STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015458	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc Millenium	5275 Millennium Drive Huntsville, AL 35806

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** 33738 Based on interviews and medical record review the facility failed to ensure Resident Identifer (RI) #335's representative was notifed of an incident and that he/she transfered to the hospital on 06/24/2024. This deficient practice affected RI #335 one of three residents reviewed for transfer and discharge. Finding Include: RI #335 was admitted to the facility on [DATE] with diagnoses of Dementia with Agitation and Major Depressive Disorder. A review of RI #335's Admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 05/08/2023, indicated RI #335's BIMS (Brief Interview for Mental Status) as five of 15, indicating RI #335 was cognitively impaired. A review of RI #335's Clinical Notes Report dated 06/24/2024, revealed RI #335 was transferred to the hospital on 06/24/2023 after an increase in agressive behaviors. There was no documentation in the Clinical Progress Notes that the representative sponsor was notified of the incident and the resident transfer to the hospital on 06/24/2023. On 06/14/2024 at 2:00 PM an intervew was conducted with RI #335's representative/sponsor. She was asked when was she made aware of the incident that happened on 06/23/2023 regarding and RI #335 that resulted in RI #335 being transferred to the hospital. The sponsor stated she was not made aware of the incident by the facility, but by the hospital social worker and then she called the facility. She further stated RI #335 had been in the hospital for a few days before she was aware of the incident and being in the hospital.

