STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015397	A. Building B. Wing	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor House	4411 McAllister Drive Huntsville, AL 35805

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and review of a facility policy titled Change of Resident Room/Roommate, the facility failed to notify Resident identifier (RI) #7's representative when RI #7 was transferred to a different room on 07/28/2023. This deficient practice affected RI #7, one of two residents sampled for notification. Findings include: A facility policy titled Change of Resident Room/Roommate, with an effective date of 05/01/2012, revealed the following: . PROCEDURE . 2. Consent must be received from the resident and/or their legally authorized representative. 3. The notification will be documented in the progress notes . RI #7 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include Disorder of the Brain, Muscle Weakness, Unsteadiness on Feet, Lack of Coordination, Cognitive Communication Deficit and Alcohol Dependence. RI #7's admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) 07/24/2023, identified RI #7 as scoring a 5 on the Brief Interview for Mental Status (BIMS) indicating RI #7 had severely impaired cognition. RI #7 was also coded as needing supervision with walking in the corridor, with locomotion on and off the unit, and used a wheelchair. A review of a facility Census List, with dates and times of room changes for RI #7, revealed the following: 1) admitted to facility on 07/19/2023 to RL #4 2) Moved to room RL #1 on 07/24/2023 3) Moved to room RL #5 on 07/28/2023 A review of RI #7's Progress Notes revealed the following: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. 7/24/2023 . Note Text: Room changed to Room Locator (RL) #1 . Family and supervisor aware of room change . Further review of RI #7's Progress Notes revealed there was no documentation in the Progress Notes indicating RI #7 moved to room RL #5 on 07/28/2023; or RI #7's representative have been notified of the room change. A review of RI #7's Progress Notes revealed there was no documentation on 07/28/2023, indicating RI #7 was moved to a different room or RI #7's representative had been notified of the room change. An interview was conducted with EI #2, DON on 09/16/2023 at 5:08 PM. EI #2 stated she could not keep up with how many times RI #7 had changed rooms since being admitted to the facility on [DATE]. EI #2 stated she was aware of RI #7's room change to RL #1 and RL #4. EI #2 stated, she does not know why RI #7 was moved to room RL #5 on 07/28/2023. EI #2 stated she is not sure if RI #7's representative was notified regarding the move. EI #2 stated she does not know where the documentation was of representative being notified of RI #7's room change to RL #5. EI #2 stated, usually the social worker, nurse or administrator will notify the family of room changes and document in resident's progress notes. EI #2 admitted RI #7's representative should have been notified. An interview was conducted with RI #7's representative on 09/19/2023 at 1:15 PM. RI #7's representative stated she only knew of one time RI #7's room had been moved. This deficiency was cited as a result of the investigation of complaint/report number AL00045069.

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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 interviews, record review, review of a facility policy titled Abuse, Neglect, Misappropriation, Exploitation Policy, review of Facility Reported Incidents (FRIs) received by the Alabama State Survey Agency, and review of the facility's investigative file, the facility failed to ensure Resident Identifier (RI) #s 1, 2, and 4 were free from abuse. 1) On [DATE], Employee Identifier (EI) #4, a CNA (Certified Nursing Assistant) and EI #5, a CNA were providing care for RI #2. During the care RI #2 had gotten feces on his/her hands and was trying to touch EI #4. EI #5 witnessed EI #4 telling RI #2 not to touch her, and that RI #2 was nasty. EI #5 said, EI #4 held RI #2's hands down pinning RI #2's arms down by his/her head and said, don't fucking touch me. The witness (EI #5) said RI #2 stated ok I'm sorry but you're hurting me. According to the facility's investigation and interviews, EI #5 did not initially identify the incident as abuse or report this incident of abuse until [DATE]. EI #5 stated she was unsure it was abuse. EI #4 continued to work in the facility on [DATE] and five more days where she had continued access to RI #2 before being discharged home, and other vulnerable residents. 2) On [DATE], a second incident was witnessed by EI #11, volunteer. EI #11 stated upon entering the room RI #1 was yelling out which was not abnormal. EI #11 said, EI #4 grabbed RI #1's head with both hands and told RI #1 to shut the fuck up and then put a washcloth in RI #1's mouth. The incident was not reported to the administrator until [DATE]. EI #4 continued to provide patient care after the second incident including full access to RI #1 and other residents on the hallway she was working. EI #4 worked the remainder of the shift on [DATE], and for three additional days after the second incident. 3) On [DATE], RI #4, stated EI #6, CNA assisted him/her to the bed. RI #4 stated after getting in bed he/she wanted some water, so RI #4 pressed the call light. RI #4 said, EI #6 stormed back into the room saying, homie don't play that. RI #4 stated, EI #6 jerked the call light and they wrestled with the call light. RI #4 said EI #6 pried RI #4's fingers open and again said homie don't play that. RI #4 said, EI #6 left the room. Again, RI #4 pressed the call light because he/she assumed another CNA would answer the light. RI #4 said, EI #6 came back into the room. RI #4 stated he/she was holding the call light as tight as he/she could when EI #6 pulled on it. RI #4 said EI #6 proceeded to remove the call light from his/her hands and wrapped it around his/her neck several times, then EI #6 went behind the bed and pulled RI #4 up in bed with the call light cord. RI #4 stated he/she was trying to say something but could not breathe. RI #4 stated he/she was fearful and thought it was the end of his/her life. These deficient practices affected RI #s 1, 2, and 4, three of eight sampled residents reviewed for abuse. 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 to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.12 Freedom from Abuse, Neglect, and Exploitation at a scope and severity of J. On [DATE] at 10:33 PM, the Administrator, EI #1, the Director of Nursing Services, EI #2, and the Director of Clinical Operations, EI #3 were provided a copy of the Immediate Jeopardy (IJ) template (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and notified of the finding of immediate jeopardy; substandard quality of care in the area of Freedom from Abuse, Neglect, and Exploitation at F 600- Free from Abuse and Neglect. The IJ began on [DATE] and continued until [DATE] when survey team verified onsite that corrective actions had been implemented. On [DATE] the immediate jeopardy was removed, F600 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. Findings include: The facility's policy titled Abuse, Neglect, Misappropriation, Exploitation Policy, with an effective date of 01/2019, revealed: . Definitions: Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . Mental Abuse: is the use of verbal or nonverbal conduct which cause or has the potential to cause the resident to experience humiliation, fear shame, agitation, or degradation . Physical Abuse: Includes, but is not limited to, hitting, slapping, punching, biting, and kicking . Verbal abuse: May be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability . 1) RI #2 was admitted to the facility on [DATE] for Hospice Respite with diagnosis to include Alzheimer's Disease, Dementia, and Palliative Care. RI #2 Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], listed RI #2's Brief Interview Mental Status (BIMS) as 03, which indicated the resident was cognitively impaired. The Alabama Department of Public Health Online Incident Reporting System form, dated [DATE], documented, . Narrative summary of incident: (name of EI # 2, DNS [Director of Nursing Services]) informed Admin (name of EI #5, CNA) told her about a previous incident (date unknown) where (name of EI #4, CNA) held patient (name of RI #2)'s arms down when providing care . An undated typed statement from EI #1, Administrator, documented, . (RI #2) . admitted to (name of facility) on [DATE] for a 5-day hospice respite stay. [DATE]: DNS interviewed (EI #5) who reported about a week ago she witnessed (EI #4) hold patient (RI #2)'s arms down when providing care. (EI #5) said patient (RI #2) had feces on (his/her) hands and (EI #4) yelled at (RI #2) to not touch her. (EI #5) said she witnessed (EI #4) hold (RI #2) arms down and (RI #2) was telling (EI #4) to stop your hurting me. (EI #5) said she then told (EI #4) she will take care of (RI #2) and (EI #4) exited the room. DNS asked (EI #5) why she did not report the incident immediately and (EI #5) did not know. (EI #5) reported (EI #4) had been acting differently lately. Allegation of abuse-physical is (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	substantiated. (EI #5) witnessed (EI #4) hold (RI #2) down when providing patient care. Admin is unable to get a statement from victim as (local hospice agency) informed Admin (RI #2) expired on [DATE]. A telephone interview was conducted with EI #5 on [DATE] at 3:20 PM. EI #5, stated on [DATE], RI #2 had feces on his/her hands. EI #5 said, EI #4 and herself went in to clean up the resident. EI #5 stated RI #2 kept trying to touch EI #4. In response, EI #4 told RI #2 not to touch her and that he/she was nasty. EI #5 stated, EI #4 held RI #2 hands down forcefully and said, don't fucking touch me. EI #5 stated RI #2 said ok, I'm sorry, but you are hurting me. EI #5 stated she told EI #4 she would hold RI #2's hands while EI #4 cleaned RI #2. EI #5 stated she told EI #9, Licensed Practical Nurse (LPN) about the incident, but admitted it was days later. EI #5 stated she considered the incident abuse. EI #5 stated the concern of not reporting abuse timely was EI #4 could have continued to hurt the resident or another resident. Review of EI #4's timecard documented that EI #4 continued to work in the facility after the [DATE] incident involving RI #2. EI #4 worked [DATE], [DATE], [DATE], [DATE] and [DATE], before the incident was reported to EI #1, Administrator on [DATE]. A telephone interview was conducted with EI #9, LPN on [DATE] at 4:39 PM. EI #9 stated she became aware of RI #2's abuse allegation on [DATE], when EI #5 came to her and said EI #4 was being rough with residents. EI #9 stated EI #5 told her it had something to do with RI #2's arms. EI #9 stated she sent EI #5 straight to EI #2, DNS to report the allegation. An interview was conducted with EI #2, DNS on [DATE] at 6:29 PM. EI #2 stated she became aware of the allegation of abuse involving RI #2, on [DATE]. EI #2 stated EI #5 informed her of the incident. EI #2 stated the incident had happened the week prior. RI #2 was discharged from the facility on [DATE]. An interview was conducted with EI #1, Administrator on [DATE] at 5:21 PM. EI #1 stated she became aware of the allegation of physical abuse on [DATE]. EI #1 stated the allegation of physical abuse was substantiated because the incident was witnessed by EI #5. 2) RI #1 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include Aphasia, Cognitive Communication Deficit, Altered Mental Status, Vascular Dementia, Anxiety Disorder and Parkinson's Disease. RI #1's admission MDS assessment, with an ARD of [DATE], revealed RI #1 had short- and long-term memory problems with severely impaired cognition. RI #1's care plan titled I sometimes have behaviors which include Shouting, Yelling during activities, with an initiated date of [DATE], revealed the following intervention . Speak to me unhurriedly and in a calm voice . On [DATE], the Alabama Department of Public Health Online Incident Reporting System received a second facility reported incident which revealed the Administrator, EI #1, was notified by the DNS, EI #2, she was informed by a team member EI #11 that EI #4, CNA put a washcloth in RI #1's mouth and told RI #2 to shut up. Review of the facility's investigative file revealed a written statement by EI #11 which documented (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the following: I (EI #11) as a volunteer at Windsor House (on) [DATE] @ [at] 1:30 pm was helping CNA (EI #4) in a resident room. Resident was screaming nonstop which occurs regularly when CNA grabbed resident by (his/her) head with both hands and told (him/her) to shut the F*** up and released (his/her) head. CNA turned up resident radio loud. CNA took a wash rag and folded it up like a burrito and stuffed it in resident's mouth. This volunteer removed wash rag from resident's mouth and went to activities and reported to my friend CNA (EI #7) over activities on the dementia unit . 10:00 pm This volunteer went to my mom nurse (EI #9) on Camelot and told her everything I had seen and heard through the day. My mom told her supervisor (EI #8) . On [DATE] at 1:00 PM, the surveyor conducted a telephone interview with EI #11. EI #11 said she was on the Memory Care unit when EI #4 came to get her to help her with RI #1. EI #11 said RI #1 was a person who yells and when RI #1 would not stop yelling EI #4 grabbed RI #1's head and told her to shut the fuck up. EI #11 said when RI #1 started screaming, EI #4 got a washcloth and put it in RI #1's mouth so RI #1 would stop screaming. EI #11 said she looked at RI #1 and took the washcloth out of his/her mouth and EI #4 looked at her (EI #11) angry like she had done something wrong. On [DATE] at 9:15 AM, a follow-up telephone interview was conducted with EI #11. When asked why she removed the washcloth from RI #1's mouth, EI #11 said RI #1 was turning red. EI #11 said when she removed the washcloth from RI #1's mouth RI #1 was trying to catch his/her breath. On [DATE] at 12:19 PM, a telephone interview was conducted with EI #9. EI #9 said on [DATE] at 10:00 PM, EI #11 informed her about EI #4 cursing RI #1 and placing a washcloth in RI #1's mouth. EI #9 said EI #11 said when EI #4 and herself went in RI #1's room, the resident was yelling. EI #9 said EI #11 said EI #4 grabbed RI #1 by the face with both of her hands and said shut the fuck up. EI #9 said EI #11 said EI #4 let RI #1's head go and RI #1 fell back into the bed. EI #9 said EI #11 said after that, EI #4 started to roll a washcloth like a burrito and proceeded to shove it into RI #1's mouth until RI #1 was gagging and turning red. EI #9 said the incident would be considered verbal, physical, and emotional abuse. On [DATE] at 8:30 PM, a telephone interview was conducted with EI #8. EI #8 said she was made aware on [DATE] around 10:30 PM that EI #4 told RI #1 to shut the fuck up and placed a washcloth in RI #1's mouth. EI #8 said the incident was physical, verbal and emotional abuse. On [DATE] at 6:09 PM, a telephone interview was conducted with EI #7, the Memory Care Director. EI #7 said EI #11 came into her office on [DATE] and said she (EI #11) had something to tell her, and EI #11 did not want EI #7 to say anything about the incident. EI #7 said EI #11 reported that EI #4 had asked her to go and help her with a resident. EI #7 said EI #11 said the resident was screaming and EI #4 shoved a washcloth in the resident's mouth. When asked what type of abuse would she consider this allegation to be, EI #7 said physical. On [DATE] at 12:10 PM, an interview was conducted with EI #2. EI #2 said she was made aware of the incident involving EI #4 cursing RI #1 and then placing a washcloth in RI #1's mouth on [DATE] by EI #7. EI #2 said informed EI #1 and EI #3, the Director of Clinical Operations. EI #2 said she came to the facility to start the investigation and all staff involved were put on administrative leave immediately. On [DATE] at 5:21 PM, an interview was conducted with EI #1. EI #1 said she became aware of the incident involving EI #4 cursing RI #1 and then placing a washcloth in RI #1's mouth on [DATE]. EI #1 said the facility's investigation substantiated that the incident did occur. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Supplemental Narrative from the local police department's report, dated [DATE], revealed the following: . On 08-14-23 I received this case and made contact with the Windsor House administrator (EI #1). (EI #1) told me she was already investigating this case and had written statements from witnesses who stated they saw the offender (EI #4) physically abuse two different victims . 1) Victim (RI #2) was seen by (EI #5) being held down forcefully by (EI #4) sometime between [DATE]th and Aug (August) 6th 2023. The incident was not reported until [DATE]th 2023. (EI #1) said that (EI #5) said the patient (RI #2) made the statement as (his/her) wrists were being held down, please stop, you are hurting me. 2) Victim (RI #1) was seen by volunteer (EI #11) having (his/her) mouth stuffed with a folded washcloth by (EI #4). The witness also, wrote a statement about the offender (EI #4) grabbing (RI #1's) head with both hands and told (him/her) to shut the fuck up. The witness actually came in to remove the wash rag which was left in the victim's mouth . if the witness (RI #11) not intervened, serious bodily injury or death could have occurred involving the victim (RI #1). The actions (EI #4) did was reckless. (EI #4) shoved the rag in the mouth of (RI #1) in such a manner that (he/she) was gagging. This restriction of air could have caused suffocation leading to death or serious injury . Supplemental Narrative [DATE] . the offender's actions were intentional and no reasonable person would want the physical contact that the offender did to the victim . Review of a PROGRESSIVE DISCIPLINE FORM for EI #4 revealed the following: Name: (name of EI #4) . Position: CNA Date Administered: [DATE] Category 1 Violation: 1.1 Patient/resident abuse . Termination [DATE] Summary of Incident: . On Saturday [DATE] we were made aware of a concern that alleged you have abused a resident on Tuesday [DATE]. You were placed on administrative leave while we investigated into the allegation . Upon conclusion of the investigation we did substantiate the allegation of abuse, and the incident has been reported to state. Abuse, neglect, or misappropriation of any patient or resident