STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015321	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Haven Health and Rehabilitation, LLC	3141 Old Columbiana Road Birmingham, AL 35226

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44165 Based on interviews, observations, resident record review, and review of a facility policy titled, Federal Rights of Resident/Guest(s) the facility failed to ensure Resident Identifier (RI) #7 was informed in his/her language, of care being provided. Findings include: A review of the facility policy titled Federal Rights of Resident/Guest(s) with an effective date of 11/28/2016 revealed: . STANDARD: (a) Resident/Guest rights. The resident/guest has the right to a dignified existence, self determination, and communication with and access to persons and services inside and outside the facility. (c) Planning and implementing care. The resident/guest has the right to be informed of, and participate in, his or her treatment, including: (c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. RI #7 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #7's quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Spanish was RI #7's preferred language. On 04/11/2024 at 09:35 AM the surveyor communicated with RI #7 using a phone translator. RI #7 stated, the staff talked to him/her in English. RI #7 stated, it was hard for him/her to communicate with the staff. On 04/11/2024 at 09:55 AM an observation was made of Licensed Practical Nurse (LPN) #27 administering medications to RI #7. LPN #27 handed RI #7 a cup of medications and in English told the resident she had his/her medications. RI #7 replied to LPN #27 in Spanish. LPN #27 spoke to RI #7 in English, and said for RI #7 to take the medications. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/11/2024 at 10:04 AM an interview was conducted with LPN #27. LPN #27 stated, when administering medications, before the medication was given to the resident, the resident should be told what medications he/she was receiving. LPN #27 stated, RI #7 did not understand English and so she did not tell him/her the name of the medications. LPN #27 stated, she wished she were able to communicate with RI #7. LPN #27 stated, she did not tell RI #7 the name of the medications before administering. On 04/16/2024 at 09:00 an interview was conducted with Minimum Data Set Coordinator (MDS). MDS stated, the MDS assessments capture the resident's diagnosis, behaviors, and what they are doing. On 04/16/2024 at 10:23 AM a follow-up interview was conducted with MDS. MDS stated, according to RI #7's 01/08/2024 MDS assessment, the preferred language was Spanish. On 04/16/2024 at 10:52 AM the Director of Nursing (DON) stated, during medication administration residents should be notified of what they were taking. DON stated, there was a risk for residents not knowing what the medication was or the risks of the medication. DON stated, even if the resident did not speak English, they should be provided that information. DON stated, staff should have utilized Google translator or the 1800 number for a translator.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44165 Based on interviews, resident record review, review of facility policies titled Incidents and Accidents and Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation and review of a facility investigative file for Resident Identifier (RI) #2, the facility failed to ensure an injury of unknown origin was reported to the Alabama Department of Public Health (ADPH) online reporting system in a timely manner when Certified Nursing Assistant (CNA) #16, discovered discoloration and bruising on RI #2's right ankle on 11/07/2023. The Licensed Practical Nurse (LPN) #19 failed to report the bruising to anyone including the abuse coordinator. On 11/10/2023 an x-ray was performed on RI #2's right ankle and revealed a fracture. The injury of unknown origin was still not reported to ADPH until 11/12/2023. This affected RI #2, one of two residents whose reportable incidents were reviewed. Findings include: A facility policy titled Incidents and Accidents with an effective date of 11/10/2014 documented . The resident/guest environment remains as free of accident hazards as is possible, however, when an accident occurs, prompt response and reporting occurs. A facility policy titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation, dated 05/01/2023 documented .PURPOSE: The facility's policy requires that it report all instances of . suspicious injuries of unknown source that might indicate abuse, neglect, as required by state and federal law. VI. b) . Notify the Administrator of any unusual situation in the facility, whether reportable or not immediately. The Administrator/Designee will report to the State Agency and all other required agencies, per regulations. All allegations of abuse and instances that result in serious bodily injury must be reported within 2 hours. Resident Identifier (RI) #2 was admitted to the facility on [DATE] and had diagnoses to include: Myocardial Infarction, Dementia with Behavioral Disturbances. RI #2's quarterly Minimum Data Set (MDS) assessment with an assessment reference date of 09/11/2023 documented RI #2 had moderate cognitive impairment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigative file for RI #2 revealed a form titled Shower Team Body Audit Sheet (STBAS) dated 11/07/2023 with RI #2's name on the form. The STBAS