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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(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 - 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** 33738 Based on interviews, medical record reviews, the facility's policy titled, Abuse Prohibition Plan, the Facility Reported Incident (FRI) received by the Alabama State Survey Agency, and the facility's investigative file, the facility failed to protect Resident Identifier (RI) #334's right to be free from physical abuse by another resident, RI #335. During lunch on 06/23/2023 RI #335 was physical and verbally abusive to staff and expressed suicidal and homicidal ideations. RI #335 was sent to the local hospital's emergency room around 1:00 PM. Upon return from the hospital around 3:00 AM, RI #335 was not supervised and went from his/her room, through the bathroom that connected to RI #334's room. On 06/24/2023 at approximately 4:30 AM, RI #335 was witnessed by a CNA (Certified Nursing Assistant) in RI #334's room, standing over RI #334's bed with a pillow over RI #334's face gripping both sides and pushing with force. It was determined the facility's noncompliance with one or more requirements of participation had cause, 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 F 600- Free from Abuse and Neglect. On 06/16/2024 at 6:56 PM, the Administrator, Assistant [NAME] President of Operations, Regional Nurse Manager, and the Director of Nursing (DON) were provided the IJ templates and notified of the findings of substandard quality of care at the immediate jeopardy level in the area of Freedom from Abuse, Neglect, and Exploitation at F 600- Free from Abuse and Neglect. The IJ began on 06/24/2023 and continued until 06/18/2024 when the survey team verified onsite that corrective actions had been implemented. On 06/19/2024, the immediate jeopardy was removed, and 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. This deficiency was cited as a result of a Facility Reportable Investigation/Complaint/Report Number AL00044582. This deficient practice affected one of seven residents reviewed for abuse and neglect prevention. Findings Include: Cross Reference F 740 A review of the facility's policy titled, Abuse Prohibition Plan, with an effective date of 04/01/2018, revealed: (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	. Purpose: The facility has a zero-tolerance policy for abuse. Verbal, mental, sexual, or physical abuse, corporal punishment . is prohibited. The resident shall not be subjected to mistreatment, neglect . The Abuse Policy applies to anyone involved with the residents of this facility, including, but not limited to all facility staff, other residents . Definitions: . Abuse means the willful infliction or injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes deprivation by an individual, . of good or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish . It includes . physical abuse, and mental abuse . Willful means the individual deliberately, not that the individual must have intended to, inflict injury harm. Physical Abuse includes but not limited to hitting, slapping, pinching, and kicking. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative visitor, another healthcare provider, . if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse . B. TRAINING All employees shall receive training during initial orientation, annually and with ongoing sessions . Training shall include, but is not limited to the following: . 2. Resident Rights 3. Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property and exploitation . 6. How to identify residents who are at risk for abuse, neglect, . 8. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond. These symptoms include, but are not limited to: a. Aggressive and/or catastrophic reactions of residents . b. Wandering or elopement type behaviors . c. Resistance to care; d. Outburst or yelling out . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	C. PREVENTION It is the policy of this facility . To prevent potential abuse, the facility leadership shall assess the needs of residents in the facility and the environment to identify concerns. F. PROTECTION It is the policy of this facility that Residents shall be protected from the alleged offender (s) . RI #335 was admitted to the facility on [DATE] with diagnoses that included Dementia with Agitation and Major Depressive Disorder. A review of RI #335's Admission MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of 05/08/2023, indicated RI #335's Brief Interview for Mental Status (BIMS) as five of 15, which indicated that RI #335 was cognitively impaired. RI #334 was admitted to the facility on [DATE] with diagnoses that included Dementia and Weakness. RI #334 Admissions MDS with ARD date of 04/11/2023 indicated RI #334 had a BIMS of seven of 15 which indicated RI #334 was cognitively impaired. A review of RI #335's care plan with a Problem Onset Date of 09/28/2022 documented: Altercation with another resident . (RI #335) has a history of verbal aggressive behavior towards family, . hx (history) of wandering behavior . hx of . Resident has threatened to kill his/her daughter and his/her family . Confusion, alteration in thought process related to (RI #335) has dementia . A review of RI #335's Clinical Notes Report entered by Registered Nurse (RN) #30 and dated 06/23/2023 at 12:00 PM, revealed the following: . Called into the dining room by restorative cna and activities director. Was informed that this resident was going off and had thrown juice all over the staff and floor, saw staff wet clothes, and this resident standing near door. Walked up to resident and resident starting telling activities director that this writer was in on it and then resident grabbed this nurse by the wrist and pulled this nurse toward him/her. This nurse pulled away from resident's grip and then resident began advancing toward this nurse . Was visibly angry and upset, would not leave dining room. Administrator walked in and was able to get him/her to leave . Before leaving, resident said, everyone in this room is going to get killed . A review of RI #335's Clinical Notes Report entered by RN #30 dated 06/23/2023 at 12:16 PM, revealed the following: resident stated he/she knows something is wrong in his/her head and feels that he/she would rather be gone then he/she hurt someone A review of RI #335's Clinical Notes Report entered by RN #30 dated 06/23/2023 at 12:59 PM, revealed the following: Stated that if he/she had a gun in front of him/her he/she would shoot himself/herself. Continue to make comments about get rid of me and I'm gonna do it. (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 RI #335's Clinical Notes