is inexcusable and will not be tolerated. Based on the information found in the investigation, we have made the decision to terminate your employment immediately . A follow-up interview was conducted with EI #1, Administrator on [DATE] at 6:38 PM. EI #1 stated the potential harm of holding a resident's arms down aggressively when providing care was bruising, skin tears, possible broken bones, trauma, fear, anxiety, and depression. EI #1 stated the potential harm of placing a washcloth in a resident's mouth is the resident could choke, and cause resident to go into respiration distress. On [DATE] at 11:08 AM, a telephone interview was conducted with EI #14, the facility's Medical Director. When asked what type of harm could potentially occur to a resident when their hands/arms are being held while staff is attempting to provide care for the resident, EI #14 said bruising. EI #14 said depending on how forceful the resident was being held a bone could be break bones. EI #14 said someone could be hurt from actions like that. When asked what type of harm could potentially occur when a washcloth was placed in a resident's mouth to keep them from hollering, EI #14 said if not taken out of the mouth, the person could not breath and could become hypoxic. EI #14 said definitely (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	this would be like abuse. On [DATE] at 10:06 AM, a telephone interview was conducted with RI #1's daughter/sponsor. RI #1's daughter said RI #1 had a stroke, has dementia and Parkinson's, required 24-hour care and was totally dependent on staff. When asked, from a reasonable person's view, how did she think it would have made RI #1 feel having the same person who cursed at him/her and placed a washcloth in his/her mouth continue to provide care to him/her. RI #1's daughter said RI #1 would have been scared. 3) RI #4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Multiple Sclerosis, Muscle Weakness, Other Lack of Coordination, Bed Confinement Status and Other Reduced Mobility. RI #4's Quarterly MDS with an ARD date of [DATE] indicated RI #4 had a BIMS of 13, which indicated RI #4 was cognitively intact. The Alabama Department of Public Health Online Incident Reporting System Form dated [DATE], documented, . (Name of RI #4) reported to (Name of EI #10) that on [DATE] (Name of EI #6, CNA) wrapped a call light around (his/her) neck. An undated typed statement from EI #1, Administrator, documented, . A full body audit was completed by (EI #10, RN) and documented that (RI #4) did have some bruising on the left side of (his/her) neck along with red areas on the right side of (his/her) neck. (RI #4) Interview with Administrator: Admin interviewed resident (RI #4) on [DATE] at 2:15pm regarding allegations (he/she) reported to nurse. (RI #4) said on Friday (9-1-23) around 2 to 3 pm this same CNA who resident reported was (EI #6) came in (his/her) room when (he/she) pushed (his/her) call light and shut the door behind her. (RI #4) as (he/she) was trying to get some water. Resident said (EI #6) told (him/her) I told you you're going somewhere because I am tired of you. (RI #4) said (he/she) was holding the call light in (his/her) left hand and (EI #6) pulled the call light out of the wall and wrestled it away from (him/her). (RI #4) said (EI #6) wrapped the call light around (his/her) neck multiple times and pulled (him/her) up then pushed (him/her) back down on the bed. (RI #4) said (he/she) tried yelling, but no one could hear (him/her). (RI #4) told Admin (EI #6) told (him/her) I don't want to be like you in the bed dying. (RI #4) said (EI #6) finally stopped choking (him/her) and threw call light on the floor by the entrance to (his/her) room. Admin asked who plugged (his/her) call light back in and resident could not tell Admin. Conclusion: Allegation of physical abuse with resident (RI #4) identified as the victim and CNA (EI #6) identified as the perpetrator is substantiated. (RI #4) had visible marks to (his/her) neck when assessed by assigned nurse, and (he/she) was consistent in (his/her) recollection of events . An interview was conducted with RI #4 on [DATE] at 6:17 PM. RI #4 stated on [DATE], EI #6 took him/her down to activities. RI #4 stated he/she was ready to go back to room and informed another staff member. RI #4 stated he was pushed back down the hallway and waited outside the room while EI #6 provided care for roommate. RI #4 stated, he/she was finally placed back in bed by EI #6 and another staff member. RI #4 stated once in bed he/she wanted some water, so he/she pushed the call light. RI #4 stated, EI #6 stormed back into the room and said homie don't play that, RI #4 stated they were wrestling for the call light. EI #6 left the room without giving RI #4 water. RI #4 stated he/she pressed the call light again thinking another staff would respond; however, EI #6 returned to the room. RI #4 stated he/she had a tight grip on the call light, but EI #6 was able to get call light out of RI #4 hands and wrapped it around RI #4's neck. RI #4 stated, EI #6 pulled the call light from out of the wall and went behind the top of the bed and was pulling back on the call light cord. RI #4 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated he/she was trying to say something, but he/she could not breathe. RI #4 stated he/she informed EI #10, Registered Nurse (RN), EI #12, CNA and EI #13, LPN of the incident soon after the incident. In a follow-up interview with RI #4 on [DATE] at 9:30 PM. RI #4 stated during the incident he/she was thinking he/she was going to die. A telephone interview was conducted with EI #10, RN on [DATE] at 5:38 PM. EI #10 stated on the evening of [DATE], RI #4 told him that EI #6 wrapped a call light around his/her neck and said abusive things to RI #4. EI #10 said RI #4 reported that EI #6 said she would not be like him/her and would not die in the bed. EI #10 stated a body audit was completed at the request of the administrator and results of the body audit showed some indention around the resident's neck. A telephone interview was conducted with EI #13, LPN on [DATE] at 8:41 PM. EI #13 stated on the evening of [DATE], RI #4 told her EI #6 came into the room to answer the call light. EI #13 stated RI #4 said EI #6 became angry took the cord and wrapped it around RI #4's neck and pulled RI #4 up and pushed him/her back down in the bed. A telephone interview was conducted with Investigator from local police Department on [DATE] at 8:20 AM. Investigator stated the case is ongoing. Investigator stated he talked with RI #4 on [DATE] and [DATE] and both times, RI #4's story was consistent. Investigator stated there was definitely a mark on RI #4's neck. An interview was conducted with EI #12, CNA on [DATE] at 2:30 PM. EI #12 stated when she went into RI #4's room on the early morning of [DATE], RI #4 told her, he/she wanted water on [DATE], so RI #4 pressed the call light and EI #6 came into the room and fought RI #4 for the call light then wrapped the call light around RI #4's neck and pulled up on it. EI #12 stated, RI #4 said after EI #6 did this she left the room. EI #12 stated she observed a couple of red spots on RI #4's neck. An interview was conducted with EI #1, Administrator on [DATE] at 5:21 PM. EI #1 stated she became aware of the allegation of physical abuse on [DATE]. EI #1 stated the allegation of physical abuse was substantiated due to RI #4 story remaining consistent and the body audit conducted by EI #10, documented a bruise on one side and redness on the other side of RI #4's neck. An interview was conducted with EI #1, Administrator on [DATE] at 6:38 PM. EI #1 stated the potential harm of holding a resident's arms down aggressively when providing care was bruising, skin tears, possible broken bones, trauma, fear, anxiety, and depression. EI #1 stated the potential harm of placing a washcloth in a resident's mouth was the resident could choke, and cause resident to go into respiration distress. EI #1 stated the potential harm wrapping a call light cord around a resident's neck was strangulation, fear, anxiety, social and psychological impact. This deficiency was cited as a result of the investigation of complaint/report number(s) AL00045242, AL00045244, and AL00045448. ********** ********** On [DATE] at 7:26 PM, the facility submitted an acceptable removal plan, which documented: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	F600 To the best of my knowledge and belief, as an agent of Windsor House, the following allegation of compliance constitutes a written plan demonstrating actions the Center took upon awareness of the deficient practice thus removing the Immediate Jeopardy cited on [DATE]. Preparation and execution of this allegation of compliance does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. The allegation of compliance is prepared and/or executed solely because it is required by the provisions of Federal and State Law. Immediate Actions for All Residents Affected by Alleged Abuse: RI #2: o discharged from the center on [DATE] at end of hospice respite stay. o EI#4 (CNA) held resident's hands down and used profanity toward resident on [DATE]. It was observed by EI#5 (CNA.) o EI#5 (CNA) reported the incident to EI#9 on [DATE] who reported to Administrator on [DATE]. Due to delay of reporting EI#5 (CNA) was trained via phone. o Administrator notified ADPH on [DATE]. o Administrator notified MD on [DATE]. o Administrator notified Huntsville Police Department and attempted to notify family on [DATE]. o Hospice was notified on [DATE] via phone and [DATE] in person. o Ombudsman was notified on [DATE] via email and via phone on [DATE] and stated she will provide an in-service for the center. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o EI#4 (CNA) was placed on Administrative Leave on [DATE] and investigation began. EI#4 (CNA) was terminated on [DATE]. o Full body audits conducted on residents on all halls with BIMS less than 8 on [DATE] with no significant findings. o Interviews conducted with residents on all halls with BIMS of 8 or greater on [DATE] with no significant findings. o Reported EI#4 (CNA) to CNA Registry and charges filed by Huntsville Police Department with upcoming court date on [DATE]. o EI#5(CNA) was placed on Administrative Leave on [DATE] and terminated on [DATE] for failing to report. Reported to CNA registry. o Additional signage added around center on [DATE] for reminders for team members to report incidents and contact information to abuse coordinator (Administrator). o Focused Quality Assurance meeting was held with Physician and Interdisciplinary Team in attendance on [DATE]. o All team members and center care partners in-serviced beginning [DATE] regarding abuse and neglect identification, residents' safety and protection, and reporting. (All team members and center care partners to include nurses, med techs, CNAs, team leaders/management, contract therapy service providers, contract housekeeping services, and contract dietary services.) o Team members and center care partners signed acknowledgement of receiving education and understanding the requirements of the Elder Justice Act training beginning on [DATE]. All team members and center care partners to include nurses, med techs, CNAs, team leaders/management, contract therapy service providers, contract housekeeping services, and contract dietary services. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Ombudsman, [NAME], provided training with team members and center care partners (to include nurses, med techs, CNAs, team leaders/management, contract therapy service providers, contract housekeeping services, and contract dietary services.) regarding resident rights, abuse, neglect, and reporting on [DATE] at 7:00 am and 3:30 pm which allowed accessibility for all shifts to attend. RI#1: o EI#4 (CNA) placed the washcloth in RI#1 mouth, EI#11 (volunteer) removed wash cloth from her mouth and reported to EI#7 (memory care director) on [DATE]. o EI#9 (LPN) and EI#11 (volunteer) together told EI#8 (LPN/Unit Manager) about the incident on [DATE]. EI#8 (LPN/Unit Manager) reported to Administrator on [DATE]. Due delay in reporting EI#8 (LPN/Unit Manager), EI#9 (LPN), EI#11 (volunteer), EI#7 (Memory Care Director) were all placed on administrative leave pending investigation due to this incident, should have been reported immediately to the Administrator. In-services began on [DATE] to include abuse identification, reporting time frames, and providing safety for the residents. o Assessed RI#1 for injury by DNS and no injuries noted on [DATE]. o Huntsville Police Department notified on [DATE] and came to center to complete the initial report. o ADPH was notified on [DATE] of incident and investigation immediately initiated. o Focused Quality Assurance meeting was held with Physician and Interdisciplinary Team in attendance on [DATE]. Recommendations included retraining with the team (to include nurses, med techs, CNAs, department leaders/management, contracted therapy services, contract housekeeping services, contract dietary services.) All team members and center care partners were in-serviced regarding abuse and neglect identification, resident safety and protection, immediacy of reporting expectations, and care partner managers following the Elder Justice Act guideline/follow up on findings, with post-test for knowledge retention. Also, to include customer service training and handling residents exhibiting behaviors. o MD notified on [DATE] and assessed RI#1 on [DATE] with no significant findings. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Family notified of incident on [DATE]. o Huntsville Police Department Investigator came into center on [DATE] and observed resident along with interviewing staff and Administrator. Administrator received completed report from Investigator Gollop. o Ombudsman notified on [DATE] via email and via phone on [DATE] and stated[TRUNCATED]

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, medical record review, review of a facility policy titled Abuse, Neglect, Misappropriation, Exploitation Policy, and review of Facility Reported Incidents (FRIs) received by the State Survey Agency, the facility failed to implement the facility's abuse policies when: 1) Employee Identifier (EI) #8, Licensed Practical Nurse (LPN), Unit Manager failed to report an allegation of sexual abuse to the Administrator and failed to implement immediate protective measures. On 07/28/2023 Resident Identifier (RI) #6's daughter reported to EI #8 that RI #7 had entered RI #6's room and touched his/her breast twice. 2) EI #5, Certified Nursing Assistant (CNA) failed to identify an incident as physical and verbal abuse and immediately report the incident to the administrator after she observed EI #4, CNA hold down RI #2's arms down while telling RI #2 to not fucking touch her on 08/06/2023. Further, no protective measures were implemented, and EI #4 provided resident care on 08/07/2023, 08/08/2023, 08/09/2023, 08/11/2023, and 08/12/2023. EI #4 perpetrated a second incident of verbal and physical abuse on 08/08/2023. 3) EI #11, facility volunteer failed to immediately report an allegation of physical and verbal abuse to the administrator after EI #11 witnessed an incident of abuse on 08/08/2023. EI #11 reported the incident to EI #7, Memory Care Director, EI #8, Unit Manager, and EI #9, LPN. EI #7, EI #8, and EI #9 failed to immediately report the allegation of abuse to the administrator. The facility staff further failed to implement protective measures to protect RI #1 and other vulnerable residents from further potential abuse. On 08/08/2023, EI #11, facility volunteer witnessed EI #4 take RI #1's head in her (EI #4's) hand and shake it while telling RI #1 to shut the fuck up. EI #11 said when RI #1 continued to yell out, EI #4 placed a washcloth in RI #1's mouth. EI #11 said she removed the washcloth from RI #1's mouth, left the room and immediately reported the incident to EI #7, the Memory Care Director around 1:30 PM. EI #11 said she later informed EI #9, LPN. EI #11 and EI #9 both informed EI #8, an LPN unit Manager, of the incident later on in the shift around 10:00 PM. EI #7 reported she was unaware of the incident until 08/11/2023. The incident was not reported to the facility's administrator until 08/12/2023. 4) EI #10, Registered Nurse (RN) and EI #13, LPN failed to identify an allegation of physical abuse, failed to immediately report the allegation to the administrator, and further failed to initiate an investigation when staff were unable to contact the administrator. On the evening of 09/01/2023 RI #4 reported to EI #10 and EI #13 that EI #6 had wrapped a call light around his/her neck and said abusive things to RI #4. No action was taken until 09/02/2023 around 6:00 AM. These deficient practices affected RI #s 1, 2, 4, and 6, four of eight sampled residents reviewed for abuse. 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 to residents. The (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.12 Freedom from Abuse, Neglect, and Exploitation at a scope and severity of J. On 09/18/2023 at 10:33 PM, the Administrator, the Director of Nursing Services (DNS) and the Director of Clinical Operations, EI #3 were given a copy of the Immediate Jeopardy (IJ) template and notified of the findings of immediate jeopardy; substandard quality of care in the area of Freedom from Abuse, Neglect, and Exploitation at F 607- Develop/Implement Abuse/Neglect, etc. Policies. Findings include: The facility's policy titled Abuse, Neglect, Misappropriation, Exploitation Policy, with an effective date of 01/2019, revealed the following: Purpose: To prohibit and prevent abuse . and to ensure reporting and investigation of alleged violations . in accordance with Federal and State Laws . Definitions: Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It included verbal abuse, sexual abuse, physical abuse, and mental abuse . Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Alleged Violation: A situation or occurrence that is observed or reported by team member, resident, relative, visitor or others but has not yet been investigated . The following protocol has been established in the event of an allegation of abuse: 1. Protection First and foremost the resident/patient will be immediately assessed and removed from any potential harm . If the suspected perpetrator is another resident/patient, the Administrator/Director of Nursing or designee shall separate the resident/patients so they do not have access to each other until the circumstances of the alleged incident can be determined and assessment completed and if applicable interventions put in place. If the suspected perpetrator is a team member, the Administrator/Director of Nursing or designee shall place the team member on immediate investigatory suspension while completing the investigation . 