STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015400	A. Building B. Wing	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Nursing Center	7300 Old Highway 78 East Pell City, AL 35128

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 45849 Based on interviews, record review, facility policy titled Administrative Abuse, and facility document review, the facility failed to ensure Resident #155 was not verbally abused by Certified Nurse Assistant (CNA) #1 on 01/13/2023. This deficient practice affected one (Resident #155) of one sampled resident reviewed for abuse. The facility implemented corrective actions to correct the identified deficient practice on 01/20/2023; thus, past noncompliance was cited. Findings included: A review of the facility's policy titled, Administrative Abuse, revised October 2017, revealed, . Residents have the right to be free from abuse, neglect . exploitation . Residents must not be subject to abuse by anyone, including, but not limited to: facility staff .VERBAL ABUSE is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to resident, or within their hearing distance regardless of the resident's age, ability to comprehend, or disability . A review of Resident #155's Facesheet revealed the facility admitted Resident #155 on 09/14/2020 with diagnoses that included dementia, chronic pain, generalized anxiety disorder, and mood disorder. A review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/14/2022, revealed Resident #155 had a Staff Assessment for Mental Status (SAMS), which indicated the resident had a short- and long-term memory problems and moderately impaired cognitive skills for daily decision making. The MDS indicated Resident #155 was totally dependent on staff for bathing. A review of Resident #155's Care Plan(s), dated 04/12/2022, revealed Resident #155 had difficulty making decisions due to their diagnosis of dementia. The Care Plan directed staff to validate the resident's thoughts and feelings when confused or anxious and approach the resident from the front in a calm, unhurried manner . On 01/14/2023 at 1:00 AM the facility submitted an initial report via the Alabama Department of Public Health Online Incident Reporting System, which indicated notification of the state agency of a verbal abuse allegation. The report indicated CNA #2, who assisted CNA #1 with the provision of a shower for the resident, witnessed CNA #1 curse at the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Witness Statement form and handwritten statement, signed by CNA #1 on 01/16/2023, revealed CNA #1 admitted to cursing while showering Resident #155. CNA # 1 acknowledged his actions were wrong and he had a bad day. Attempts to contact CNA #1 during the survey were unsuccessful. According to CNA #2's handwritten statement dated 01/13/2023, she indicated she assisted CNA #1 in the provision of a shower for Resident #155. Per CNA #2, when the resident yelled out that they were cold, their arm and back hurt, CNA #1 told the resident to shut the [expletive F word] up. Per the CNA #2, every time the resident said something, CNA #1 would say to the resident that he did not give a [expletive F word], that he could care less and [expletive F word] you. In a telephone interview on 06/06/2023 at 5:10 PM, CNA #2 stated the incident occurred on the night shift when CNA #1 requested she assist him with showering Resident #155. CNA #2 reported that CNA #1 was rude, had no compassion and stated to shut the [expletive F word] up. In a telephone interview on 06/07/2023 at 5:52 AM, Licensed Practical Nurse (LPN) #3 stated she did not see or hear the abuse, but it was reported to her by a CNA. According to LPN #3, she immediately went to the shower room, removed CNA #1 from the shower room, and escorted the CNA out of the building. During an interview with the Administrator on 06/21/2023 at 1:28 PM, the Administrator stated the facility reviewed the abuse allegation in their quality assurance meeting and identified there had been an issue with verbal abuse. A review of the facility's Verification of Investigation, signed by the Administrator and dated 01/20/2023, revealed, the allegation of verbal abuse was substantiated. Per the investigation, CNA #1 verbally abused Resident #155 and was terminated on 01/20/2023. ********** ********** A review of a facility document titled, QA [quality assurance] Committee Meeting,' dated 01/19/2023, revealed the facility reviewed the verbal abuse of Resident #155 as part of their weekly quality assurance meeting and identified corrective actions related to the verbal abuse incident. The facility implemented the following corrective actions: 1. On 01/19/2023, staff education was provided for all staff regarding abuse with an emphasis on to never leave the resident alone with the person suspected of abuse, protection of the resident, and the reporting of suspected abuse immediately. 2. On 01/20/2023, the facility terminated CNA #1's employment. 3. On 01/20/2023, the facility terminated CNA #2's employment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. The facility implemented monthly audits with staff interviews for six months to ensure staff could recall appropriate interventions if abuse was suspected. Evidence was provided that indicated the audits were conducted monthly between January 2023 and May 2023 with no concerns identified. The survey team reviewed documentation to support the above corrective actions, including the facility's education records, employee files, and audit logs. Interviews with staff confirmed they were able to state what measures should be taken in the event of suspected abuse. Registered Nurse (RN) #13, the nurse manager and educator, conducted audits following the incident of verbal abuse involving Resident #155, was interviewed on 06/19/2023 at 4:14 PM. She confirmed she conducted the post-incident audits and indicated she quizzed various staff members, to include CNAs, housekeeping staff, dietary staff, and management staff, on what should be done in various abuse situations. The survey team determined necessary actions had been implemented on 01/20/2023 to correct the identified deficient practice and prevent recurrence; thus, past noncompliance was cited.