STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015047	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northway Health and Rehabilitation, LLC	1424 North 25th Street Birmingham, AL 35234

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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 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 29671 Based on an interview and a review of a policy titled, Federal Rights of Resident/Guest(s) the facility failed to ensure mail was delivered to residents on Saturday. This affected 13 residents who attended the Resident Council Meeting on 04/17/2024 and had the potential to affect all residents in the facility. Findings Include: A review of a policy titled, Federal Rights of Resident/Guest(s) with an effective date of November 28, 2016, documented the following: .(g)(8) The resident/guest has the right to . receive mail . On 04/16/2024 at 3:15 PM during the Resident Council Meeting, 13 residents reported mail was not delivered to them on Saturday. Residents reported that mail received by the facility on Saturday would be passed out to them on Monday. On 04/16/2024 at 4:18 PM an interview was conducted in the Social Services Director (MSW). The MSW said that mail delivered by the Postman to the facility on Saturday was placed in the Activity Director's box and given to the residents on Monday. On 04/16/2024 at 4:27 PM an interview was conducted with the Activity Director (AD). The AD stated she worked Monday through Friday and did not work on Saturday or Sunday. The AD stated she was responsible for passing out mail to the residents when it was delivered to the facility. When asked about the residents' mail on Saturday she said the staff who work placed the delivered mail in her box and she delivered it to the residents on Monday when she returned to work. When asked if any staff delivered mail to residents on Saturday, she stated that, to her knowledge, no staff delivered mail to residents on the weekend. In response to whether residents should receive mail on the weekend, she said that very few residents received mail on Saturday, and if they did, they were aware they would receive it on Monday. An interview was conducted with the Director of Nursing (DON) on 04/17/2024 at 2:43 PM. The DON said that residents should receive their delivered mail on Saturday because it was their personal mail and they should receive it in a timely manner. When asked what was the concern of residents not receiving mail on Saturday she said they could miss greetings from family or important information.

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 - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41928 Based on observations, interviews and the facility's Residents Rights, the facility failed to ensure rooms on three of five halls were not found in need of repair. This deficient practice affected seven residents' rooms on three halls. Findings Include: The facility's undated Residents Rights, documented, These are YOUR Rights: YOU have the right .to live in a safe, clean, comfortable and homelike environment. On 04/14/2024 at 1:18 PM, surveyor observed Resident Identifier (RI) #56's closet was missing a door. On 04/14/2024 at 4:09 PM, surveyor observed RI #100's wall behind bed with scraped paint. On 04/14/2024 at 4:25 PM, surveyor observed RI #67's wall behind bed with scraped paint. On 04/15/2024 at 8:28 AM, surveyor observed RI #18's wall behind bed with scraped paint and chipped paint and hole in the wall on the side of bed. On 04/15/2024 at 10:56 AM, surveyor observed dark stain and no caulking at base of RI #9's toilet. On 04/15/2024 at 9:00 AM, surveyor observed stained ceiling tile and wall at foot of RI #103's bed scuffed and peeling. On 04/14/2024 at 8:45 AM, surveyor observed a hole in RI #35's wall under the sink. On 04/17/2024 at 11:29 AM surveyor and Maintenance Director (MTD) made observations of the noted concerns in residents' rooms. Observed RI #100's wall behind bed. The MTD stated the wall had scraped paint. An observation was made of RI #67's wall behind bed, maintenance stated had scraped paint behind his/her bed. An observation was made of a hole under the sink in RI #35's room. An observation was made of a brown stained on ceiling tile, the wall scuffed and peeling in RI #103's room. An observation was made of RI #56's room which had a missing closet door. An observation was made of scraped paint and wall with hole in the wall behind the bed in RI #18's room. An observation was made of the toilet in RI #'9's bathroom. The MTD stated the toilet had a red-brownish stain around the base and missing caulking. An interview was conducted with the MTD on 04/17/2024 at 11:50 AM. The MTD stated the walls behind the bed that had scraped paint, the hole under the sink, the missing closet door, the holes in the walls, the stained ceiling and the red/brownish base of the toilet that needed caulking did not look good and needed to be repaired.