had a hand drawn mark next to the right ankle and handwritten on the top of the form were the words, right ankle swollen and discoloration. The form was signed by Certified Nursing Assistant (CNA) #16 and the form was also signed by Licensed Practical Nurse (LPN) #19. On 04/13/2024 at 11:02 AM CNA #16 was asked about the body audit conducted on RI #2 on 11/07/2023. CNA #16 said, she saw the bruise, put it on the body audit sheet and told the nurse. On 04/13/2024 at 10:20 AM LPN #19 was asked about the body audit sheet for RI #2 dated 11/07/2023. LPN #19 said, she did sign the body audit sheet and she thought everyone (other nurses) were aware of the bruise. A hand written statement signed by CNA #17 documented he found the bruise on RI #2's foot going up the leg and stopped immediately to notify the nurse RN #30. A typed statement signed by Registered Nurse (RN) #30 documented the following: . on 11/10/2023 the CNA reported to her in the hallway that the resident in (RI #2's room) right ankle had a bruise. Upon assessment, there was a bruise to the right ankle going up (his/her) lower leg. After my assessment I notified MD (Medical Doctor) of findings and received verbal order for x-ray to the right ankle. RI #2's x-ray report dated 11/10/2023 documented . Conclusion: A [NAME] B distal fibular fracture. On 04/11/2024 at 6:53 PM an interview with the Abuse Coordinator/Administrator (ADM) was conducted. ADM stated, the facility had two hours to report an injury of unknown origin to the Alabama Department of Public Health. On 04/12/2024 at 8:47 AM a follow-up interview was conducted with the ADM and she was asked about RI #2's incident with fracture that was reported to ADPH. ADM stated, she was informed of the fracture on 11/12/2023. ADM said, CNA #16 saw the discoloration on RI #2 on 11/07/2023. ADM stated, RI #2 was unable to be interviewed regarding the cause of the bruise due to impaired cognition. ADM stated, she was unable to determine the root cause of the bruise and fracture. ADM stated, she could not determine the cause of the discoloration that was identified on 11/07/2023. The ADM said, after the nurse, LPN #19 was made aware of the bruise on RI #2's right ankle she did not notify anyone. ADM said, she did not know why LPN #19 did not document or report the incident and the risk of not reporting an incident of unknown origin was the resident was not protected. On 04/16/2024 at 10:52 AM the Director of Nursing (DON) was asked about RI #2's injury of unknown origin reported to ADPH on 11/12/2023. The DON said, the bruise was identified on 11/07/2023 on a body audit but the nurse did not report it to the abuse coordinator. The DON said, RI #2 had an x-ray on 11/10/2023 due to the bruising and discoloration to the skin. The DON said, she could not say why the fracture was not reported to ADPH on 11/10/2023. The DON said, a root cause was not determined.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44165 Based on interviews, resident record review, review of facility policies titled Incidents and Accidents and Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation, and review of the facility investigative file for Resident Identifier (RI) #2, the facility failed to thoroughly investigate an injury of unknown origin for Resident Identifier (RI) #2 when a bruise was identified on 11/07/2023. This affected RI #2 one of two residents for whom reportable incidents were reviewed. Findings include: Cross-reference F609 Review of facility policy titled Incidents and Accidents with an effective date of 11/10/2014 indicated . The resident/guest environment remains as free of accident hazards as is possible, however, when an accident occurs, prompt response and reporting occurs. Accidents may involve resident/guest(s), employees, or visitors. c) Develop a brief investigation plan. Review of a facility policy titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation dated 05/01/2023 indicated . A complete and thorough investigation must be conducted on all incidents including suspicious injuries of unknown origin, whether reportable or not, within five working days to determine the cause of the injury or incident. The outcomes of the investigation must also determine whether or not the incident was abusive or neglectful in nature. RI #2 was admitted to the facility on [DATE] and had diagnoses to include: Dementia with Behavioral Disturbances. Review of the facility's investigative file for RI #2 revealed a form titled Shower Team Body Audit Sheet (STBAS) dated 11/07/2023 with RI #2's name on the form. The STBAS had a hand drawn mark next to the right ankle and handwritten on the top of the form were the words, right ankle swollen and discoloration. The form was signed by Certified Nursing Assistant (CNA) #16 and the form was also signed by Licensed Practical Nurse (LPN) #19. On 04/13/2024 at 11:02 AM CNA #16 was asked about the body audit conducted on RI #2 on 11/07/2023. CNA #16 said, she saw the bruise, put it on the body audit sheet and told the nurse. On 04/13/2024 at 10:20 AM LPN #19 was asked about the body audit sheet for RI #2 dated 11/07/2023. LPN #19 said, she did sign the body audit sheet and she thought everyone (other nurses) were aware of the bruise. A hand written statement signed by CNA #17 documented he found the bruise on RI #2's foot going up the leg and stopped immediately to notify the nurse RN #30. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A typed statement signed by Registered Nurse (RN) #30 documented the following: . on 11/10/2023 the CNA reported to her in the hallway that the resident in (RI #2's room) right ankle had a bruise. Upon assessment, there was a bruise to the right ankle going up (his/her) lower leg. After my assessment I notified MD (Medical Doctor) of findings and received verbal order for x-ray to the right ankle. The facility investigative file for RI #2 did not contain interviews with staff who may have had knowledge of occurrences that could have caused or contributed to the injury of bruising and fracture. On 04/12/2024 at 8:47 AM the Administrator (ADM) stated she did not interview the staff that cared for RI #2 before November 7, 2024, when the bruise was documented. ADM stated that she could not determine the root cause of the bruise for RI #2. ADM stated she should have interviewed staff members that cared for RI #2 before the bruise was found to determine if the staff saw the bruise.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44165 Based on interviews, resident record review, and review of a facility policy titled Federal Rights of Resident/Guest(s) the facility failed to ensure staff assisted Resident Identifier (RI) #1 with hair washing and oral care on 04/09/2024 . This had the potential to affect RI #1, one of three residents sampled for Activity of Daily Living care. Findings include: Review of a facility policy titled Federal Rights of Resident/Guest(s) with an effective date of 11/28/2016, revealed: . STANDARD: The resident/guest has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident/guest needs and preferences, . RI #1 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include: Multiple Sclerosis. On 04/10/2024 at 10:20 AM RI #1 reported to the surveyor, staff does not assist him/her with oral care and he/she must get water from the sink for oral care. RI #1 said to get the water he/she used the sliding board to get into the wheelchair by himself/herself. RI #1 stated that staff has not taken him/her to the shower since March and do not offer to wash his/her hair. RI #1 stated that staff had never offered to assist with oral care, brushing or washing hair, or assisting with dressing. On 04/10/2024 at 6:09 PM CNA #14 stated, she provided care for RI #1 on 04/09/2024. CNA #14 stated RI #1's bath/shower days were on Tuesday, Thursday, and Saturday on the second shift. CNA #14 stated, she assisted with providing towels, washcloth, soap, clean gown, and she put water in the basin. CNA #14 stated, RI #1 was supposed to have his/her hair washed during care on 04/09/2024 but she did not do it. CNA #14 stated, she did not ask if RI #1 wanted his/her hair washed on 04/09/2024, because she forgot. CNA #14 said, hair would become flaky if not washed and she should have washed RI #1's hair. On 04/10/2024 at 10:58 AM an interview was conducted with CNA #10. CNA #10 stated, she assisted RI #1 with his/her activities of daily living (ADL). CNA #10 stated, she had provided care for RI #1on 04/09/2024 and did not provide oral care for him/her. CNA #10 stated that she did not assist RI #1 with oral care because he/she brushes them. CNA #10 stated the care plans for RI #1 stated to assist with brushing teeth and oral care. CNA #10 stated that she should have assisted RI #1 with oral care to follow the care plan. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/2024 at 10:52 AM the Director of Nursing (DON) was asked about staff assisting with washing residents' hair, brushing teeth and oral care. The DON said, staff should assist with washing hair on assigned bath days, when visibly soiled, or upon request. The DON stated, she could not say why staff would not wash a resident's hair. DON said, RI #1i's care plan stated to assist with brushing teeth and oral care. The DON stated the staff should set up and stay at the resident's bedside during oral care. The DON stated, there was a risk for infection control by not assisting residents with washing their hair or providing oral care.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44165 Based on observations, interviews, resident record review, and review of a facility policy titled Federal Rights of Resident/Guest(s) the facility failed to ensure Resident Identifier (RI) #3 a resident with upper and lower extremity range of motion limitations, had hand splints or rolled washcloths placed in his/her hands as care planned. RI #3 was observed on 04/09/2024, 04/10/2024, and 04/11/2024, without anything placed in his/her hands. This had the potential to affect RI #3, one of three residents reviewed for extremity limitations. This tag is cited as a result of the investigation of complaint/report number AL00043223. Findings include: Review of a facility policy titled Federal Rights of Resident/Guest(s) with an effective date of 11/28/2016 revealed: . Facility Responsibilities (a)(1) Resident/Guest rights. A facility must treat each resident/guest with respect and dignity and care for each resident/guest in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident/guest(s) individuality. (c)(2)(iv) The right to receive the services and/or items included in the plan of care. RI #3 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include: Dementia, Personal History of Traumatic Brain Injury, and Monoarthritis. RI #3's annual Minimum Data Set (MDS) assessment dated [DATE] documented RI #3 was assessed with severly impaired cognition and was impaired on both sides for functional limitation in range of motion in upper and lower extremities. RI #3 had a care plan with a problem of actual contractures upon admission to bilateral upper and lower extremities, with a start date of 03/16/2022. The care plan had an intervention documented for staff to apply splints or rolled washcloths to bilateral hands every morning and to remove at bedtime. On 04/09/2024 at 5:39 PM an observation was made of RI #3 with his/her right hand on top of the covers with no splint or rolled washcloth. On 04/10/2024 at 4:50 PM an observation of RI #3 was made of right hand on top of the blanket with no rolled washcloth or splint. On 04/10/2024 at 6:58 PM an observation was made of RI #3's right arm and hand with no splint or rolled washcloth. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/2024 at 7:14 PM an observation was made with Certified Nursing Assistant (CNA) #28. CNA #28 uncovered RI #3's left arm and lower extremities. RI #3's left hand was balled up in a tight fist, there were no splints or rolled washcloths noted. On 04/11/2024 at 9:02 AM an observation was made of RI #3's left hand clenched fist with no splint or washcloth noted. On 04/11/2024 at 10:47 AM an interview with Nursing Assistant (NA) #20 was conducted. NA #20 stated, she was told late on 04/11/2024 that RI #3 was to have hand rolls or splints. NA #20 stated, she did not know why she was supposed to put them on RI #3. NA #20 stated, she did not know what the hand rolls were for. On 04/16/2024 at 10:52 AM the Director of Nursing (DON) was asked about contractures and care plans for RI #3. The DON stated, according to RI #3's care plan interventions, there should be splints or rolled washcloths to bilateral hands. The DON stated, the nursing staff were responsible for ensuring the splints or rolled washcloths were being implemented. The DON stated, there would be a risk of injury if not implemented and there could also be risk of increased contractures.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44165 Based on observations, interviews, resident record review, and review of a facility policy titled Hand Hygiene, the facility failed to ensure staff provided care in a manner to prevent the spread of infection. On 04/09/2024 Certified Nursing Assistant (CNA) #8 was observed not washing or sanitizing her hands when going between Resident Identifier (RI) #4 and RI #5's rooms. Further, CNA #26 was observed on 04/11/2024 wearing the same gloves for care and transport of RI #6 in the hallway and while obtaining clean clothes and supplies for RI #6's shower. This had the potential to affect RI #4, RI #5, and RI #6, three of eight sampled residents. Findings include: A review of the facility policy titled Hand Hygiene with an effective date of 06/11/2020, revealed: . PURPOSE: To provide guidelines to employees for proper and appropriate 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. Upon and after coming in contact with a resident/guest(s) intact skin . After removing gloves or aprons . RI #4 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include: Urinary Tract Infection and Chronic Kidney Disease. RI #5 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include: Acute Respiratory Failure with Hypoxia and Heart Failure. On 04/09/2024 at 1:10 PM CNA #8 was observed in RI #4's room preparing to transfer RI #4. CNA #8 moved RI #4's bedside table and a pillow from RI #4's bed, and without washing her hands walked out of the room and into RI #5's room. CNA #8 then picked up a pair of gloves out of the glove box and walked out of RI #5's room, still without washing or sanitizing her hands. CNA #8 donned the gloves and walked back into RI #4's room. An interview was conducted on 04/09/2024 at 1:28 PM with CNA #8. CNA #8 stated, she did not wash or sanitize her hands before leaving RI #4's room and after coming out of RI #5's room. CNA #8 stated, she did not know why she did not wash her hands either time. CNA #8 stated, there was a risk for cross contamination when not washing or sanitizing hands between rooms. CNA #8 said, she should have washed hands after exiting RI #4 and RI #5's rooms. RI #6 was admitted to the facility on [DATE]. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/11/2024 at 09:15 AM CNA #26 was observed assisting RI #6 with a transfer to a shower bed. CNA #26 wore gloves during the transfer and did not remove them or wash her hands after the transfer and she then transported RI #6 on the shower bed down the hall while wearing the gloves. CNA #26 left RI #6 with other staff at the shower and went back to RI #6's room still wearing the gloves to get clean clothing and shower supplies to take to the shower room. On 04/11/2024 at 10:38 AM CNA #26 was asked about the gloves she had been wearing. CNA #26 stated, she had left RI #6's room with dirty gloves on. CNA #26 stated, she went into RI #6's closet with the same dirty gloves on. CNA #26 stated, there was a risk for cross contamination. An interview on 04/16/2024 at 10:52 AM was conducted with Director of Nursing (DON). The DON stated, staff should wash or sanitize their hands before entering and after leaving a resident's room. The DON stated, there was a risk of cross contamination if staff did not remove dirty gloves before exiting a room. The DON further stated, there was a risk of cross contamination if not removing contaminated gloves before entering a resident's closet.