STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015175	A. Building B. Wing	03/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Place on Honeysuckle	718 Honeysuckle Road Dothan, AL 36305

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 0584 Level of Harm - Potential for minimal 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. Based on observations, interviews and a facility's policy titled, Homelike Environment, the facility failed to ensure rooms on one of seven halls were not found in need of repair. This deficient practice affected eight resident's rooms on one hall. Findings Include: A facility policy titled, Homelike Environment, with a revised dated of 02/2021, revealed, Policy Statement Residents are provided with a safe, clean, comfortable and homelike environment . Policy Interpretation and Implementation . the facility staff and management maximizes, to the extent possible the characteristics of the facility that reflect a . homelike setting . These characteristics include: a. clean, sanitary and orderly environment; . 1. On 03/18/2024 at 5:35 PM the surveyor observed a large amount of wall material missing behind the Resident Identifier (RI) #70's bed. 2. On 03/18/2024 at 5:40 PM the surveyor observed a large amount wall material missing behind the RI #13's bed. 3. On 03/18/2024 at 5:45 PM the surveyor observed a large amount of wall material missing behind RI #43's bed. 4. On 03/18/2024 at 5:50 PM the surveyor observed a large amount of wall material missing behind RI #138 's bed. 5. On 03/18/2024 at 5:55 PM the surveyor observed a large amount of wall material missing behind RI #1's bed. 6. On 03/18/2024 at 6:00 PM the surveyor observed a large amount of wall material missing behind RI #19's bed. 7. On 03/18/2024 at 6:30 PM the surveyor observed a large amount of wall material missing behind RI #67 's bed. 8. On 03/18/2024 at 6:15 PM the surveyor observed a large amount of wall material missing behind RI #40's bed and the ceiling tile over the bed was reddish-brown and sagging. (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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	On 03/20/2024 from 1:45 PM to 1:55 PM, the Maintenance Director (MTD) made observation of the noted concerns in residents' rooms. Large chunk of sheetrock was observed missing behind residents' headboards. The ceiling tile directly over RI #40's bed was discolored reddish-brown and sagging. An interview was conducted with the MTD on 03/20/2024 at 2:00 PM. The MTD stated the areas observed on the walls behind the beds in the residents' room were gouges in the drywall. He stated the ceiling over the bed in RI #40's room looked like an old leak. He stated the ceiling was discolored and had a small sag to it. The MTD stated it was unsightly for the facility to have gouges in the resident's walls and sagging, discolored ceiling. The MTD stated it was the facility's job to make their address a better place.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and review of a facility policy titled, Care Plans -Baseline, the facility failed to ensure Resident Identifier (RI) #196's and RI #198's baseline care plans addressed the use of their Continuous Positive Airway Pressure (CPAP) machines. This deficient practice affected RI #196 and RI #198, two of six sampled residents whose baseline care plans were reviewed. Findings include: A review of a facility policy titled, Care Plans-Baseline, with a revised date of 03/2022, revealed the following: . Policy Interpretation and Implementation 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: . b. Physician orders . 4. c. Any services and treatments to be administered by the facility . RI #196 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included Obstructive Sleep Apnea and Chronic Obstructive Pulmonary Disease. RI #196's March 2024 Order Summary Report (Physician Orders) revealed RI #196 had a physician order dated 03/12/2024 for . CPAP at night set to manufactures guidelines and settings . A review of RI #196's Baseline Care Plan, dated 03/08/2024, revealed under the section Health Conditions/Special Treatments . CPAP - while a resident . was not checked. On 03/19/2024 at 12:03 PM, RI #196's CPAP machine was observed on top of RI #196's dresser drawer. RI #198 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included Acute Respiratory Failure with Hypoxia and Acute Pulmonary Edema. A review of RI #198's Baseline Care Plan, dated 03/15/2024, revealed under the section Health Conditions/Special Treatments . CPAP - while a resident . was not checked. 03/19/2024 at 3:47 PM, RI #198's CPAP machine was observed on top of the nightstand in RI #198's room. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/22/2024 at 1:20 PM, an interview was conducted with Licensed Practical nurse (LPN) #17. LPN #17 said RI #198 used his/her CPAP at night, and RI #196 used one as well. On 03/22/2024 at 6:01 PM, an interview was conducted with Registered Nurse (RN) #18/Clinical Coordinator (CC) for the Rehab unit. RN #18 said it was the responsibility of the person that admitted the resident to the facility to develop a resident's baseline care plan. RN #18 said the baseline care plan should address that the resident was using respiratory equipment such as a CPAP. RN #18 said RI #196 used a CPAP. RN #18 looked at RI #196's baseline care plan and said it did not address the use of the CPAP. RN #18 said the care plan should have included the use of the CPAP and that it was an oversite. RN #18 said RI #198 used his/her CPAP. RN #18 said the use of CPAP should have been included on RI #198's baseline care plan but she did not see it on the baseline care plan. RN #18 said the purpose of a baseline care plan was to show what type of care was occurring with the resident. RN #18 said it would be important to ensure all resident's care information was included on the baseline care plan to make sure the resident's care was being properly administered.