Report entered by the Social Services Designee (SSD) dated 06/23/2023 at 1:32 PM, revealed the following: I sent information to (name of Psychiatric Facility) for (RI #335) to go over there due to behavior. I was trying my best to get him/her . next door instead of going to ER . I called (name of Mental Health Center) to see if they could speed up the process of getting him/her over there. No one responded, so they sent him/her to the ER (emergency room) . A review of RI #335's Clinical Notes Report entered by Registered Nurse (RN) #18 dated 06/24/2023, revealed the following: Resident brought by .to facility at 3 AM . no new orders given . he/she did not know why he/she was sent to hospital. A review of RI #335's Clinical Notes Report entered by RN #18 dated 06/24/2023 at 5:33 AM, revealed the following: . Resident came back from (name of hospital) went into 200 hall being combative going into other resident rooms, brought him/her back to 100 he/she tried to hit CNA with the hole puncher he/she kept saying we are going to hell and CNA is dead and he/she took a statue from his/her room and tried to hit us with it he/she was throwing the snack tray around trying to hit the nurse. He/She tried to hit the CNA with the pill crusher, he/she tried to smother another resident with a pillow the CNA walked in on him/her and he/she tried to run back to his/her room. called the administrator and she said send him/her back to the (name of hospital) . On 06/24/2023 at 8:59 AM the facility submitted a report to The Alabama Department of Public Health Online Incident Reporting System. The report indicated at 4:30 AM RI #334 .was found in bed with another resident over him/her with a pillow in his/her hand. Other resident had pillow over resident face . Residents were immediately separated. Aggressor resident was placed on one on one supervision until ambulance arrived and he/she was sent to the hospital. Other resident was assessed head toe for any signs of injury. None noted. Assessment attempted to see if incident caused any distress to resident. Hard to determine due to resident mental condition . The report indicated the incident was report to the Assistant Director of Nursing (ADON), Director of Nursing (DON) and Administrator (ADM) who then reported to medical director, corporate office, state, adult protective services, and local police. The facility's undated incident summary documented the resident on resident Physical was substantiated. The reports summary documented: .Summary: On 06/24/2023 at approximately 4:30-5:00 a.m. the CNA heard the door slam and went to check on what (RI #335) was doing. He/She wasn't in his/her room and found him/her in (RI #334's) room with a pillow over (RI #334's) face with him/her moving his/her arms and legs. CNA immediately pulled (RI #335) away and moved the pillow, she removed (RI #335) from the room, he/she was placed on one-to-one with the nurse . medical director was notified and (RI #335) was sent to (name of hospital) . The immediate intervention was to separate see if incident cause any distress. Psychosocial assessment difficult due to his/her mental condition . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	After concluding the investigation which included obtaining statement from all involved staff, interviewing residents with a BIM's of 13 and over to ensure resident that was engaging in behaviors not came into their room on the date of concern . We notified the police of incident and (RI #335) was sent to (name of hospital) by (name of ambulance). Unsuccessful attempts were made to interview CNA #27, the witness of the incident, on the phone several times during the survey. An undated written statement from CNA #27 documented: At approx (approximately) 4:30 AM I heard a door slam down 101 hall I went down the hall and checked in room and resident in room, so I walked through adjoining bathroom and noticed resident (RI #335) standing over . (RI #334) holding a pillow over his/her face/head. Resident was gripping pillow on both sides and pushing with force. (RI #335) was immediately removed from room . and was placed 1 to 1 with the nurse. The other nurse came . The resident (RI #334) . was ok . An undated witness statement from RI #188, a resident who was discharged at the time of the survey documented: (typed) Did any resident wake you up last night? . (handwritten) Yes . Resident stated the aggressor came in his/her room and was yelling and screaming leave him/her alone and don't touch him/her resident said the aggressor was talking to himself/herself. Resident said he/she was afraid because the aggressor was running in and out of his/her room and bathroom . An undated witness statement from another resident, RI #33 documented: (typed) Did any resident come in your room last night? (handwritten) Yes, a female/male resident walked in to my room with a vase in his/her hand, walked in bathroom, and then CNA came and got him/her and walked him/her out. He/She was yelling, leave me alone . On 06/13/2024 at 12:10 PM, a telephone interview was conducted with the Former Assistant Director of Nursing (FADON). The FADON was asked about the incident that occurred on 06/24/2023 with RI #334 and RI #335. She stated, she was told that a CNA was walking past the room and observed RI #335 with a pillow over RI #334's head, the CNA immediately intervened by separating RI #335 from RI #334. FADON said that she considered this incident to be resident to resident physical abuse, she further said that RI #335 had been exhibiting aggressive, impulsive, and combative behaviors prior to this incident. On 06/13/2024 at 1:00 PM during an interview, Registered Nurse (RN) #18 stated on the night of the incident, RI #335 was acting strange and was not acting like himself/herself. RN #18 said RI #335 was uncooperative and would not go to his/her room. RN #18 said when RI #335 was asked to go to his/her room, RI #335 got mad and pushed all the snacks off the table. On 06/13/2024 at 6:20 PM a follow-up interview was conducted with RN #18 who said a nursing assessment was not completed when RI #335 returned from the hospital because he/she was not gone over 24 hours. RN #18 said between 3:00 AM and 4:30 AM, the CNA was walking the halls and saw RI #335 with the pillow over RI #334's face. She further stated, the CNA intervened and stopped RI #335, and RI #335 ran back to his/her room and the CNA followed. RN #18 said RI #335 was placed on one-on-one supervision until discharged to the hospital. On 06/14/2024 at 12:05 PM an interview was conducted with Regional Nurse Manager (RNM). The RNM said incident that occurred on 06/24/2023 regarding RI #335 was substantiated as physical abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**********