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 45849 Based on interviews, record review, facility policy titled Administrative Abuse, and review of the facility's investigation file, the facility failed to implement two (protection and investigation) of seven components of their abuse policy when Resident #155 was verbally abused by Certified Nurse Assistant (CNA) #1 on 01/13/2023. Specifically, the facility failed to interview CNA #20 and Licensed Practical Nurse (LPN) #3, who had knowledge of the incident. Further, the facility failed to ensure CNA #2, who witnessed the verbal abuse did not leave Resident #155 alone, unattended with the alleged perpetrator, CNA #1, while she reported the allegation of abuse to the nurse. Findings included: A review of the facility's policy titled, Administrative Abuse, revised October 2017, revealed Policy . The facility has developed and implemented policies and procedures that prohibit abuse, (.verbal, mental .) . These policies and procedures include the following seven components: . 5) Investigation 6) Protection . INVESTIGATION OF ALLEGED ABUSE, NEGLECT AND EXPLOITATION .Policy .The facility shall thoroughly investigate . all suspected or reported abuse . 8. Interview all employees who work near the resident during the times, which the incident occurred. 9. All interviews with . employees . are to be documented . RESIDENT PROTECTION DURING INVESTIGATION . Policy . The facility shall protect the resident(s) from further abuse, neglect . or mistreatment immediately when the suspicion is formed, or when the allegation is made, or when the event is witnessed and while the investigation is in process . A review of Resident #155's Facesheet revealed the facility admitted Resident #155 on 09/14/2020 with diagnoses that included dementia, chronic pain, generalized anxiety disorder, and mood disorder. A review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/14/2022, revealed Resident #155 had a BIMS (Brief Interview for Mental Status) score of zero of fifteen which indicated Resident #155 was rarely or never understood. The Staff Assessment for Mental Status (SAMS) for Resident #155 indicated the resident had a short- and long-term memory problems and moderately impaired cognitive skills for daily decision making. The MDS indicated Resident #155 was totally dependent on staff for bathing. A review of Resident #155's Care Plan(s), dated 04/12/2022, revealed Resident #155 had difficulty making decisions due to their diagnosis of dementia. The Care Plan directed staff to validate the resident's thoughts and feelings when confused or anxious and approach the resident from the front in a calm, unhurried manner. On 01/14/2023 at 1:00 AM the facility submitted an initial report via the Alabama Department of Public Health Online Incident Reporting System, which indicated notification of the state agency of a verbal abuse allegation. The report indicated CNA #2, who assisted CNA #1 with the provision of a shower for the resident, witnessed CNA #1 curse at the resident. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to CNA #2's handwritten statement dated 01/13/2023, she indicated she assisted CNA #1 in the provision of a shower for Resident #155. Per CNA #2, when the resident yelled out that he/she was cold, his/her arm and back hurt, CNA #1 told the resident to shut the [expletive F word] up. Per the CNA #2, every time the resident said something, CNA #1 would say to the resident that he did not give a [expletive F word], that he could care less and [expletive F word] you. In a telephone interview on 06/06/2023 at 5:10 PM, CNA #2 stated she should not have left Resident #155 alone with CNA #1 when she left to go and report the allegation of verbal abuse to the nurse (LPN #3). In an interview on 06/19/2023 at 9:08 AM, LPN #3 stated CNA #2 should have stayed with the resident and activated the call light in the shower room to get assistance to report the abuse. Per LPN #3, CNA #2 should not have left the resident unattended with CNA #1. In an interview on 06/19/2023 at 2:22 PM CNA #20 reported that she was on the hall when CNA #2 left the shower room and went to report the incident to LPN #3. CNA #20 said that CNA #2 told her that CNA #1 was cursing at resident. CNA #20 said she went to the shower room door and did not hear any cursing. During a follow-up interview on 06/21/2023 at 12:14 PM, CNA #20 stated that CNA #2 did not ask her to stay with the Resident #155, but did ask that she listen at the door. CNA #20 said the total time Resident #155 was in the shower room with CNA #1 after CNA #2 left the shower room was two minutes and she did not hear any further abuse. In an interview on 06/19/2023 at 10:30 AM, the Director of Nursing (DON) stated her expectation was that CNA #2 should have asked CNA #1 to leave the shower room and CNA #2 should have activated the call light to get assistance. The DON stated the first thing in their abuse policy was to protect the resident, then to report the abuse. In an interview on 06/19/2023 at 11:32 AM, the Social Services Director stated CNA #2 should not have left Resident #155 alone with CNA #1. In an interview on 06/19/2023 at 1:02 PM, the Administrator indicated CNA #2 should have stuck her head out of the shower room and hollered for help or activated the call light. The Administrator said to leave Resident #155 alone with CNA #1 could have resulted in further abuse. A review of the facility's investigation file revealed there was not a documented interview done with CNA #20 or LPN #3. In a follow-up interview on 06/21/2023 at 10:49 AM, the Administrator confirmed CNA #20 and LPN #3 were not interviewed during the investigation of the allegation of verbal abuse that involved Resident #155 and CNA #1.