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of Resident Identifier (RI) #195's medical records, review of a third-party complaint, and the facility's policies titled, Care Plans, Comprehensive Person-Centered and Perineal Care, the facility failed to ensure care planned interventions were developed to instruct staff how to safely position RI #195 in bed during incontinent care; including how many staff members were required to safely provide incontinent care for RI #195. The facility further failed to ensure RI #195's care planned interventions for bilateral half side rails for safety during care was implemented by Certified Nursing Assistance (CNA) #6. This deficient practice affected RI #195; one of 51 sampled residents whose care plans were reviewed. On 09/14/2023, CNA #6 was providing incontinent care to RI #195 without the assistance of another staff. CNA #6 repositioned RI #195 to his/her left side, CNA #6 turned around to obtain a wipe, and when she turned back around RI #195 was sliding from the bed. RI #195 fell head and upper body first from the bed to the floor. According to CNA #6, the left side rail was not in the upright position at this time. RI #195 was sent to the ER (Emergency Room) for evaluation and was found to have two brain bleeds, a right-side mandible fracture, dental fractures, a right-side scapula fracture, and a right-side acromion fracture. It was determined the facility's noncompliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, §483.21(b)(1) Develop/Implement Comprehensive Care Plans at a scope and severity of J. On 03/23/2024 at 7:26 PM, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), were provided a copy of the Immediate Jeopardy Templates and notified of the findings of immediate jeopardy in the area of Comprehensive Resident Centered Care Plan, F 656-Develop/Implement Comprehensive Care Plans. The facility implemented corrective actions including ongoing monitoring to correct the identified deficient practice and prevent reoccurrence on 09/18/2023; thus, immediate jeopardy past non-compliance was cited. Cross-Reference F 689. Findings Include: The facility policy titled, Care Plans, Comprehensive Person-Centered, with a revised date of 03/2022, documented, Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical . functional needs is developed and implemented for each resident. Policy Interpretation and Implementation . 7. The comprehensive, person-centered care plan: . (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. A facility policy titled, Perineal Care, with a revised date of 02/2018, documented, Purpose The purposes of this procedure are to provide cleanliness and comfort to the resident . Preparation 1. Review the resident's care plan to assess for any special needs of the resident. RI #195 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include Dysphagia following Cerebral Infarction, Aphasia following Cerebral Infarction, Dementia and Alzheimer's Disease. RI #195's bowel incontinence care plan dated 07/02/2021 documented, . check (RI #195) every two hours and assist with toileting as needed . See care plans on . ADLs (Activities of Daily Living), . RI #195's ADL care plan, dated 07/02/2021, documented, BED MOBILITY: . dependent on two staff for repositioning and turning in bed . TOILET USE: (RI #195) is not toileted. (he/she) requires staff to check and change (him/her) q (every) 2 (two) hours as needed. (he/she) is unable to participate in any aspect of the task. SIDE RAILS: bilateral half rails up as per Dr's (doctors) order for safety during care provision . The care plan did not include instructions on how many staff were needed to assist RI #195 during incontinent care. On 09/15/2023, the State Agency received a complaint that alleged the following: DHR (Department of Human Resources) was notified by the hospital that the resident (RI #195) arrived to the emergency room (ER) with multiple fractures and a head injury that were reported as a result of a fall from bed in the facility that occurred while staff was changing the resident . A review of an ASSOCIATE COUNSELING REPORT for CNA #6, dated 09/20/2023, revealed the following: . Date of Incident 09/14/2023 Time of Incident 3-11 shift . Nature of Incident (explain in detail) Certified nursing assistant failed to follow the care plan for a resident under (his/her) care which resulted in an injury . (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #195's hospital report, documented, Clinical Impressions as of 09/15/2023 . fall, initial encounter subarachnoid bleed . Subdural hematoma . closed fracture of right scapula, unspecified part of scapula, initial encounter closed nondisplaced fracture of acromial process of right scapula, initial