4. Prevention Establish safe environment: Team members are required to report incidents of suspected abuse without fear or reprisal . 5. Identification If actual violation or alleged violation occurs the resident will immediately be assessed and (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	removed from any potential harm . 6. Investigation If actual violation or alleged violation occurs the resident will immediately be assessed and removed from any potential harm (as applicable) . In the event an alleged violation/violation occurs when the Administrator or Director of Nursing are unavailable, the manager in charge is responsible for initiating the investigation procedure unless there is a conflict of interest or the person is implicated in the alleged violations. 7. Reporting/Response Alleged violations will be reported to the Administrator, designee immediately . 1) RI #6 was admitted to the facility on [DATE] with diagnoses of Muscle Weakness, Unsteadiness on Feet and Abnormalities of Gait and Mobility. RI #6's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/28/2023, indicated RI #6 was cognitively intact for daily decision making. RI #7 was admitted to the facility on [DATE] with diagnoses of Disorder of Brain, Unsteadiness on Feet and Cognitive Communication Deficit. RI #7's admission MDS with an ARD of 07/24/2023 indicated RI #7 was severely impaired in cognitive skills for daily decision making. The facility reported the FRI to the State Agency on 07/30/2023. The report stated the Administrator was informed that resident (RI #6)'s daughter reported resident (RI #7) went into (RI #6)'s room and pulled his/her covers and touch his/her breast twice. The daughter stated that RI #7 was observed standing at RI #6 while the daughter was at the facility in early morning hours. A telephone interview was conducted on 09/14/2023 at 11:17 AM with EI #8, LPN/Unit Manager. She stated RI #6's daughter notified her of the incident on 07/28/2023 via text and phone. EI #8 said that RI #6's daughter said that RI #7 had touched RI #6's breast. EI #8 said she did not report the incident to Administrator. EI #8 said the staff were supposed keep RI #7 away from RI #6's room. EI #8 stated her last date of employment with the facility was 09/11/2023 and that she was terminated for failure to report the incident. An interview with the EI #2, DNS was conducted on 09/14/2023 at 5:30 PM. EI #2 said that on 07/30/2023 RI #6's daughter reported to her that RI #7 touched RI #6's breast. She said RI #6 called her and told her RI #7 pulled RI #6's covers at his/her feet and touch RI #6's breast. EI #2 said she immediately called EI #1 (Administrator) who suggested staff move EI #7 to the other hall, keep double doors close, and perform checks every 15 minutes. On 09/15/2023 at 6:38 PM, an interview was conducted with EI #1, the Administrator. EI #1 said protective measures were not implemented after RI #7 allegedly entered RI #6's room three times and touched his/her breast twice. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This deficiency was cited as a result of the investigation of complaint/report number AL00045069. 2) RI #2 was admitted to the facility on [DATE] for Hospice Respite with diagnosis to include Alzheimer's Disease, Dementia, and Palliative Care. RI #2 Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/06/2023, indicated RI #2's Brief Interview Mental Status (BIMS) was 03, which indicated the resident was cognitively impaired. The Alabama Department of Public Health Online Incident Reporting System form, dated 08/12/2023, documented, . Narrative summary of incident: (EI # 2, DNS) informed Admin (EI #5, CNA) told her about a previous incident (date unknown) where (EI #4, CNA) held patient (RI #2)'s arms down when providing care . A telephone interview was conducted with EI #5, CNA on 09/14/2023 at 3:20 PM regarding EI #4 holding RI #2's arms down and telling RI #2 to don't fucking touch her. EI #5 admitted after witnessing the incident between EI #4 and RI #2, she did nothing to protect RI #2 and other residents from further potential abuse. EI #5 stated did not report the incident until days later, because she thought it was not that big of a deal and did not immediately identify the incident as abuse. EI #5 stated she witnessed EI #4 holding RI #2's hands down and cursing at RI #2. EI #5 admitted she did not follow the facility's abuse policy when she failed to immediately report what she witnessed to the administrator. EI #5 stated the concern of not following the facility's abuse policy and reporting allegations of abuse immediately was not protecting the resident. EI #5 stated, EI #6 could have continued to hurt RI #2 or another resident. A review of a PROGRESSIVE DISCIPLINE FORM for EI #5 revealed the following: Name: (EI #5) . Position: CNA .Date Administered: 08/17/2023 .Category 1 Violation: 1.2 Failure to report any incident of patient/resident abuse .Termination 08/17/2023 .Summary of Incident: . Due to your failure to report the incident per our policy you failed to protect our residents and patients, and potentially provided an opportunity for the abuse to continue. Cased on this we have made the decision to separate employment effective immediately. An interview was conducted with EI #1 on 09/14/2023 at 5:21 PM. EI #1 said the facility's policy stated staff were to notify the abuse coordinator immediately of allegations. EI #1 said, EI #5 not reporting the incident involving RI #2 for several days was not timely reporting and the facility's policy was not followed. EI #1 stated the concern of not reporting timely was subjecting those residents to further abuse. 3) RI #1 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include Aphasia, Cognitive Communication Deficit, Altered Mental Status, Vascular Dementia, Anxiety Disorder and Parkinson's Disease. RI #1's admission MDS assessment, with an ARD of 06/21/2023, revealed RI #1 had short- and long-term memory problems with severely impaired cognition. On 08/12/2023, the Alabama Department of Public Health Online Incident Reporting System received a second FRI. The report indicated the Administrator, EI #1, was notified by the DNS, EI #2, she was informed by EI #11 that EI #4, a CNA put a washcloth in RI #1's mouth and told RI #2 to shut up. (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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/13/2023 at 1:00 PM, the surveyor conducted a telephone interview with EI #11, volunteer. EI #11 said she observed EI #4 grab RI #1's head, tell RI #1 to shut the fuck up, and place a washcloth in RI #1's mouth. EI #11 said she left out of the room and told EI #7, Memory Care Director. EI #11 said later that day she told EI #9 about EI #4 cursing at RI #1 and putting a washcloth in the resident's mouth. EI #9 said they needed to tell EI #8, the Unit Manager on the unit RI #1 resided. EI #11 reported that EI #9 and herself reported the allegation to EI #8. On 09/13/2023 at 12:19 PM, a telephone interview was conducted with EI #9. EI #9 said on 08/08/2023 at 10:00 PM, EI #11 informed her about EI #4 cursing RI #1 and placing a washcloth in RI #1's mouth. EI #9 said she and EI #11 told EI #8, Unit Manager what happened. EI #8 said it would be handled. On 09/14/2023 at 12:10 PM, an interview was conducted with EI #2, DNS. EI #2 said she was made aware of the incident involving EI #4 cursing RI #1 and then placing a washcloth in RI #1's mouth on 08/12/2023 when she was talking with EI #7, the Memory Care Director on the phone. EI #2 said EI #7 said EI #11 asked her not to report the allegation to the administrator. EI #2 said EI #8 also knew about the allegation and had not reported to the administrator either. EI #2 said everyone named (EI #7 and #8) knew the day of the incident, which was 08/08/2023, and no one had reported it to her or EI #1, who was the Abuse Coordinator. EI #2 said the facility's abuse policy indicated that alleged violations should be reported immediately. EI #2 said the policy indicated if the alleged perpetrator was a team member, the team member should be put on administrative leave immediately pending investigation. EI #2 said EI #4 was the identified perpetrator. EI #2 said EI #4's timecard indicated that she worked in the facility after the incident occurred with RI #1 for three days, 08/09/2023, 08/11/2023 and 8/12/2023, before she was suspended and terminated. EI #2 said when a perpetrator continued to have access to the victim, there could be a potential for more harm. EI #2 said with EI #4 working in the facility for three additional days after the incident occurred on 08/08/2023, RI #1 and other residents at the facility were not protected. On 09/13/2023 at 6:09 PM, a telephone interview was conducted with EI #7, the Memory Care Director. EI #7 said EI #11 reported to her the EI #4 had placed a washcloth in RI #1's mouth. EI #7 said this was reported