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33739 Based on interviews, record review, review of the facility's investigation titled Verification of Investigation, and review of facility policy Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation, the facility failed to ensure Licensed Practical Nurse (LPN) #6, did not misappropriate Resident Identifier (RI) #43's Percocet and Lyrica after signing the medication as administered. This was cited as a result of investigation of complaint/report number AL00045405, and affected one of one residents reviewed for misappropriation of resident property. Findings Include: Review of a facility policy Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation, with an effective date of 05/01/2023 documented PURPOSE: . All of our resident/guest(s) have a right to be free from . misappropriation of resident/guest property. The Policy also prohibits the misappropriation of resident/guest property. D. Misappropriation of Resident/Guest Property. Misappropriation of resident/guest property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident/guest(s) belongings or money without the resident/guest(s) consent. The facility's investigation of the incident titled Verification of Incident documented . On the morning of Monday 08/28/2023 (RI #43) reported to the charge nurse not receiving medication on the 3 p - 11p shift. He/she was interviewed by the Director of Nursing and repeated the same allegation . Stated had pain medication due at 10:00 PM realizing had not received it around 11:30 PM asked the nurse on duty she stated could not give it as the 3 - 11 shift nurse had signed it out. OUTCOME OF INVESTIGATION: . As a part of the investigation, a review of the Electronic Medical Record (EMR) and a printed narcotic log stated all medications scheduled during the 3 - 11 pm shift were signed out as given by Nurse (LPN #6). Nurse was contacted by phone and stated . passed all medication scheduled . The administrator reviewed the camera system . While counting . medication cart, LPN #6 is seen punching seven pills from the narcotic box into one cup and signing the medication log. LPN #6 is witnessed placing the medication in her right hand and transferring it to a personal pill bottle, and then to her purse. RI #43 was admitted to the facility on [DATE] with diagnoses of Pain and Neuropathy. Review of RI #43's August 2023 Physician Orders documented . Lyrica Capsule Three Times a Day DX (Diagnosis) Neuropathy .Percocet 10-325 Milligram 1 Tablet every 8 hours DX Pain . Review of RI #43's Controlled Drug Record for Oxycodone (Percocet) indicated the medication signed out on 08/27/2023 at 9:00 PM by LPN #6. Pregabalin (Lyrica) indicated it was signed out by LPN #6 on 08/27/2023 at 8:00 PM. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/14/2024 at 1:40 PM during an interview with RI #43 when asked if any nurses did not give medications as scheduled, RI #43 said one did. When asked how long he/she went without pain medication, RI #43 said a few hours. RI #43 denied increased pain when the pain medication was not administered. On 04/15/24 at 10:37 AM during an interview with (Registered Nurse) RN #4, she said she came on shift at 11:00 PM, counted with LPN #6 and all counts were correct. She said it was around midnight when she went into RI #43's room, he/she said he/she did not get pain medications, RN #4 said she would check on it. She said she looked in the record it was signed out as administered. On 04/15/2024 at 11:23 AM during an interview with the oncoming nurse LPN #5, she recalled RI #43 telling her he/she did not get pain medication the evening before. She said she told the Director of Nursing (DON) because it was unusual. She said RI #43 was alert, oriented and aware of medications administered. LPN #5 said RI #43 said he/she did not receive the Lyrica or the Percocet. On 04/16/2024 at 8:34 AM during an interview with the DON, she said RN #4 told the morning nurse, LPN #5, RI #43, said he/she did not get medication for pain at 10:00 PM, she checked the books found it signed as administered. The next morning RI #43 told LPN #5 the nurse on 3 to 11 did not give his/her pain medication. The DON said LPN #5 said RI #43 was alert, and oriented. The DON said she told the Administrator, and they started an investigation. The DON said the Administrator watched the camera footage. The DON said RI #43 said did not get Lyrica and Percocet, those medications were signed out as administered. The DON said they called LPN #6 to come to the facility, she said she could not, she said she gave it to RI #43, she said she gave all the medications. The Administrator said he watched the video and wrote down her actions. The Administrator said he could not tell which resident's medications she was pulling while she was in the cart and could only tell she was in the narcotic drawer. LPN #6 was observed taking the medication cup around the nurses' station and poured the medication into her personal prescription bottle. On 04/16/2024 around 2:00 PM during a phone interview with the previous Administrator, he said he was made aware of RI #43 not receiving medication on the evening before shift after the morning nurse told the DON, what RI #43 told that morning. He said the medication was signed out as administered. He said because RI #43 was alert, and the nurses knew him/her he thought to look on camera. He said he documented a timeline according to the camera footage. He said he saw LPN #6 was pushing medications in a cup and hid it under the binder. He said they did a review of the medications that were signed out by LPN #6 and recalling by memory not sure, he thought he saw her punching out seven, that may not have been exact. The Administrator said they could be sure of RI #43's by him/her saying he/she did not get his/hers. They could only validate RI #43 not receiving his/her pain medications as he/she told two nurses. The Administrator said after watching the video they saw some concerns, and called her back with no answer, she was terminated although she never returned calls or returned to the facility. The Administrator said it was abuse by misappropriation when the nurse did not give scheduled pain medication, however signed them out as given, and the timeline from watching the video indicated she punched pills and did not give to a resident. The Administrator said the concern with LPN #6 misappropriating RI #43's medication was abuse, and the nurse being untrustworthy. He said during her orientation she was presented with the policy on abuse and went through a week of orientation; he said the event was her first shift out of orientation. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/2024 at 4:09 PM during a follow-up interview with the DON, she said it was misappropriation of resident property when a nurse signed out a resident's medication, but did not administer it to the resident. The DON said they could only determine RI #43 had medication misappropriated as LPN #6 took medication from the narcotic box, signed it out as administered and never administered it to the resident. The DON said the facility determined the misappropriation when RI #43 told the nurses he/she had not received pain medication on the evening shift, although it was signed out as given. On 04/17/2024 at 9:26 AM during an interview with the Regional Nurse she it was misappropriation of property when a nurse signed out a resident medication, but did not administer the medication. She said the only medication determined misappropriated was RI #43's as RI #43 told two nurses he/she did not receive it.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33739 Based on interview, record review, review of a facility policy Pre-Admission Screening Resident Review, and review of Resident Identifier (RI) #103's PASRR (Preadmission Screening and Resident Review), the facility failed to ensure RI #103's PASRR was accurately marked with an admission diagnosis of Bipolar Disorder, which indicated a Level II was indicated. This affected one of two residents sampled for PASRR. Findings Include: A review of a facility policy titled Pre-admission Screening Resident Review, with a revised date of 06/2009 documented . 4. The nursing facility is responsible for ensuring that a level I screening is completed, submitted and has a Level I Determination on or before nursing home admission . Process for PASRR . 3. Nurse Consultants and Case Managers will review Level I and/or Level II Determination during medical records audits for newly admitted or readmitted residents. 4. QA Nurses will review Level I and/or Level II Determinations as part of their audit of the admissions process. On 04/15/2024 at 2:15 PM a review of RI #103's PASRR which was signed on 09/15/2023 did not indicate resident had a Major Mental Illness of Bipolar Disorder. Based on the results there was no need for a Level II. The PASRR review revealed only a Level I and no diagnoses were selected or marked on the screening form. RI #103 was admitted to the facility on [DATE] with a diagnosis of Bipolar Disorder. A review of RI #103's diagnoses sheet included Bipolar Disorder with onset date of 10/27/2023. On 04/15/2024 at 3:00 PM during an interview with Social Services staff, when she was asked what was the facility's process to identify residents needing a Level I or Level II. She said they looked at the diagnoses and medications, marked diagnoses and medications on the screening form, then submitted it to the screening office. When asked what the date of onset for RI #103's Bipolar Disorder, she said 10/27/2023 which was the date RI #103 admitted to that facility. She was asked if Bipolar Disorder should be marked on the PASRR, she said yes she would have marked it. She said Social Service was responsible for ensuring the PASRR was accurate if a resident was admitted from another facility. She said the PASRR not having Bipolar Disorder marked or selected resulted in an inaccurate PASRR. She said the concern in the PASRR not updated to include Bipolar Disorder was not having accurate diagnosis.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33739 Based on interviews, record review, and review of the facility policy titled Medication Administration Documentation for Medication Administration, facility failed to ensure Resident Identifier (RI) #43's Medication Administration Record (MAR) was accurate. On 08/27/2023 Licensed Practical Nurse (LPN) #6 documented the administration of Lyrica and Percocet in RI #43's medical record and did not administer the medications to RI #43. This affected RI #43, and was cited as a result of investigation of complaint/ report number AL00045405. Findings Include: Review of a facility policy Documentation for Medication Administration with an effective date of 04/2020 documented . Procedures 1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. RI #43 was admitted to the facility on [DATE] with diagnoses of Pain and Neuropathy. Review of RI #43's August 2023 Physician Orders documented . Lyrica Capsule Three Times a Day DX (Diagnosis) Neuropathy . Percocet 10-325 Milligram 1 Tablet every 8 hours DX Pain . Review of RI #43's August 2023 Medication Administration Record (MAR) indicated Percocet and Lyrica was documented as administered by LPN #6 on 08/27/2023. An interview was conducted with RI #43 on 04/14/2024 at 1:40 PM. RI #43 stated one nurse did not give him/her medication as scheduled around 10:00 PM on 08/27/2023. An interview was conducted with Registered Nurse (RN) #4 on 04/15/2024 at 10:37 AM. RN #4 stated she went into RI #43's room around midnight, and he/she stated he/she did not get his/her pain medication. RN #4 stated she reviewed the record and confirmed that it was signed out as administered. An interview was conducted with LPN #5 on 04/14/2024 at 11:23 AM. She stated she became aware of RI #43 not getting pain medication on second shift on 08/27/2023 when RI #43 told her. She stated she told the DON because RI #43 was alert and oriented and it was unusual. A telephone interview was conducted with the Former Administrator on 04/16/2024 at 2:00 PM. He stated LPN #6 did not administer RI #43 his/her scheduled pain medication on 08/27/2023, however signed them out as given. He stated it was inaccurate documentation. An interview was conducted with The Director of Nursing (DON) on 04/16/2024 at 4:09 PM. The DON stated RI #43's medication was signed out by LPN #6 on the Medication Administration Record (MAR) and it was not given to him/her on 08/27/2023. The DON stated it was falsifying the records when LPN #6 signed out medication and she did not administer the medications. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Regional Nurse on 04/17/2024 at 9:26 AM. She stated RI #43's medications was signed out on both the narcotic sheet and MAR on 08/27/2023 as given. The Regional Nurse stated it was falsifying the records when LPN #6 signed out medication and she did not administer the medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41928 Based on observations, interviews and a facility policy titled, Hand Hygiene, the facility failed to ensure: 1) staff sanitized their hands on 04/14/2024 while passing meal trays on Station 4. The facility further failed to ensure staff performed hand hygeine while assisting Resident Identifer (RI) #1 and RI #47 with their meal. This deficient practice affected residents residing on two of five halls, including RI #1 and RI #47. 2) staff followed Standard Precautions and properly disinfected the glucometer after routine testing of blood glucose. This affected RI #73, one of two residents observed for blood glucose testing. Findings Include: A facility policy titled, Hand Hygiene, with an effective date of 06/11/2020, documented, PURPOSE: To provide guidelines to employees for proper and approriate hand washing techniques that will aide in the prevention of the transmission of infections. III. Hand Hygiene . The following is a list of some situations that require hand hygiene. Before and after . handling food . Before and after assisting a resident/guest with meals . On 04/14/2024 at 5:12 PM, surveyor observed the dinner meal cart on hall. Certified Nursing Assistant (CNA) #13 was observed as she sanitized her hands, took dinner tray off meal cart and took into room came back to the meal cart, retrieved another tray. CNA #13 passed three meal trays before she sanitized her hands again. CNA #12 walked up to the meal cart and began to pass trays. She passed four trays then sanitized her hands. An interview was conducted with CNA #12 on 04/14/2024 at 5:18 PM. CNA #12 stated she washed her hands before she began passing trays. CNA #12 admitted she did not perform hand hygiene between passing each tray and stated she should have. CNA #12 stated the concern of not performing hand hygiene between each tray was passing bacteria. An interview was conducted with CNA #13 on 04/14/2024 at 5:24 PM. CNA #13 admitted she only sanitized her hands after passing the third tray. CNA #13 stated the concern of not performing hand hygiene after passing each tray was the possibilty of contamination. 47408 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/14/2024 at 5:17 PM CNA #18 obtained trays and proceeded to assist two residents, RI #47 and RI #1 with their meal at the same time and without performing hand hygiene. At 5:18 PM CNA #18 was observed as she got up, picked up a soiled tray from another resident, and continued to assist RI #47 and RI #1 without performing hand hygiene. Next, CNA #18 washed her hands, escorted a resident out of dining room, and resumed assisting RI #1 and RI #47 with their dinner meals without performing hand hygiene. An interview was conducted with CNA #18 on 04/16/2024 at 10:19 AM. CNA #18 said that she did not perform hand hygiene between trays and assisted RI #1 and RI #47 with their dinner meal on 04/14/2024 simultaneously. CNA #18 stated it was not possible to perform hand hygiene while assisting two residents with their meals at the same time. CNA #18 stated the concern of not performing hand hygiene while passing trays and assisting with feeding two residents at the same time is cross-contamination. An interview was conducted with the Director of Nursing (DON) on 04/17/2024 at 12:11 PM. The DON stated staff should perform hand hygiene after passing each tray. The DON stated the concern of not performing hand hygiene between each tray was possible cross-contamination. The DON also stated staff should never feed two residents at the same time. She stated the concern of feeding two residents at the same time was cross-contamination. 2) On 04/15/2024 at 3:47 PM, surveyor observed MAC #12, obtain a blood glucose level for RI #73. Afterwards, MAC #12 left RI #73's room and placed the used barrier tray which contained the glucometer on the med cart. MAC #12 cleaned the glucometer with tissue paper and hand sanitizer. The glucometer was then placed on the med cart. An interview was conducted with MAC #12 on 04/15/2024 at 4:00 PM. MAC #12 said she should have thrown the used barrier away instead of bringing it out of RI #73's room. She also said that she cleaned the glucometer with hand sanitizer. MAC #12 stated there were Clorox wipes on the cart, but stated she usually just wiped off the glucometer with hand sanitizer. MAC #12 stated the concern of bringing a used barrier from resident's room and placing on medication cart was cross-contamination. An interview was conducted with The DON on 04/17/2024 at 12:15 PM. The DON stated it was never acceptable to take a used barrier from a resident's room and place it on the medication cart. She stated glucometers were to be cleaned with Clorox wipes, never hand sanitizer. She stated the concern was cross-contamination and infection control.