encounter . Physical Exam . Swelling at right temporal region . A review of RI #195's ALABAMA CERTIFICATE OF DEATH, with a date of death of [DATE], revealed the following: . CAUSE OF DEATH . Subdural, subarachnoid hematoma due to . Fall at nursing home . An interview was conducted with CNA #6 on 03/20/2024 at 2:08 PM. CNA #6 stated when it came to checking RI #195 required one-person assist, but repositioning required two people. CNA #6 said on 09/14/2023 she was providing incontinent care to RI #195 without the assistance of a second staff. CNA #6 said she repositioned RI #195 for the care and he/she fell from the bed to the floor. CNA #6 said RI #195's right shoulder and head hit the floor first. CNA #6 said after RI #195 fell to the floor, she looked and saw RI #195's side rail on the left side of the bed was down and it should have been up. CNA #6 stated when providing care for RI #195 side rails should have been raised and she was not sure why the side rails were down. CNA #6 said RI #195 was not in a safe position when she was providing care on 09/14/2023, due to the side rail being down. On 03/22/2024 at 2:22 PM a follow-up interview was conducted with CNA #6. CNA #6 said she would have asked a second staff member to assist her with RI #195's incontinent care if his/her care plan indicated two staff were required to provide incontinent care. An interview was conducted with Registered Nurse (RN) #14, former Clinical Coordinator, on 03/22/2024 at 10:07 AM. RN #14 stated the level of assistance required to assist RI #195 depended on what ADL care that was being provided. She stated most of the time RI #195 required two-person assistance. She stated RI #195 was a total assist and they anticipated all of his/her needs. RN #14 stated RI #195's side rail on the left side should have been up when CNA #6 was providing care from the right side of the bed because no one was on the opposite side. A follow-up phone interview was conducted with RN #14 on 03/23/2024 at 5:36 PM. RN #14 stated she completed the ADL care plan for RI #195. She stated she did not remember why there was no assist level on his/her toileting/incontinent ADL care plan. She stated she guessed that she forgot to put one- or two-person assist on the care plan. An interview was conducted with the Director of Nursing (DON) on 03/22/2024 at 1:35 PM. The DON stated RI #195 had a physician's order for bilateral side rails and according to his/her care plan they were to be up for safety during care to assist with bed mobility. She stated an investigation was conducted after RI #195's fall and it was determined that RI #195 fell from the left side of the bed and the left side rail was down. The DON said the side rail should have been up. A follow-up interview was conducted with Director of Nursing (DON) on 03/23/2024 at 11:53 AM. The DON stated the toilet use care plan should have instructed staff on how many staff was needed to assist with changing RI #195. The DON said RI #195's toilet use care plan did not indicate the number of staff needed to assist for toileting. The DON stated RI #195's toileting care plan should have specified an assist level. She stated the level of assistance required was very important information (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	for all staff to know in order to provide care. This deficiency was cited as a result of complaint/report number AL00045797. ********** The facility took immediate action to correct the noncompliance by: 1. On 09/15/2023 CNA #6 was placed on administrative leave pending results of investigation. CNA #6 was not permitted to work until after 1 on 1 retraining on following the care plans was completed and after CNA #6 received a final warning in her employee file. 2. On 09/15/2023 QAPI meeting held to discuss root cause analysis. 3. On 9/15/2023 all residents care plans were reviewed be RN clinical coordinators/care coordinators for correct information regarding amount of assistance required for ADL care including incontinent care. No discrepancies were identified. 4. Ending on 09/18/2023 all nursing staff including all licensed nurse and CNAs were educated by RN Care Coordinators/RN supervisors on ensuring that the care plan is followed and ensure that staff are aware of the location to view the care plan within the point of care system. Education was completed on 09/18/2023. 5. 09/15/2023 All RN Care Coordinators were provided inservices and re-education to include the ADL sections of the care plan as it relates to the level of assistance required by staff for performing ADL care including incontinent care. 6. Return demonstration of location of the Kardex tab on the point of care tablets was performed on all CNAs by RN coordinators/supervisors by 09/18/2023. 7. Beginning on 09/15/2023, education on care plans to include ADL care completed upon new hire orientation process and at least annually. 8. Care plan compliance monitoring observations began on 09/18/2023 (nurses observed to ensure residents care plans were followed regarding ADL care assist levels). Date of compliance: 09/18/2023 ********** After review and verification of the information provided in the facility's corrective action plan, in-service education records, monitoring tools, and the facility's investigation, as well as staff interviews, the survey team determined the facility implemented corrective actions from 09/15/2023 through 09/18/2023 with ongoing monitoring implemented; thus, immediate jeopardy past noncompliance was cited.