On 06/18/2024 at 6:00 PM, the facility submitted an acceptable removal plan, which documented:

Safety:

1. Resident's #334 and #335 were separated by the CNA on 6/24/23.

Assessment:

2. Resident #334 was assessed by the Charge Nurse on 6/24/23, with no injuries noted.

3. On 06/26/2023 the Psychiatric Nurse Practitioner assessed Resident #334 and documented in a provider note with no negative findings. On 6/26/23 Resident #334 was assessed by the Nurse with no negative findings.

4. Resident #335 was placed on one on one by the Charge Nurse on 6/24/23 until resident transferred to the hospital by HEMSI and ultimately discharged .

5. Resident interviews were conducted by the Social Services Director and Activity Coordinator with a BIMS of 13 or greater regarding physical or verbal abuse by another resident on 06/24/2023 with no negative findings.

6. Residents with a BIMS of 12 or less, a body audit was completed by the Director of Nursing and Charge Nurse on 06/24/2023 with no negative findings.

7. Alabama Department of Health, Adult Protective Services, and law enforcement were notified of the reported events on 06/24/2023 by the Administrator.

8. Resident interviews were conducted by the Social Services Director with a BIMS of 13 or greater regarding abuse by anyone on 06/11/2024 and 06/18/2024 with no negative findings.

9. Residents with a BIMS of 12 or less, a body audit was completed by the Director of Nursing, Staffing Coordinator, and Charge Nurse on 06/11/2024 with no negative findings.

Notification:

1. On 06/24/2023 Charge Nurse made notifications to the practitioners and responsible parties for resident #334 and #335.

Audits:

2. Clinical Record Review from 03/01/2024 to 06/16/2024 was initiated on 06/16/2024 and completed on 06/17/2024 by the Director of Clinical Education and Regional Nurse Managers to include clinical notes, event notes, and daily skilled notes to identify any potential residents for instances of physical abuse, with no unknown new findings.

In-services:

(continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. On 06/16/2024 Inservice was provided by the Assistant [NAME] President of Operations and the Regional Nurse Manager to the Administrator, DON, Staffing Coordinator, Social Services, and Receptionist/CNA on the Abuse Policy Protocol, updated Behavior Health Services Policy, and interventions related to abuse, aggressive, distress and combative behaviors and suicidal/homicidal ideation. Education was also provided regarding staff unavailable to receive education will not be permitted to work until required education is completed. The Staffing Coordinator was designated as responsible for ensuring staff are educated on abuse prohibition plan, behavioral health services policy, and list of interventions for behaviors 2. On 06/16/2024 Inservice was provided by the DON, Staffing Coordinator, Social Services, and Receptionist/CNA on the Abuse Policy Protocol, updated Behavior Health Services Policy, and interventions related to abuse, aggressive, distress, and combative behaviors and suicidal/homicidal ideation to all staff. Staff unavailable to receive education will not be permitted to work until the required education is completed. 73 out of 77 employees have been educated. 3. On 06/16/2024 competency and validation questions were answered by staff currently working to ensure competency verbalized from education received. 4. On 06/17/2024 the Regional Nurse Manager placed signage in break rooms, nurses stations, and behavior communication binders that list interventions for behaviors including abuse, aggressive, distress and combative behaviors and suicidal/homicidal ideation. QAPI: 1. Adhoc QAPI was conducted on 06/24/2023 to include Administrator, Director of Nursing, Senior [NAME] President of Operations, Assistant [NAME] President of Operations, Regional Nurse Manager, Assistant [NAME] President of Clinical Operations, Regional Nurse Manager to discuss resident to resident altercation event, education, root cause, and interventions. 2. The Medical Director was notified of the immediate jeopardy citations on 06/16/2024 by the Assistant [NAME] President of Operations. 3. A Root cause analysis was conducted on 06/16/2024 by the Administrator, Regional Director of Operations, Assistant [NAME] President of Clinical Operations, Regional Nurse Manager, Directors of Nursing, Assistant [NAME] President of Quality, Director of Clinical Education. Root cause was identified as ineffective training and education related to behavioral health services. 4. QAPI meeting was conducted on 06/16/2024 to include Administrator, Director of Nursing, Staffing Coordinator, Dietary Manager, Activity Coordinator, Treatment Nurse, Receptionist, MDS Coordinator, Social Service Director, Business Office Manager, Maintenance Director, Regional Nurse Manage, Assistant [NAME] President of Operations, Regional Nurse Manager, Medical Director, Assistant [NAME] President of Clinical Operations, Senior [NAME] President, and Director of Clinical Education regarding Immediate Jeopardy citations, Abuse and Behavior Health Services policy review, education, interventions for immediate removal plan, Medical Director notification, facility assessment updated/reviewed and root cause analysis determined. a. Abuse Prohibition Plan reviewed with no recommendation for changes 06/16/2024 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. On 06/16/2024 the Behavior Health Services Policy reviewed with recommendation made to include suicidal and homicidal ideation's (Section 5, Subset F) under procedures- to include risk factors, triggering events, examples used to harm self. Definition of Suicidal Ideation added to provide clarification of terminology related to behavioral health services. c. On 06/16/2024 Updated Intervention list attachment included in the updated Behavior Health Policy for behaviors to include immediate action steps to implement related to abuse, aggressive, distress, combative, and Suicidal and Homicidal Ideations. d. On 06/16/2024 the facility assessment plan was revised to include suicidal ideations. 5. A Governing Body meeting was held to include the Administrator, Director of Nursing, Assistant [NAME] President of Operations, Assistance [NAME] President for Clinical, Senior [NAME] President of Operations, and Regional Nurse Managers on 6/16/24 at 9 PM to discuss the corrective action plans to address the immediate concerns for F 600 for Resident's #334 and #335 and all current residents have the potential to be affected. The Medical Director agreed with the current action plan and had no new recommendations. Facility implemented all corrective Actions on 6/18/2024. ********** After a review of documentation supporting the above corrective actions, including the facility's investigative file, in-service/education records, QAPI documentation, and staff interviews, the survey team verified the facility implement corrective actions including ongoing monitoring on 06/18/2024.