to her on 08/11/2023. EI #7 said abuse should be reported immediately to the Abuse Coordinator who was EI #1. The review of the facility's investigative file contained a typed, signed statement by EI #2 the DON which revealed On 08/12/2023, I spoke with (EI #7), the memory care director to get an update on a resident on memory care. During our conversation (EI #7) voiced some concerns on the MCU (Memory Care Unit). She also reported that a volunteer, (EI #11) informed her that (EI #4), a CNA pushed a resident's head (RI #1) telling the resident to shut the f*** up, and put a washcloth in the resident's mouth. I asked (EI #7), Did you report it? (EI #7) stated No, (EI #11), the volunteer, did not want me to tell anyone. She did not want to get anyone in trouble. (EI #7) reported that the volunteer, (EI #11) reported the incident to (EI #9) LPN (Licensed Practical Nurse) and (EI #8) LPN on 08/08/2023 . A review of a PROGRESSIVE DISCIPLINE FORM for EI #7 revealed the following: Name: (name of RI #7) .Position: Memory Care Director . Date Administered: 08/16/2023 .Category 1 Violation: 1.2 Failure to report any incident of patient/resident abuse . Termination 08/16/2023 . Summary of Incident: . On 8/12/2023, during the course of an investigation involving suspected abuse of a resident, we were made aware that a team member reported this allegation of abuse to you on 8/8/2023, but you failed to report the allegation to the Center Administrator/Abuse Coordinator as you have been trained to do. We have concluded the investigation and substantiated the allegation of abuse. Due to your failure (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	report the allegations per out policy you failed to protect our residents and patients, and potentially provided an opportunity for the abuse to continue. Based on this we have made the decision to separate employment effective immediately . On 09/13/2023 at 8:30 PM, a telephone interview was conducted with EI #8, Unit Manager. EI #8 said on 08/08/2023 around 10:30 PM she was made aware that EI #4 told RI #1 to shut the fuck up and placed a washcloth in RI #1's mouth. EI #8 said EI #9 and EI #11 had apparently told EI #7, prior to her being told. EI #8 said when she received the this information she tried to call EI #1 but EI #1 did not answer. EI #8 said she did not press the issue and assumed EI #1 would call her back. EI #1 said she got off at 3 or 4 AM that morning, went to bed and slept all day, EI #8 said this would have been 08/09/2023. EI #8 admitted to having opportunity on 08/10/2023 and 08/11/2023 to report to EI #1 the allegation but failed to report it. EI #8 said it should have been reported by EI #7 since EI #7 knew about it hours before she did. EI #8 said the time frame for reporting abuse when you are made aware of it is immediately and it should be reported to EI #1 the Abuse Coordinator. EI #8 said there was plenty of opportunity for everyone who knew about the incident to report it. EI #8 said it was important to report abuse immediately, especially when a perpetrator had been identified, to be sure the perpetrator was removed from the facility. When asked did she get written statements from EI #9 and EI #11, the volunteer who witnessed the incident, EI #8 said no she assumed EI #7 had done that since she was initially informed of the situation. Review of a PROGRESSIVE DISCIPLINE FORM for EI #8 revealed the following: Name: (name of RI #8) .Position: Unit Manager LPN . Date Administered: 08/16/2023 Category 1 Violation: 1.2 Failure to report any incident of patient/resident abuse . Termination 08/16/2023 .Summary of Incident: . On 8/12/2023, during the course of an investigation involving suspected abuse of a resident, we were made aware that a team member reported this allegation of abuse to you on 8/8/2023, but you failed to report the allegation to the Center Administrator/Abuse Coordinator as you have been trained to do. We have concluded the investigation and substantiated the allegation of abuse. Due to your failure to report the allegations per out policy you failed to protect our residents and patients, and potentially provided an opportunity for the abuse to continue. Based on this we have made the decision to separate employment effective immediately . On 09/16/2023 at 5:53 PM, a follow-up interview was conducted with EI #2. EI #2 said when the allegation was brought to EI #8's attention that EI #4 had cursed RI #1 and placed a washcloth in RI #1's mouth, EI #8 was Unit Manager and was considered to be in charge at that time. EI #2 said according to the facility's abuse policy, under the investigation component, EI #4 should have been put on leave immediately and EI #11 and EI #9's statements about the incident should have been obtained. On 09/14/2023 at 6:20 PM, an interview was conducted with EI #3, the Director of Clinical Operations. EI #3 said the facility's abuse policy said alleged violations should be reported immediately to the abuse coordinator. EI #3 said the facility did substantiate the abuse allegations involving EI #4, RI #1 and RI #2. EI #3 said since EI #4 continued to work in the facility for days after the alleged incident occurred, RI #2 and other residents at the facility were not protected. 4) RI #4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis to include Multiple Sclerosis, Muscle Weakness, Other Lack of Coordination, Bed Confinement Status and Other Reduced Mobility. RI #4's Quarterly MDS with an ARD date of 09/08/2023 indicated RI #4 had a BIMS of 13, which (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	indicated RI #4 was cognitively intact. The Alabama Department of Public Health Online Incident Reporting System Form dated 09/02/2023, documented, . (Name of RI #4) reported to (Name of EI #10) that on 09/01/2023 (Name of EI #6, CNA) wrapped a call light around (his/her) neck. Review of text messages between EI #10, RN and EI #1, dated 09/02/2023, revealed EI #10 sent initial notification of the allegation to EI #1 on 09/10/2023 at 3:23 AM. EI #1 responded on 09/10/2023 at 6:35 AM. A telephone interview was conducted with EI #10 on 09/14/2023 at 9:33 PM. EI #10 stated during his medication pass around 9 PM, RI #4 first reported that EI #6 wrapped a call light cord around his/her neck. EI #10 said it did not register in his mind that it was abuse. EI #10 said he knew the facility's abuse policy stated that an abuse allegation should be reported immediately. EI #10 stated around 2 AM, EI #12, CNA was talking about the incident and stated that it sounded like abuse. EI #10 said at that time, he went back to RI #4 for clarification and then reported the allegation to the administrator. A review of a PROGRESSIVE DISCIPLINE FORM for EI #10 revealed the following: Name: (name of EI #10) .Position: Date Administered: 09/16/2023 .Category 1 Violation: 1.2 Failure to report any incident of resident abuse .Administrative Leave 08/17/2023 Summary of Incident: . you failed to report abuse of a resident immediately to the abuse coordinator once you were informed of the allegations. You are required to call the abuse coordinator (Administrator) with any allegations of abuse and neglect immediately as discussed in the in-services on abuse, neglect, and the elder justice act. You cannot text the Administrator on allegations of abuse. You must call to report any allegations of resident/patient abuse, neglect, or misappropriation, and please CALL until you speak to someone, no texting or leaving voicemail. A telephone interview was conducted with EI #13, LPN on 09/12/2023 at 8:41 PM. EI #13 stated she became aware of the incident of EI #6 wrapping a call light cord around RI #4's neck, when RI #4 told her on 09/01/2023 around 9 PM. EI #13 stated she went and reported the incident to EI #10 because EI #10 was the supervisor for the night. An interview was conducted with EI #1 on 09/14/2023 at 5:21 PM. EI #1 stated after RI #4 informed EI #10 and EI #13 about the incident, they should have notified her no later than two hours after being informed. EI #1 stated the facility's policy stated staff were to notify abuse coordinator immediately of allegations. EI #1 admitted this was not timely reporting and the facility's policy was not followed. ********** On 09/20/2023 at 7:26 PM, the facility submitted an acceptable removal plan, which documented: F 607 To the best of my knowledge and belief, as an agent of Windsor House, the following allegation of compliance constitutes a written plan demonstrating actions the Center took upon awareness of the deficient practice thus removing the Immediate Jeopardy cited on 09/18/23. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Preparation and execution of this allegation of compliance does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. The allegation of compliance is prepared and/or executed solely because it is required by the provisions of Federal and State Law. Immediate Actions for All Residents Potentially Affected: RI #6 and RI #7: o EI #8 (LPN/Unit Manager) was informed about the incident on 7/28/23. o On 7/28/23 RI #6 and RI #7 were separated, and RI#7 was redirected from the room. RI #6 later reported RI #7 had touched her inappropriately. o On 7/28/23 RI #7 had a care plan initiated for wandering to include anticipating and meeting residents needs and redirection by staff to assist resident with developing more appropriate methods of coping and interaction with peers. o On 7/30/23 Administrator was notified by DNS after DNS was notified of incident by RI #6 family member. o Administrated notified ADPH on 7/30/23 and immediately initiated an investigation. o Physician notified on 7/30/23 of alleged incident. o Huntsville Police Department notified on 7/30/23 and arrived at center on 8/2/23 to take initial police report. o Ombudsman notified via email on 7/30/23 and by phone on 7/31/23. o EI#8 (LPN Unit Manager) was placed on administrative leave on 8/12/23 and terminated due to failure (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to report alleged abuse. On 8/16/23 EI#8 (Unit Manager) was reported to Alabama Board of Nursing. o Additional signage was added around the center on 8/12/23 for reminders for team members to report incidents and contact information for abuse coordinator (Administrator). Instructing to report allegations to the abuse coordinator, contact information included on the signage. 9 signs placed throughout the center. o All team members and center care partners (to include nurses, med techs, CNAs, team leaders/management, contract therapy service providers, contract housekeeping services, and contract dietary services.) in-serviced regarding abuse and neglect identification, residents' safety and protection, reporting. o Team members and center care partners (to include nurses, med techs, CNAs, team leaders/management, contract therapy service providers, contract housekeeping services, and contract dietary services.) acknowledgement of receipt of Diversicare Elder Justice Act training on 8/25/23. Signed acknowledgement of receiving education and understanding the requirements of the Elder Justice Act training beginning on 8/25/23. o Ombudsman notified on 7/31/23 and discussed reeducation with all team members (to include nurses, med techs, CNAs, team leaders/management, contract therapy service providers, contract housekeeping services, and contract dietary services.) o Ombudsman, [NAME], provided training with team members and center care partners (to include nurses, med techs, CNAs, team leaders/management, contract therapy service providers, contract housekeeping services, and contract dietary services.) regarding resident rights, abuse, neglect, and reporting on 9/13/23 at 7:00 am and 3:30 pm which allowed accessibility for all shifts to attend. o RI#7 was referred to Remedy Behavioral Health and seen on 9/14/23 with recommendations to continue current medication regimen, monitor for medication efficacy and side effects, and Mini [NAME] evaluation. Follow up in one to two weeks. o (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI#7 has been transferred to another facility with Memory Care Unit on 9/20/23. RI#7 has been sent to a center that has a male memory care unit due to Windsor House has a Female only memory care unit. RI #2: o discharged from the center on 8/6/2023 at end of Hospice Respite Stay. o EI#4 (CNA) held resident's hands down and used profanity toward resident on 8/6/23. It was observed by EI#5 (CNA.) o EI#5 (CNA) reported the incident to EI#9 on 8/12/23 who reported to Administrator on 8/12/23. Due to delay of reporting EI#5 (CNA) was trained via phone. o Administrator notified ADPH on 8/12/23. o Administrator notified MD on 8/12/23. o The administrator notified Huntsville Police Department and attempted to notify family on 8/12/23. o Hospice was notified on 8/12/23 via phone and 8/14/23 in person Ombudsman was notified on 8/12/23. o The Ombudsman was notified on 8/12/23 via email and via phone on 8/14/23 and stated she will provide an in-service for the center. o EI#4 (CNA) was placed on administrative leave on 8/12/23 and investigation began. EI#4 (CNA) was terminated on 8/16/23 due to substantiated abuse reports identifying EI#4 as aggressor. o Full body audits conducted on residents on all halls with BIMS less than 8 on 8/13/23 with no (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	significant findings. o Interviews conducted with residents on all halls with BIMS of 8 or greater on 8/14/23 with no significant findings. o Reported EI#4 (CNA) to CNA Registry and charges filed by Huntsville Police Department with upcoming court date on 10/15/23. o EI#5(CNA) was placed on Administrative Leave on 8/12/23 and terminated on 8/16/23. Reported to CNA registry. o Additional signage was added around the center on 8/12/23 for reminders for team members to report incidents and contact information for abuse coordinator (Administrator). o Focused Quality Assurance meeting was held with Physician and Interdisciplinary Team in attendance on 08/12/23. o All team members and center care partners in-serviced beginning 8/12/23 regarding abuse and neglect identification, residents' safety and protection, and reporting. (All team members and center care partners to include nurses, med techs, CNAs, team leaders/management, contract therapy service providers, contract housekeeping services, and contract dietary services.) o Team members and center care partners signed acknowledgement of receiving education and understanding the requirements of the Elder Justice Act training beginning on 8/25/23. All team members and center care partners include nurses, med techs, CNAs, team leaders/management, contract therapy service providers, contract housekeeping services, and contract dietary services. o Ombudsman, [NAME], provided training with team members and center care partners (to include nurses, med techs, CNAs, team leaders/management, contract therapy service providers, contract housekeeping services, and contract dietary services.) regarding resident rights, abuse, neglect, and reporting on 9/13/23 at 7:00 am and 3:30 pm which allowed accessibility for all shifts to attend. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI#1: o EI#4 (CNA) placed the washcloth in RI#1 mouth, EI#11 (volunteer) removed wash cloth from her mouth and reported to EI#7 (memory care director) on 8/8/23. o EI#9 (LPN) and EI#11 (volunteer) together told EI#8 (LPN/Unit Manager) about the incident on 8/8/23. EI#8 (LPN/Unit Manager) reported to Administrator on 8/12/23. Due to delay in reporting EI#8 (LPN/Unit Manager), EI#9 (LPN), EI#11 (volunteer), EI#7 (Memory Care Director) were all placed on administrative leave pending investigation due to this incident, should have been reported immediately to the Administrator. In-services began on 8/13/23 to include abuse identification, reporting time frames, and providing safety for the residents. o Assessed RI#1 for injury by DNS and no injuries noted on 8/12/23. o &nbs[TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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 and review of a facility policy titled Means of Egress, the facility failed to maintain an environment that was free of accident hazardous. Resident Identifier (RI) #7, a resident with a history of wandering in and out of other resident's room, began to exhibit more frequent wandering behaviors, and on 07/28/2023, facility staff built a barricade across the hallway to prevent the resident from wandering. This affected RI #7, one of three sampled residents care planned for wandering, and had the potential to affect all residents residing in Room locators (RL) 2-5. Findings include: Review of a facility policy titled Means of Egress, with an effective date of 09/01/2014, revealed the following: . PURPOSE To safeguard residents, visitors, and personnel by ensuring all emergency egress paths and exits are clear, unobstructed, completely accessible and illuminated from any residential area within the center to a public way . PROCEDURE . 1. Clean linen, soiled linen bins, housekeeping carts, computers on wheels, food carts, etc. are permitted while in use - 30 minutes or less Walking surface must be . unobstructed at all times . RI #7 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include Disorder of the Brain, Muscle Weakness, Unsteadiness on Feet, Lack of Coordination, Cognitive Communication Deficit and Alcohol Dependence. RI #7's admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 07/24/2023, identified RI #7 as scoring a 5 on the Brief Interview for Mental Status (BIMS) indicating RI #7 had severely impaired cognition. RI #7's Progress Notes revealed the following: . Effective Date: 07/25/2023 . Type: Behavior Charting . Resident has been noted to be going into all the other resident's room on the hall. Redirection unsuccessful continues to enter other residents' room unwanted . (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Effective Date: 07/26/2023 . Type: Daily skilled Nurses Note Summary: . Self propels in wheelchair into other residents' room and has complaints of resident rumbling through things in other residents' rooms. Redirection unsuccessful wandering continues . Effective Date: 07/29/2023 . Type: Daily skilled Nurses Note Summary: . Self propels in wheelchair into other residents' rooms . RI #6 was admitted to the facility on [DATE] with diagnoses to include Muscle Weakness and Unsteadiness on Feet. RI #6's MDS assessment, with an ARD of 07/28/2023 revealed RI #6 scored a 14 on the BIMS indicating RI #6 was cognitively intact. On 09/12/2023 at 5:00 PM a telephone interview was conducted with RI #6. RI #6 said RI #7 had wandered into his/her room twice and a barricade had been made to keep RI #7 out of his/her room. RI #6 said the barricade was made with a nurses' cart and an ice chest. On 09/16/2023 at 12:27 PM, an interview was conducted with Employee (EI) #1, the Administrator. EI #1 was shown a picture received by the State Agency of the barricade. EI #1 said the picture looked like the facility, and based off the chandelier in the picture, it looked like it was in the unit where RI #7 resided. EI #1 identified nurses' carts, an ice chest, and a linen cart in the picture blocking anyone attempting to leave RL #'s 2-5. RI #7 was residing in RL #5. EI #1 said the harm of the barricade was the residents could knock the barricade over and fall. On 09/16/2023 at 5:08 PM, an interview was conducted with EI #2, the Director of Nursing. EI #2 was shown the picture received by the State Agency of the barricade. EI #2 said the residents have attempted to get through the barrier and fall. EI #2 said that would not be safe. This deficiency was cited as a result of the investigation of complaint/report number AL00045069.