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and review of facility policies titled, Crushing Medications, Administering Medications, and Gastrostomy/Jejunostomy Site Care, the facility failed to ensure: 1) Resident Identifier (RI) #3 had a crush order to crush his/her Clonazepam 1 mg (milligram) tablet, and 2) RI #40's PEG (Percutaneous Gastrostomy) site was cleaned with peroxide as ordered by the physician. These deficient practices affected RI #3, one of six residents observed during the medication pass administration; and RI #40, one of one resident whose PEG site care was observed. Finding include: 1) RI #3 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of Epilepsy and Dysphasia. A facility policy titled, Crushing Medications, with a revised date of 04/2018, included the following: Policy Statement Medications shall be crushed only when it is . consistent with physician orders. Policy Interpretation and Implementation . 3. In addition, the following guidelines shall be followed when crushing medications: a. The MAR or other documentation must indicate why it was necessary to crush the medication . RI #3's Order Summary Report (Physicians Orders) noted as Active Orders as of 03/20/2024 included: . ClonazePAM Oral Tablet 1 mg .Give 1 tablet by mouth two times a day . Further review of the March 2024 Physicians Orders revealed there was not an order to crush any of RI #3's medications. On 03/20/2024 at 4:19 PM, the surveyor observed Licensed Practical Nurse (LPN) #11 prepare and administer RI #3 his/her medications. LPN #11 placed RI #3's Clonazepam 1 mg tablet in a pill crush pouch and crushed the tablet while stating RI #3's medications were crushed. LPN #11 then administered the medication to RI #3. In an interview on 03/21/224 at 5:21 PM, the surveyor asked LPN #11 was there an order to crush RI #3's medications. LPN #11 reviewed RI #3's electronic Physicians Orders and paper Physicians Orders and stated she did not see one. When asked if there should be an order to crush RI #3's medications before crushing them, LPN #11 stated yes. In an interview on 03/23/2024 at 8:26 AM with Registered Nurse (RN) #7, the Clinical Coordinator (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(CC) for South Two, was asked if a resident's medication were crushed should there be a crush order. RN #7's response was yes there should be. RN #7 said according to RI #3's Physicians Orders there was not an order to crush RI #3's medications. When asked why it was important to have an order to crush medications before crushing a resident's medication, RN #7 said so the nurse would know which medication could be crushed. In an interview on 03/23/2024 at 10:01 AM with the Assistant Director of Nursing (ADON), the surveyor asked the ADON when a resident's medication was crushed, should there be a crush order. The ADON's response was yes. When asked why it would be important to have a may crush order before crushing a resident's medication, the ADON responded it would alert the staff that it would be ok to crush that medication. 2) A review of a facility policy tilted, Gastostomy/Jejunostomy Site Care, with a revised date of 10/2011, documented: Purpose The purposes of this procedure are to promote cleanliness and to protect the gastrostomy . site from irritation, breakdown and infection. Preparation 1. Verify that there is a physician's order for this procedure. RI #40 was admitted to facility on 03/21/2022 and re-admitted on [DATE] with a diagnosis of Gastrostomy Status. RI #40's Order Summary Report (Physicians Orders) for 03/2024, documented: . Clean peg site daily w (with)/ peroxide . 03/22/2024 at 10:10 AM, the surveyor observed LPN #3 clean RI #40's PEG stoma site with soap and water. On 03/22/2024 at 11:58 AM, an interview was conducted with LPN #3. LPN #3 was asked why she did not follow the physicians orders to clean RI #40's PEG site with peroxide. LPN #3 said she thought the order was for soap and water. When asked what was the concern of not following physician orders, LPN #3 said she could cause an infection or the resident could have a reaction to the wrong item used. On 03/23/2024 at 01:47 PM, an interview was conducted with the ADON. The ADON was informed of the surveyor's observation of gastrostomy site care being performed on RI #40 on 03/22/2024 by LPN #3, who used soap instead of peroxide. The ADON said LPN #3 should have followed the physicians orders and used peroxide.