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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 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. 33739 Based on record review, interviews, the Facility Reported Incident (FRI) received by the Alabama State Survey Agency, and the facility policy titled Abuse Prohibition Plan, the facility failed to protect Resident Identifier (RI) #40's right to be free from misappropriation of property when Registered Nurse (RN) #6 placed RI #40's temazepam in her pocket and left the facility. This affected RI #40 one of seven residents sampled for abuse prevention. This was cited due to the investigation of facility reported incident/complaint/report number AL00047874. Findings Include: Review of a facility policy titled Abuse Prohibition Plan, with an effective date of 11/02/2023 documented . Purpose: . The resident shall not be subjected to . misappropriation of property . Definitions: . Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. RI #40 was admitted to the facility 12/18/2022. On 05/16/2024 at 3:26 PM the facility reported an incident by way of The Alabama Department of Public Health Online Reporting Incident System. The report indicated that the facility was notified on 05/16/2024 by a Drug Enforcement Agency (DEA) Officer that RN #6 was found with a white substance in her possession during a K-9 search at her other job. The DEA Officer reported that RN #6 told the officer it was a temazepam from RI #40 that was refused and she placed in her pocket to return or destroy later. The report indicated that RN #6 said she forgot it was in her pocket until discovered by the DEA Officer several months later. On 06/12/2024 at 10:46 AM during an interview with DEA Officer, he said routinely the correctional facility performed K-9 search and on 05/16/2024 a search of employees was conducted. The search found a white substance which was in RN #6's wallet in her purse. It was sent to the lab, tested , and returned as temazepam. He said in questioning RN #6 she said it was from the facility. He said RN #6 gave the name of RI #40, said the resident had refused the medication and she put it in her pocket instead of getting the other nurse to destroy with her. He said she was arrested for possession of a controlled substance and theft. Interview with resident RI #40 on 06/12/2024 at 11:27 AM said he/she did not recall refusing sleeping pill but might have. When RI #40 was told it might have been in January he/she said too long ago. (continued on next page)

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Ahc Millenium	5275 Millennium Drive Huntsville, AL 35806

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/2024 at 11:00 AM during an interview with the facility Regional Nurse Manager (RNM) he said he worked on this investigation. He said the DEA officer called and told found white substance on RN #6 during a K-9 search at the correction facility while working. The RNM said RN #6 said RI #40 refused the medication and she put it in her pocket. He said they were notified of the incident on 05/16/2024 and the best they could gather it occurred 01/07/2024. He said it was abuse by misappropriation when RN #6 placed the medication in her pocket. On 06/12/2024 at 3:07 PM during an interview with RN #6, she said she went to give RI #40 the temazepam the last time she worked at the facility January 2024. RN #6 said RI #40 said he/she did not want it. RN #6 said she put it in a plastic bag and in her pocket. She said she did not recall the exact date. She said she forgot to get the other nurse to come destroy it with her, and when she got home, she realized it was still in her pocket, so she put it in her wallet in her purse and forgot about it. She said she worked at the correctional facility and a K-9 search was done and it was found in her car. She said she was arrested and charged with possession and theft. She said she should never have placed the medication in her pocket.