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and review of Resident Identifier (RI) #7's medical record, the facility failed to identify and address the behavioral health care needs of RI #7, a resident with repeated incidents of wandering. In addition, the facility further failed to ensure their Behavioral Assessment policy/procedure was followed to direct the staff on how to assess the resident behaviors, utilizing the Behavioral Assessment Tool to help determine the factors contributing to identified behavior problems. The facility also did not identify specific behavioral interventions for RI #7, to deal effectively with the situation of wandering, after it was document, the resident continued to wander in/out other residents' rooms. This deficient practice affected RI #7; one of three sampled residents reviewed for wandering behaviors. Findings include: The facility Behavioral Policy and Procedure with an effected date of May 1, 2012 identified, Behavioral Assessment .PURPOSE it is the policy of this facility to assess a resident behavior, utilizing the Behavior Assessment Tool to help determine the factor(s) contributing to identified resident behavior problem(s) . PROCEDURE Social Service/Nursing completes the Behavioral Assessment Tool whenever . danger to harm others .The Behavior Assessment Tool is used to explore possible cause for the resident behavior. RI #7 was readmitted to the facility on [DATE] with an admitting diagnosis of Disorder of Brain, Unsteadiness on Feet and Cognitive Communication Deficit. The admission Minimum Data Set for RI #7, with an assessment reference date of 07/24/2023 indicated RI #7 was severely impaired in cognitive skills for daily decision making. According to this MDS, RI #7 displayed no physical behavioral symptoms directed toward others. The facility's Progress Notes for RI #7 identified the follow episodes of wandering into other resident's rooms without successful interventions being implemented: 07/24/2023 at 5:47 PM written by Employee Identifier (EI #9), a Licensed Practical Nurse, documented Room changed to 302A D/T resident going to glass doors. Redirection unsuccessful resident is sitting by the glass doors at this time. This nurse asked resident what he was doing down their resident stated, just looking. 07/25/2023 at 1:10 PM written by Employee Identifier (EI #9), a Licensed Practical Nurse, documented Resident is roaming the hallways going to glass doors and pushing the handles. Resident has been noted to be going into all the other resident s room on the hall. Redirection unsuccessful continues to enter other residents' room unwanted. 07/26/2023 at 6:59 PM written by Employee Identifier (EI #9), a Licensed Practical Nurse, documented . Self propels in wheelchair into other residents' room and has complaints of resident rumbling through things in other resident's rooms. Redirection unsuccessful wandering continues. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015397	A. Building B. Wing	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor House	4411 McAllister Drive Huntsville, AL 35805

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/27/2023 at 5:47 PM written by Employee Identifier (EI #8), a RN Unit Manager, documented . Propels self in w/c in hallways with frequent redirection needed due to entering other residents' rooms uninvited . 07/28/2023 at 12:35 PM written by Employee Identifier (EI #16), a Director Care Coordinator documented . Care plan with patient and (him/her) family . They also stated that a patient would often enter (RI # 6's) room wandering around lost . 07/29/2023 at 1:05 PM written by Employee Identifier (EI) #9, a Licensed Practical Nurse, documented .Resident ambulates self in room without calling for assistance. Self-propels in wheelchair into other resident's rooms has been placed on 15 min watch. The facility initiated a care plan on 07/28/2023 for RI #7's wandering with three interventions, one intervention was added while survey was in progress. The interventions documented in care plan were to, . Anticipate and meet the resident's needs. Date initiated: 07/28/2023 .Assist the resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feeling appropriately. Date initiated: 07/28/2023 Revision on: 09/18/2023 . Resident placed on 1:1 supervision. Dated initiated: 09/17/2023 Revision on: 09/17/2023. None of the interventions listed were specific to address wandering in/out of resident rooms. On 08/14/2023 the facility received verbal consent from RI #7's sponsor for referral to Remedy Behavioral Health however, behavioral did not visit the resident until 09/14/2023. Behavioral Health documented, Initial visit w/Remedy Behavioral health to evaluate cognition and behaviors It is my opinion the patient is good candidate and would benefit from Psychiatric services and treatment. An interview with the Remedy Behavioral Health CRNP (Certified Registered Nurse Practitioner) on 09/16/2023 at 12:00 PM, confirmed she did not receive the referral until 09/14/2023. My recommendation was to do a Mini Mental Status Exam, but I did not do it because he was so distracted. 09/17/2023 in the early AM a note was placed under DON door that RI #7 wandered had into RI #9 a female resident's room and he/she refusal to stay out of him/her room The note also documented that RI #7 was also wandering into other resident room. A review the progress notes revealed the LPN did not document this behavior and only left the note for the DON regarding RI #7 behaviors. On 09/14/2023 and interview was conducted with EI #5 (CNA) a direct care staff member who identified RI #7 was known to wander. EI #5 said one intervention used was to transfer RI #7 to another room because of a complaint of him/her wandering to into RI #6's room. On 09/16/2023 1:00 PM, an interview was conducted with EI #18 Social Services Director (SSD) regarding the Behavioral Assessment Tool to explore possible causal or RI #7 behavior. EI #18 said she was not made aware of the incident until the police showed up. EI #18 said the Behavioral Assessment should be implemented Quarterly or after an incident has taken place. EI #18 said in a normally run facility Social Services completes the assessment. EI #18 did say in the interview that the Behavioral Assessment Tool should have been completed when the incident occurred but was not completed. EI #18 said she was told not to complete the Behavioral Assessment Tool because the Administrator was handling it. EI #18 said it would have been important for her to complete the assessment because it would have allowed her to monitor the resident. An interview was conducted on 09/17/2023 at 1:00 PM, with Director of Nursing Services (DNS) EI #2 (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding RI #7 Behavioral Assessment Tool. EI #2 said, the tool is used to establish possible causes of the behavior. Usually, if a resident has a behavior the nurse should document the behavior and the Social Worker assist the care plan staff in updating the care plan. EI #2 said, she did not think the Behavioral Assessment Tool was completed on RI #7. The DNS said the Social Worker was responsible for completing the Behavioral Assessment Tool and was responsible for behavioral monitoring/management. EI #2 said once EI #13 became aware of RI #7's recent behavior of wandering she should have documented the behavior and placed RI #7 on one to one and make sure he/she did not wander into another resident's room. An interview was conducted with the Administrator (EI #1) on 09/18/2023 at 01:30 PM, regarding RI #7's wandering behavior. EI #1 said it was a collaboration of everyone to revise the care measure to prevent reoccurring behavior and the measure should be documented. EI #1 said that specific intervention used with RI #7 were to increased activities involvement, do every 15 minutes checks for medical issues and notify the physician of new behaviors. This deficiency was cited as a result of the investigation of complaint/report number AL00045069.