . X marked for Related Condition (RC) specify: DD . On 11/14/2024 at 1:56 PM an interview was conducted with the MDS Coordinator. When asked if RI #60 was marked on the MDS as a Level II, she said no. In referencing RI #60's Level II document, the MDS Coordinator noted where RI #60 's document revealed he/she was a Level II. When asked what the importance of the MDS being marked correctly, she said to ensure accuracy of the MDS data. 2) RI #82 was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis Depression. On 11/18/2024 at 10:00 AM, a review of RI #82's Annual MDS dated [DATE] documented: . A1500 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Preadmission Screening and Resident Review (PASRR) . Is the resident currently considered by the state level II PASRR . was marked 0 indicating No. A review of RI #82's PASRR Level II Service Determination dated 05/25/2022 documented: .Section I: Diagnosis X marked for Serious Mental Illness (MI) specify: Depression . On 11/18/2024 at 11:20 AM a follow up interview was conducted with MDS Coordinator. When asked if RI #82 was marked on the MDS as a Level II, she said no. In referencing RI #82's Level II document, MDS coordinator noted where RI #82's document revealed he/she was a Level II. When asked why RI #82's MDS was not marked as being a Level II, she said this was an error and that it should have been marked.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, the facility's policy for Sanitation Principles, and the United States (U.S.) Food and Drug Administration (FDA) 2022 Food Code; the facility failed to prevent the potential for cross-contamination by allowing: 1. staff who were chewing gum to assist residents with meals, 2. clean pots and pans to be stored on a rusty wire shelving rack, 3. a dirty floor in the storeroom for thickened liquids and nutritional supplements and additionally allowing a delivery of nutritional supplements to be placed on the dirty floor, 4. wooden shelving with gaps along the floor line, which could not be cleaned beneath, in the thickened liquids and nutritional supplement storeroom, and 5. the double sink used for food preparation to have a direct connection to the sewer. Findings include: The facility's policy for Sanitation Principles, dated 08/10/2018, included the following: . PURPOSE: To prevent the spread of bacteria that may cause food borne illnesses. STANDARD: Food service areas should be maintained in a clean and sanitary manner. The current . Food Code should be utilized as guidelines for the department. PROCESS: a. Kitchens . should be kept clean, free from litter and rubbish, and protected from rodents, roaches, . b. shelves and equipment should be kept clean, maintained in good repair, and should be free from breaks, corrosion, open seams, cracks . 1. Chewing Gum The U.S. FDA 2022 Food Code included the following: . 1-201.10 Statement of Application and Listing of Terms. (A) The following definitions shall apply in the interpretation and application of this Code. Food means a raw, cooked, or processed edible substance, . or chewing gum. 2-401 Food Contamination Prevention (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2-401.11 Eating, Drinking, or Using TOBACCO PRODUCTS. (A) . an EMPLOYEE shall eat, . only in designated areas where the contamination of exposed FOOD; clean . UTENSILS, and LINENS; . or other items needing protection can not result. Resident Identifier (RI) #323 was admitted to the facility on [DATE]. Resident Identifier (RI) #322 was admitted to the facility on [DATE]. During a dining observation in the facility's dining room for the lunch meal on 11/12/2024 at 11:48 AM, Employee Identifier (EI) #7 CNA (Certified Nursing Assistant) was actively chewing gum and opening/closing her mouth when assisting residents with condiments. EI #7 CNA was observed chewing gum and hovering over RI #322's Puree lunch meal while assisting the resident. On 11/12/2024 at 11:50 AM, EI #7 CNA was chewing gum with her mouth opening and closing while setting up RI #323's Puree lunch meal. On 11/12/2024 at 11:52 AM, EI #8 CNA was observed chewing gum with her mouth opening and closing while setting up residents' lunch meal trays. On 11/12/2024 at 12:07 PM, EI #7 CNA was actively chewing gum while feeding RI #323 his/her Puree lunch meal. EI #7 CNA was widely opening and closing her mouth during the process of feeding RI #323, with her mouth almost over the resident's plate. EI #7 CNA's open and closing mouth was directly over a bowl of puree food and later directly over a Magic Cup dessert she held in her hand to feed RI #323 with a spoon. During a dining observation in the facility's dining room on 11/13/2024 at 11:45 AM, the Restorative Nurse was observed chewing gum. During an interview on 11/14/2024 at 11:05 AM, EI #7 CNA said she assisted with meals in the dining room on 11/12/2024. EI #7 CNA said she did not normally chew gum during work, like she was doing on Tuesday, 11/12/2024. EI #7 CNA said somebody just gave her a piece of gum before she went into the Dining Room. When asked if she was allowed to chew gum while assisting residents with meals, EI #7 CNA said she was not sure about that. Upon