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, the facility's investigative file, hospital record review, the facility policy titled, and review of a third-party complaint, the facility failed to ensure Resident Identifier (RI) #195's upper side rails were up for safety during the provision of incontinent care; and failed to ensure two staff assisted to reposition RI #195 during the incontinent care. On 09/14/2023, Certified Nursing Assistant (CNA) #6 was providing incontinent care to RI #195 without a second staff to assist. CNA #6 repositioned RI #195 to the left side, turned around to obtain a wipe, and when she turned back around RI #195 was sliding from the left side of the bed. RI #195 fell head and upper body first from the bed to the floor. According to CNA #6, the left side rail was not in the upright position at the time. RI #195 was sent to the ER (Emergency Room) for evaluation and was found to have two brain bleeds, a right-side mandible fracture, dental fractures, bleeding in the mouth, a right-side scapula fracture, and a right-side acromion fracture. This deficient practice affected RI #195; one of three residents sampled for falls with major injuries. It was determined the facility's noncompliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, §483.25(d) Free of Accident Hazards/Supervision/Devices at a scope and severity of J. On 03/23/2024 at 7:26 PM, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), were provided a copy of the Immediate Jeopardy Template and notified of the finding of substandard quality of care at the immediate jeopardy level in the area of Quality of Care, at F-689-Free of Accident Hazards/Supervision/Devices. The facility implemented corrective actions to correct the identified deficient practice and prevent recurrence on 09/18/2023; thus, immediate jeopardy past non-compliance was cited. Cross-Reference F 656. Findings include: On 09/15/2023, the State Agency received a complaint that alleged the following: DHR (Department of Human Resources) was notified by the hospital that the resident (RI #195) arrived to the emergency room (ER) with multiple fractures and a head injury that were reported as a result of a fall from bed in the facility that occurred while staff was changing the resident . injuries . included two brain bleeds, right side mandible fracture, dental fracture, bleeding in mouth, right side scapula fracture, and right side acromion fracture . RI #195 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include Dysphagia following Cerebral Infarction, Aphasia following Cerebral Infarction, Dementia and Alzheimer's Disease. RI #195's Annual Minimum Data Set assessment, with an Assessment Reference Date of 07/03/2023, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	revealed RI #195 had short- and long-term memory problems with severely impaired cognition, was totally dependent on staff with the assist of two for bed mobility, and had impairment on both sides of the upper and lower extremities. RI #195's ADL (Activities of Daily Living) care plan, with an initiated date of 07/02/2021, revealed RI #195 had a self-care performance deficit related to Alzheimer's, Dementia, and Contractures. There were interventions for . BED MOBILITY: (name of RI #195) is totally dependent on 2 staff for repositioning . SIDE RAILS: bilateral half rails up as per Dr's order for safety during care provision . A review of RI #195's Order Summary Report (Physicians Orders) with a date order of 07/29/2021, revealed RI #195 had a physician's order for . bilateral 1/2 upper side rails for the purpose of increasing safety per family request . Review of the facility's investigative file revealed a statement given by CNA #6, dated 09/15/2023, which revealed the following: I am used to doing RI #195 by myself because his/her body will stay in one position. He/She had a really big bowel movement and I was trying to push him/her over enough to clean his/her whole back side. I failed to realize that the side rail wasn't up. So, I pushed him/her just a little bit more so I could clean his/her left cheek and then as soon as I turned around to grab the wipes behind me I turned back around and I saw his/her upper body go down first. It was his/her shoulder and head that went down first . On 03/20/2024 at 2:08 PM, an interview was conducted with CNA #6. CNA #6 said RI #195 required total care and when it came to repositioning, RI #195 was a two-person assist. CNA #6 said on 09/14/2023 she was providing incontinent care without the assistance of a second staff. CNA #6 said during the care she turned RI #195 over and pushed RI #195 more toward the edge of the bed so she could clean RI #195. CNA #6 said she turned around to get the wipes which were on the table behind her. CNA #6 said when she turned back around she saw RI #195's upper body and head slide off the left side of the bed to the floor. CNA #6 said RI #195's right shoulder and head hit the floor first. CNA #6 said after RI #195 fell to the floor, she looked and saw RI #195's side rail on the left side of the bed was down and it should have been up. CNA #6 said RI #195 was not in a safe position when she provided care to RI #195 on 09/14/2023, because the side rail was down. CNA #6 said the fall was avoidable because if she had been more aware of the environment she would have seen the side rail was down. On 03/20/2024 at 6:20 PM, an interview was conducted with Licensed Practical Nurse (LPN) #12, the LPN assigned to care for RI #195 on the 3-11 shift on 09/14/2023. LPN #12 said CNA #6 informed her RI #195 had fallen. When she entered the room RI #195 was on the floor on the left side of the bed lying on his/her back. LPN #12 said two staff should have been assisting RI #195 to turn. LPN #12 said RI #195's side rails should have been in the up position at all times. LPN #12 said RI #195's fall was avoidable because CNA #6 should have had someone with her if she was not sure about how to care for RI #195. On 03/22/2024 at 4:16 PM, an interview was conducted with RN #16. RN #16 said she was made aware RI #195 had fallen out of bed on 09/14/2023, when CNA #6 called her. RN #16 said she immediately went to RI #195's room and saw RI #195 on the floor on the left side of the bed. RN #16 said the left side rail was down and it should have been up especially since CNA #6 was repositioning RI #195. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/21/2024 at 6:29 PM, a telephone interview was conducted with CNA #13. CNA #13 said RI #195's side rails should have been up at all times. CNA #13 said when she entered the room after RI #195 fell, RI #195 was on the floor on his/her back on the left side of the bed and the left side rail was down. CNA #13 said CNA #6 told her she forgot to let RI #195's side rail back up. RI #195's Progress Notes, dated 09/14/2023, revealed the following: . Note Text: Resident sent to ER via (by way of) Ambulance @ (at) 9pm due to sliding off of bed during care . RI #195's ED (Emergency Department) Provider Notes from the local hospital, with a Date of Service of 09/14/2023, revealed the following: . Chief Complaint Patient present with .Fall Pt (patient) arrived via EMS (Emergency Medical Service) from SNF (Skilled Nursing Facility) nonverbal and bedbound w (with)/contractures of the BUE (Bilateral Upper Extremities). EMS states that while being changed the pt was rolled off the bed to the L (left) side . Physical Exam . (revealed a contusion to the left and right forehead and right mandible) . Clinical Impression as of 09/15/23 . Subarachnoid bleed . Subdural hematoma . Closed fracture of right scapula, unspecified part of scapula . closed nondisplaced fracture of acromial process of right scapula . Medical Decision Making CT (Computed Tomography) scans display subarachnoid hemorrhage and hematoma . Questionable right mandibular fracture and dental fracture which is thought to be the source of the dried blood in the mouth along with a right scapula fracture and acromial process fracture . Problems addressed: Closed fracture of right scapula . Closed nondisplaced fracture of acromial process of right scapula . Subarachnoid bleed . Subdural hematoma . On 03/22/2024 at 10:07 AM, an interview was conducted with Registered Nurse (RN) #14, the former (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Patient was admitted to hospitalist service for further evaluation of reported fall at nursing home reportedly while (he/she) was being changed. On admission he had multiple images including CT head, maxillofacial . (He/She) was noted to have right hemispheric subdural hematoma with 7.8 mm (millimeter) in size in parieto-occipital region . Patient's family was aware of (his/her) poor condition . Subsequently patient passed away on 09/21/2023 at 6:59 p.m. A review of RI #195's ALABAMA CERTIFICATE OF DEATH, with a date of death of [DATE], revealed the following: . CAUSE OF DEATH . Subdural, subarachnoid hematoma due to . Fall at nursing home . This deficiency was cited as result of the investigation of complaint/report #AL00045797. ********** The facility took immediate action: 1. On 09/15/2023 CNA #6 was placed on administrative leave pending results of investigation. CNA #6 was not permitted to work until after 1 on 1 retraining on following the care plans was completed and after CNA #6 received a final warning in her employee file. 2. On 09/15/2023 QAPI meeting held to discuss root cause analysis. 3. On 9/15/2023 all residents care plans were reviewed by RN clinical coordinators for correct information regarding amount of assistance required for ADL care including incontinent care. No discrepancies were identified. 4. Ending on 09/18/2023 all nursing staff including all licensed nurse and CNAs were educated by RN clinical Coordinators/RN supervisors on ensuring that the care plan is followed and ensure that staff are aware of the location to view the care plan within the point of care system. Education was completed on 09/18/2023. 5. 09/15/2023 All RN Care Coordinators were provided inservices and re-education to include the ADL sections of the care plan as it relates to the level of assistance required by staff for performing ADL care including incontinent care. 6. Return demonstration of location of the Kardex tab on the point of care tablets was performed on all CNAs by RN coordinators/supervisors by 09/18/2023. 7. Beginning on 09/15/2023, education on care plans to include ADL care completed upon new hire orientation process and at least annually. 8. Care plan compliance monitoring observations began on 09/18/2023 (nurses observed to ensure residents care plans were followed regarding ADL care assist levels). Date of compliance: 09/18/2023 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	********** After review and verification of the information provided in the facility's corrective action plan, in-service education records, monitoring tools, and the facility's investigation, as well as staff interviews, the survey team determined the facility implemented corrective actions from 09/15/2023 through 09/18/2023 with ongoing monitoring implemented; thus, immediate jeopardy past noncompliance was cited.