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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. 33738 Based on interviews, medical record review, review of the facility reported incident and a review a of the facility policy titled, Abuse Prohibition, the facility failed to report an allegation of abuse within the time frame of two hours to the state Agency on 06/24/2023. On 06/24/2023 at 4:30 AM, the facility staff reported an allegation of physical abuse by RI #335. The facility reported the allegation of physical abuse at 8:59 AM on 06/24/2023 to ADPH (Alabama Department of Public Health) State Agency. This deficient practice affected one out of three sampled residents reviewed for abuse concerns. Finding Include: A review of the facility's policy titled, Abuse Prohibition Plan, with an effective date of 04/01/2018, revealed: . EXTERNAL REPORTING . All alleged violations are reported immediately, but not later than 2 hours after the allegations is made . On 06/24/2023 at 8:59 AM the facility submitted a report to The Alabama Department of Public Health Online Incident Reporting System. The report indicated staff became aware of an incident of physical abuse at on 06/24/2023 at 4:30 AM. An interview was conducted on 06/26/2026 at 9:39 AM with the Administrator (ADM). The ADM stated he was the Abuse Coordinator for the facility, and that all allegations of abuse should reported to our office (ADPH). When asked what was the time frame for reporting alleged physical, he said within two hours of discovery.

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety 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** 33738 Based on interviews, medical record reviews, and the facility policy titled Behavioral Health Services, the facility failed to ensure interventions were developed and implemented to address Resident Identifier (RI) #335's behaviors which included being physically and verbal aggressive towards staff and homicidal and suicidal ideation. On 06/23/2023, RI #335 was sent to the hospital emergency room after being physical and verbally abusive to staff and expressing homicidal and suicidal ideation. RI #335 returned from the hospital around 3:00 AM on 06/24/2023. The facility had not developed a plan for RI #335's return to ensure residents' safety. No new orders were provided, and no new interventions were developed or implemented. On 06/24/2023 around 4:30 AM, Certified Nursing Assistant (CNA) #27 witnessed RI #335 in RI #334's room. RI #335 was standing over RI #334's bed with a pillow over RI #334's face gripping both sides and pushing with force. It was determined the facility's noncompliance with one or more requirements of participation had cause, 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, 443.40 Behavioral Health Services. On 06/16/2024 at 6:56 PM, the Administrator, Assistant [NAME] President of Operations, Regional Nurse Manager, and the Director of Nursing (DON) were provided the IJ templates and notified of the findings at the immediate jeopardy level in the area of Behavioral Health at F 740- Behavioral Health Services. The IJ began on 06/24/2023 and continued until 06/18/2024 when the survey team verified onsite that corrective actions had been implemented. On 06/19/2024, the immediate jeopardy was removed, and 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. This deficiency was cited as a result of a Facility Reportable Investigation/Complaint/Report Number AL 00044582. This deficient practice affected one of four residents reviewed for behavioral health services. Findings Include: Cross reference F 600 and F 741. A review of a facility's policy titled, Behavioral Health Services, with an effective date of 10/02/2023 revealed: (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Purpose: To ensure that residents receive necessary behavior health services. Policy: It is the policy of this facility that all residents receive care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning. Definitions: Definitions are provided to clarify terminology related to behavioral health services and the attainment or maintenance of a resident's highest practicable well-being. Highest practicable physical, mental and psychosocial well-being is defined as the highest possible level of functioning and well-being-limited by the individual's recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental, and psychosocial needs of the individual . Procedure: . 3. The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. 4. Behavioral health care and services shall be provided in an environment that is conducive to mental and psychosocial well-being. 5. Conditions that are frequently seen in nursing home residents and may require the facility to provide specialized services and supports base upon residents' individual needs, include, but are not limited to: . a. Depression- It is not a natural part of aging, however, older adults in the nursing home setting are more at risk than older adults in the community. e. Aggressive Behaviors-defined as behaviors that cause harm, threaten to harm, or put the health and safety of people risk . 6. The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-center care . b. Obtaining history from medical records, the family, and the resident regarding mental, psychosocial, and emotional health; c. MDS and care area assessments; d. Ongoing monitoring of mood and behavior; (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. Care plan development and implementation, and f. Evaluation. 