being asked the problem with chewing gum while assisting residents with their meals, EI #7 CNA said maybe spit on the food, which could cause cross contamination. During an interview on 11/14/2024 at 11:13 AM, EI #8 CNA said she assisted with meals in the dining room on 11/12/2024. EI #8 CNA said she did not normally chew gum during work, as she was doing on Tuesday. EI #8 CNA said someone gave her a piece and she just stuck it in her mouth. When asked if she was allowed to chew gum while assisting residents with meals, EI #8 CNA said she was not sure, but normally she does not chew gum in the Dining Room. EI #8 CNA further said she should have spit it out before going in the Dining Room. Upon being asked the problem with chewing gum, EI #8 CNA said spit or something coming out of your mouth could get on their food or anything. During an interview on 11/14/2024 at 11:22 AM, the Restorative Nurse said she assisted with meals in the dining room on Wednesday, 11/13/2024. The Restorative Nurse said she did not normally chew gum during work, like she was doing on Wednesday. The Restorative Nurse further said she was nervous and someone was passing around a pack of gum. When asked if she was allowed to chew gum while (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	assisting residents with meals, the Restorative Nurse said it had never really come up or been addressed before. Upon being asked the problem with chewing gum, the Restorative Nurse said I can see where it could be unclean. The Restorative Nurse further said one should definitely not be chewing while standing over and setting up the tray. During an interview about resident dining on 11/14/2024 at 12:52 PM, the Dietary Manager was asked the problem with staff serving meals to residents in the dining room, assisting residents with meal set-up, and feeding residents while chewing gum. The Dietary Manager said that would be an infection control issue. During an interview about resident dining on 11/14/2024 at 1:11 PM, the Registered Dietitian (RD) was asked the problem with staff serving meals to residents in the dining room, assisting residents with meal set-up, and feeding residents while chewing gum. The RD said that could create cross contamination and physical contamination. 2. Pot and Pan Shelving The U.S. FDA 2022 Food Code included the following: . 4-101.19 Nonfood-Contact Surfaces. NonFOOD-CONTACT SURFACES of EQUIPMENT that are exposed to splash, spillage, or other FOOD soiling or that require frequent cleaning shall be constructed of a -RESISTANT, nonabsorbent, and SMOOTH material. 4-201 Durability and Strength 4-201.11 Equipment and Utensils. EQUIPMENT and UTENSILS shall be designed and constructed to be durable and to retain their characteristic qualities under normal use conditions. 4-903 Storing 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) . cleaned EQUIPMENT and UTENSILS, . shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; . During the initial kitchen tour on 11/12/2024 at 10:55 AM, the storage rack for clean pots and pans had a build-up of rust on the wire shelves. Clean pans were sitting on this shelving. When a finger was rubbed along the wire shelf, a reddish substance transferred to the finger. The Dietary Manager was asked to describe the substance on the racks. The Dietary Manager said, Dirt and rust. When asked the potential problem, the Dietary Manager said dirt and rust can contaminate the pans. The Registered Dietitian (RD) was interviewed about kitchen concerns on 11/14/24 at 1:18 PM. The RD (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	said rust touching the clean pans could lead to contamination of the pans and increased germ exposure. 3. Dirty Floor The U.S. FDA 2022 Food Code included the following: . 3-305 Preventing contamination from the premises 3-305.11 Food Storage. (A) . FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination . 6-501.12 Cleaning, Frequency and Restrictions. (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. During the initial kitchen tour on 11/12/2024 at 10:45 AM, the storeroom for thickened liquids and supplements had a very dirty floor. The floor needed sweeping. The floor had a build-up of dirt stain and had several paper scraps upon it. A supplement delivery was stored on the floor. The Dietary Manager was interviewed about kitchen concerns on 11/14/24 at 1:02 PM. The Dietary Manager said the dirty floor could contaminate the items sitting on the floor. The Registered Dietitian (RD) was interviewed about kitchen concerns on 11/14/24 at 1:18 PM. The RD said the dirty floor in the Thickened Liquids and Supplements Storeroom could attract pests and dirt could be transferred from the floor to the food containers. 4. Wooden Shelving with Gaps The U.S. FDA 2022 Food Code included the following: . 6-201 Cleanability 6-201.11 Floors, Walls, and Ceilings. . floors, floor coverings, walls, . shall be designed, constructed, and installed so they are SMOOTH and EASILY CLEANABLE. 6-201.13 Floor and Wall Junctures, Coved, and Enclosed or Sealed. (A) In FOOD ESTABLISHMENTS in which cleaning methods other than water flushing are used for cleaning floors, the floor and wall junctures shall be coved and closed to no larger than 1 mm [millimeter] (one thirty-second inch). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the initial kitchen tour on 11/12/2024 at 10:45 AM, the storeroom for thickened liquids and supplements had a very uneven floor. The Dietary Manager said the floor was supposed to be replaced when the kitchen floor was recently re-tiled. The wooden shelving could not be cleaned beneath and the shelving had gaps on the wooden edge along the floor line. The Registered Dietitian (RD) was interviewed about kitchen concerns on 11/14/24 at 1:18 PM. The RD said since the wooden shelving has gaps along the floor line and it cannot thoroughly be cleaned beneath, it could result in a pest infestation. During a follow-up interview on 11/14/24 at 5:20 PM, the Director of Maintenance said the floor in the Thicken Liquids and Supplement Storeroom was supposed to be tiled along with the rest of the kitchen floor, but the company putting in the floor did not do it. 5. Food Preparation Sink The U.S. FDA 2022 Food Code included the following: . 5-402.11 Backflow Prevention. (A) . a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed. During the initial kitchen tour on 11/12/2024 at 10:55 AM, an observation was made of a double sink for food preparation with cabinet built around its base. The cabinet had 2 doors. Upon looking into the cabinet, a drain pipe was observed going from the double sink and into the wall, but no air gap was seen. The Director of Maintenance was interviewed in the kitchen on 11/14/2024 at 11:50 AM. The Director of Maintenance was asked if there was a backflow device or a special drain to prevent a direct connection between the sewer and the food preparation double sink or if the county code allowed the current plumbing for the food preparation double sink. The Director of Maintenance said he would have to check on that and he might need to check with the plumber. During a follow-up interview on 11/14/24 at 5:20 PM, the Director of Maintenance said he still needed to contact their plumber to find out what method of backflow prevention was in use for the food preparation double sink.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, the facility's policy for Sanitation Principles, and the United States (U.S.) Food and Drug Administration (FDA) 2022 Food Code; the facility failed to ensure the Three-compartment Pot and Pan Sink was in good repair for use. Two of three drain levers did not work, resulting in the rinse sink and the sanitizing sink being unable to hold water. This had the potential to affect 108 of 108 residents receiving meals from the kitchen. Findings include: The facility's policy for Sanitation Principles, dated 08/10/2018, included the following: . PURPOSE: To prevent the spread of bacteria that may cause food borne illnesses. STANDARD: Food service areas should be maintained . The current . Food Code should be utilized as guidelines for the department. PROCESS: . b. equipment should be . maintained in good repair . The U.S. FDA 2022 Food Code included the following: . 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair . During the initial kitchen tour on 11/12/2024 at 10:55 AM, the Three-compartment Pot and Pan Sink was observed to not be set up for use. The Dietary Manager said it was out of order. The Dietary Manager further said the levers don't work so the sinks cannot hold water and the water slowly leaks out. The Dietary Manager said the Three-compartment Pot and Pan Sink had been out of order since March or April of 2024, when the kitchen floor was redone. The Dietary Manager said they were using the dishroom to scrap and wash the pans and then they were sanitizing the pans by putting them through the dishmachine. During an interview on 11/14/2024 at 1:02 PM, the Dietary Manager said the Three-compartment Pot and Pan Sink should not have been out of working order for so long. The Dietary Manager further said it was a basic piece of kitchen equipment. The Registered Dietitian (RD) was interviewed on 11/14/24 at 1:18 PM. The RD agreed the Three-compartment Pot and Pan Sink was a basic piece of kitchen equipment. The RD also said we have a system for Maintenance called TELS, so it should have been addressed by now. During a follow-up interview on 11/14/2024 at 5:29 PM, the Dietary Manager was asked how would pans be washed if the dishmachine broke down. The Dietary Manager said we would have to keep refilling the sinks, the rinse sink and the sanitizing sink of the Three-compartment Pot and Pan Sink. During an interview on 11/14/2024 at 5:20 PM, the Director of Maintenance was asked why the Three-compartment Pot and Pan Sink had not been repaired. The Director of Maintenance said he did not know. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015115	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cordova Health and Rehabilitation, LLC	70 Highland Street West Cordova, AL 35550

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Director of Maintenance further said when we put it back in after the new kitchen floor was installed, they (Dietary management) said something about the two levers.