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and review of a facility policy titled, Medication Labeling and Storage, the facility to ensure: 1) Resident Identifier (RI) #395's vial of 70/30 insulin was labeled correctly; and 2) an expired bottle of Enteric Coated (EC) Aspirin (ASA) was not left on the medication cart on the Rehab unit. These deficient practices affected RI #395, and had the potential to affect all resident with orders for EC ASA on the Rehab unit. Findings include: Review of a facility policy titled, Medication Labeling and Storage, with a revised date of 02/2023, revealed the following: . Policy Interpretation and Implementation .6. Medications . are labeled accordingly . Medication Labeling . 2. The medication label includes,at a minimum: . 2. d. expiration date, when applicable; e. resident's name . 5. vials that have been opened or accessed (e.g. [for example] needle punctured) are dated and discharged within 28 days . 1) RI #395 was admitted to the facility on [DATE] with a diagnosis of Type Two Diabetes. RI #395's Order Summary Report (Physicians Orders) for March 2024 revealed RI #395 had orders to include Aspirin 325 mg (milligrams) once a day and Novolog mix 70/30 inject ten units subcutaneous two times a day. On 03/22/2024 at 8:55 AM, the surveyor observed Licensed Practical Nurse (LPN) #17 prepare RI #395's medications. LPN #17 went to refrigerator and returned with a vial of Novolog 70/30 for RI #395. The surveyor observed that there no label on the vial of insulin as to when the vial was opened or when the insulin was to be discarded. On 03/22/2024 at 1:20 PM, an interview was conducted with LPN #17. The surveyor asked LPN #17, when a vial of insulin was opened, what type of information should be placed on the vial. LPN #17 said (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the opened date, the expiration date and the resident's name. LPN said it was important to ensure the vial was labeled with this information so all staff would know who the medication belonged to and how long the medication could be used. LPN #17 said RI #395's vial of 70/30 insulin should have been labeled. On 03/22/2024 at 6:01 PM, an interview was conducted with Registered Nurse (RN) #18/Clinical Coordinator (CC) for the Rehab unit. RN #18 was asked, when insulin was opened, what should be on the vial of the insulin. RN #18 said the residents name, the date opened, and the expiration date. 2) On 03/22/2024 at 8:55 AM, the surveyor observed LPN #17 prepare RI #395's medications. LPN #17 removed a stock bottle of EC ASA 325 mg from the drawer of the medication cart. The bottle of ASA had an expiration date of 10/23 (2023) on the bottle. On 03/22/2024 at 1:20 PM, an interview was conducted with LPN #17. When asked why was there a bottle of expired EC ASA on the medication cart that morning, LPN #17 said she had not noticed the date on it. LPN #17 said expired medication should be placed in a medication destruction box and sent back to the pharmacy. LPN #17 said the expired medication may not have the effectiveness and would not have a therapeutic health benefits to the resident. On 03/22/2024 at 6:01 PM, an interview was conducted with RN #18. RN #18 said expired stock medications should not be on the medication cart. RN #18 said the MAC (Medication Administration Certified), CNA (Certified Nursing Assistant), or the nurse had the responsibility for ensuring expired medications were not left on the medication cart. RN #18 said the medication cart should be checked for expired medication weekly; but the medication nurse should be checking for expired medications when medications are passed. When asked what would there be a potential for when expired medications are left on the medication cart, RN #18 said the resident would get a medication where the effectiveness would be decreased.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, review of facility policies titled, Handwashing/Hand Hygiene and Gastrostomy/Jejunostomy Site Care, and review of guidelines from CDC's (Center for Medicare and Medicare) Core Infection and Prevention and Control Practices for Safe Healthcare in All Settings, the facility failed to ensure: 1) Certified Nursing Assistant (CNA) #19 removed her mask before exiting a resident on Droplet Precautions's room, Resident Identifier (RI) #53, 2) Licensed Practical Nurse (LPN) #3 changed her gloves and sanitized her hands while performing gastrostomy site care on RI #40; and 3) Registered Nurse (RN) #4 did not use her gloved finger to pack foam into RI #295's wound during wound care. Further RN #4 used her ungloved hands and hand sanitizer to clean RI #295's. These deficient practices affected three of 51 sampled residents. Findings include: Review of undated guidelines for CDC's Core Infection and Prevention and Control Practices for Safe Healthcare in All Settings, revealed the following: . Core Practice Category 5d. Risk Assessment with Appropriate Use of Personal Protective Equipment (PPE) . Core Practices . d. Remove and discard PPE, other than respirators, upon completing a task before leaving the patient's room or care area . RI #53 was admitted to the facility on [DATE] and readmitted on [DATE], with a diagnosis of Methicillin Resistant Staphylococcus Aureus (MRSA) Infection. RI #53's Order Summary Report (Physicians Orders) for March 2024 revealed RI #53 was to be on Droplet precautions 3/15-03/21 for MRSA in sputum. RI #53's Care Plan included a care plan for Droplet Precautions r/t (related to) MRSA in sputum, with an initiated date of 03/15/2024, with an intervention for Change PPE prior to caring for another resident . On 03/19/2024 at 3:19 PM, CNA #19 was observed passing ice on the hall. CNA #19 put on a blue surgical mask and took a bag of ice into room RI #53's room. RI #53 had a Droplet Precaution sign on his/her door with instruction to Remove face protection before room exit. On 03/19/2024 at 3:24 PM, CNA #19 exited RI #53's room with the face mask still on, walked down hall with a clear tied bag of trash in her hand and took the bag to the soiled utility room. CNA #19 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	walked back down the hall with the face mask still on and entered another resident's room. On 03/19/2024 at 3:26 PM, an interview was conducted with CNA #19. CNA #19 said RI #53 was on droplet precautions. CNA #19 said she was required to have on a mask and sanitize her hands when entering RI #53's room. CNA #19 said she should have disposed of the mask in the room. The surveyor asked CNA #19 what type of concern would it be to not dispose of the mask in the correct manner. CNA #19 said germs could be spread. On 03/22/2024 at 6:01 PM, an interview was conducted with Registered Nurse (RN) #18/Clinical Coordinator (CC) for the Rehab unit. RN #18 was asked what type isolation was RI #53 on. RN #18 said RI #53 was on droplet precautions. When asked what type PPE was required when entering RI #53's room, RN #18 said the surgical face mask, gloves and a gown. RN #18 said before exiting the room, the mask should be thrown in the trash receptacle in the bathroom. RN #18 said there was a potential for the spread of infection when the face mask was not removed and staff walked down the hall, and entered other resident's room with the face mask on. On 03/23/2024 at 09:47 AM, an interview was conducted with the Infection Preventionist (IP). The IP was asked, before exiting a resident who was on any type precaution room, where should the face mask be discarded. The IP said in the trash container on the inside of the room. The IP said when this was not done in that manner, the concern was infection control and the potential to spread germs elsewhere. 2) Review of Facility's policy titled, Handwashing /Hand Hygiene, with a Revised date of 08/2015, documented, Policy Statement . This facility considers hand hygiene the primary means to prevent means to prevent the spread of infections. Policy interpretation and Implementation . 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents . 3. Hand hygiene products and supplies (.alcohol-based rubs,etc) shall be readily accessible . 6. Wash hands with soap (antimicrobial or nonantimicrobial) and water for the following situations: a. When hands are visibly soiled; .7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or nonantimicrobial) and water for the following situations: .b. Before and after direct contact with residents; .e. Before and after handling invasive device (e,g,,urinary catheters .g. Before handling clean or soiled dressings, gauze pads,etc; .k. After handling used dressings . RI #40 was admitted to facility on 03/21/2022 and re-admitted on [DATE] with a diagnosis of Gastrostomy Status. RI #40's Order Summary Report (Physicians Orders) for 03/2024, documented: . Clean peg site daily w (with)/ peroxide . On 03/22/2024 at 10:10 AM, Surveyor observed LPN #3 clean RI #40's peg site. While perfoming wound care with gloves on, LPN #3 ran out of gauze, went to RI #40's chest of drawers, and obtained more gauze to clean the stoma. LPN #3 kept on the same pair of gloves and continued to clean the stoma. An interview was conducted with LPN #3 on 03/22/2024 at 11:58 PM. LPN #3 stated it did not cross her mind to remove her gloves before she retrieved the gauze from RI #40's drawer. LPN #3 stated the (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concern of not changing gloves after touching a potentially soiled/contaminated item was the potential for infection. On 03/23/2024 at 1:47 PM, an interview was conducted with the Infection Preventionist (IP). The IP stated the concern of not changing gloves during wound care was cross-contamination. 3) RI #295 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis to include Heart Failure, Other Disorders of the Lungs, and Unspecified Osteoarthritis. RI #295's Order Summary Report dated 03/19/2024, revealed, Wound Vac intermittent at 125 to Right buttocks wound change q(every)72 hrs (hours). On 03/19/2024 at 11:00 AM, surveyor observed Registered Nurse (RN) #4 perform wound care on RI #295. During care RN #4 packed three pieces of precut foam into RI #295's wound with her gloved fingers. Later in the wound care RN #4 picked up bandage scissors and wiped off the tip of the scissors with hand sanitizer and her bare hands. An interview was conducted with RN #4 on 03/21/2024 at 6:11 PM. RN #4 said Q tips or cotton tipped swabs should be used to pack a wound during wound care. RN #4 stated she used her gloved fingers to pack RI #295's. RN #4 said the scissors should have been cleaned with sani-wipes and stated the concern of not cleaning scissors would be infection control. On 03/23/2024 at 1:47 PM, an interview was conducted with the Infection Preventionist (IP). The IP was informed surveyor observed RN #4 perform wound care on RI #295 on 3/19/2024. The IP stated when packing a wound, a Q tip would be sterile; a gloved hand would not be and it would increase the risk of infection.