8. Facility staff shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. Education shall be based on the role of the employee and needs identified through the facility assessment . 9. Interventions shall be evidence-based, culturally competent, trauma-informed . RI #335 was admitted to the facility on [DATE] with diagnoses that included Dementia with Agitation and Major Depressive Disorder. A review of RI #335's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/08/2023, indicated RI #335's Brief Interview for Mental Status (BIMS) as five of 15, which indicated that RI #335 was cognitively impaired. A review of RI #335's care plan effective 09/21/2022 through 01/31/2023 included that RI #335 had wandering behaviors with interventions that included monitor his/her location to ensure safety. RI #335's care plan included the he/she had a history of paranoid statements about family taking items from her in a nursing home, has reported seeing men in living room at home when no home was present/seeing bugs on wall, hearing family members talking when they were not there, resident has threatened to kill his/her daughter and his/her family with interventions that included to remove from the situation. The care plan also included 9/28/22 Altercation with another resident. RI #335's care planned interventions did not indicate the level of supervision required. A review of RI #335's Clinical Notes Report entered by Registered Nurse (RN) #30 and dated 06/23/2023 at 12:00 PM, revealed the following: . Called into the dining room by restorative cna and activities director. Was informed that this resident was going off and had thrown juice all over the staff and floor, saw staff wet clothes, and this resident standing near door. Walked up to resident and resident started telling activities director that this writer was in on it and then resident grabbed this nurse by the wrist and pulled this nurse toward him/her. This nurse pulled away from resident's grip and then resident began advancing toward this nurse . Was visibly angry and upset, would not leave dining room. Administrator walked in and was able to get him/her to leave . Before leaving, resident said, everyone in this room is going to get killed . On 06/13/2024 at 12:38 PM an interview was conducted with Restorative Certified Nursing Assistant (RCNA) #19. She described an incident that occurred during dining on 06/23/2023. She said, RI #335 was sitting at a table with two male residents and RI #335 was fixated on one male at the table. RCNA #19 stated she redirected the resident, and he/she got angry stood up and cursed. Then RI #335 grabbed a cup off another resident's plate and threw the juice cup. The resident threatened to do it again and grabbed another cup, but another staff intervene and was able to redirect him/her. A review of RI #335's Clinical Notes Report entered by RN #30 dated 06/23/2023 at 12:16 PM, revealed the following: resident stated he/she knows something is wrong in his/her head and feels that he/she would rather be gone then he/she hurt someone. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of RI #335's Clinical Notes Report entered by RN #30 dated 06/23/2023 at 12:59 PM, revealed the following: Stated that if he/she had a gun in front of him/her he/she would shoot himself/herself. Continue to make comments about get rid of me and I'm gonna do it. A review of RI #335's Clinical Notes Report entered by the Social Services Designee (SSD) dated 06/23/2023 at 1:32 PM, revealed the following: I sent information to (name of Psychiatric Facility) for resident's name RI #335 to go over there due to behavior. I was trying my best to get (him/her) next door instead of going to ER . I called (name of Mental Health Center) to see if they could speed up the process of getting him/her over there. No one responded, so they sent him/her to the ER . A review of RI #335's Clinical Notes Report entered by Registered Nurse (RN) #18 dated 06/24/2023, revealed the following: Resident brought by .to facility at 3 AM no new orders given . he/she did not know why he/she was sent to hospital The facility's investigative file included an undated witness statement from RI #188, a resident who was discharged at the time of the survey documented: . Resident stated the aggressor came in his/her room and was yelling and screaming leave him/her alone and don't touch him/her resident said the aggressor was talking to himself/herself. Resident said he/she was afraid because the aggressor was running in and out of his/her room and bathroom, so staff put a chair at the bathroom door to keep the aggressor from coming in through the bathroom. An undated witness statement from another resident, RI #33 documented: (typed) Did any resident come in your room last night? (handwritten) Yes, a female/male resident walked in to my room with a vase in his/her hand, walked in bathroom, and then CNA came and got him/her and walked him/her out. He/She was yelling, leave me alone . A review of RI #335's Clinical Notes Report entered by RN #18 dated 06/24/2023 at 5:33 AM, revealed the following: . Resident came back from (name of hospital) went into 200 hall being combative going into other resident rooms, brought him/her back to 100 he/she tried to hit CNA with the hole puncher he/she kept saying we are going to hell and CNA is dead and he/she took a statue from his/her room and tried to hit us with it he/she was throwing the snack tray around trying to hit the nurse. He/She tried to hit the CNA with the pill crusher, he/she tried to smother another resident with a pillow the CNA walked in on him/her and he/she tried to run back to his/her room. ADON (Assistant Director of Nursing) called the administrator and she said send him/her back to the (name of hospital) . The facility's investigative file included an undated written statement from CNA #27 documented: At approx (approximately) 4:30 AM I heard a door slam down 101 hall I went down the hall and checked in room and resident in room, so I walked through adjoining bathroom and noticed resident (RI #335) standing over . (RI #334) holding a pillow over his/her face/head. Resident was gripping pillow on both sides and pushing with force. (RI #335) was immediately removed from room . and was placed 1 to 1 with the nurse. The other nurse came . The resident (RI #334) . was ok . Unsuccessful attempts were made to interview CNA #27, the witness of the incident, on the phone several times during the survey. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/13/2024 at 1:00 PM during an interview, Registered Nurse (RN) #18 stated on the night of the incident, RI #335 was acting strange and was not acting like himself/herself. RN #18 said RI #335 was uncooperative and would not go to his/her room. RN #18 said when RI #335 was asked to go to his/her room, RI #335 got mad and pushed all the snacks off the table. RN #18 said she went to ask for help from another nurse and when she returned to the hall CNA #27 told her what happened. On 06/13/2024 at 6:20 PM a follow-up interview was conducted with RN #18 who said a nursing assessment was not completed when RI #335 returned from the hospital, because he/she was not gone over 24 hours. RN #18 said between 3:00 AM and 4:30 AM, CNA #27 was walking the halls and saw RI #335 with the pillow over RI #334's face. She further stated, the CNA intervened and stopped RI #335, and RI #335 ran back to his/her room and the CNA followed. RN #18 said RI #335 picked up a statue in his/her room and tried to hit the CNA. RN #18 said, they were able to get RI #335 to the nurses' station to sit one to one and made sure RI #335 was away from other residents. The ADM and the DON were notified and the staff were instructed to remain one on one with him/her and he/she was sent back to the hospital. On 06/13/2024 at 10:10 AM an interview was conducted with Social Service Designee (SSD). The SSD stated, RI #335 became fixated on a male resident and began having behaviors, his/her mood would fluctuate, and he/she would really get upset and other times he/she would be calm. The SSD further said, RI #335 was aggressive toward other staff. RI #335 would always say, he/she could not get straight in her/his head and would hold his/her head. The SSD was asked what interventions did the facility implement for RI #335 behaviors. The SSD stated, she would walk RI #335 up to her office, allow RI #335 to sit with her and vent, and she got RI #335 involved in activities. The SSD was asked when did RI #335 start having aggressive behavior. She stated when he/she became attached to the male resident. When asked what interventions were put in place at that time. The SSD stated, RI #335 was moved to a different hall. On 06/15/2024 at 3:54 PM an interview was conducted with Social Services Designee. The SSD said that when RI #335 returned to the facility on Saturday, 06/24/2023, there were no interventions put in place, because the facility's staff did not know the hospital would send him/her back. The SSD said the facility thought the hospital would have kept him/her and they would have discussed his/her behavior and added interventions on Monday, 06/26/2023. On 06/13/2024 at 12:10 PM and interview was conducted with the Former Assistant Director of Nursing (FADON). The FADON was asked what actions/interventions were put in place as a result of the incident involving RI #335 on 06/23/2023. She stated she did not recall exactly. The FADON further stated RI #335 had been exhibiting behavior prior to the incident on 06/23/2023 which was impulsive and combative behavior but did not recall what psychiatric interventions were put in place. On 06/16/2024 at 12:46 PM an interview was conducted with the MDS Coordinator, RN. The MDS Coordinator (MDSC) was asked on 06/23/2024 when RI #335 was having behaviors, what interventions were developed and implemented. She said RI #335 was sent out to the hospital emergency room , but when RI #335 returned to the facility on [DATE], no interventions were added to his/her care plan. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/16/2024 at 1:04 PM a follow-up interview was conducted with the MDSC who said when RI #335 returned to the facility on [DATE] a nursing assessment was not done, but most likely should have been. The MDSC was asked, why was a nursing assessment not done on the resident upon return. The MDSC said the nursing notes indicated RI #335 was still combative and aggressive, so the staff might have not been able to do an assessment, but she was not sure. The MDSC said the facility did not put any interventions in place upon RI #335's return from the hospital on 06/24/2023. The MDSC said the facility should have put a plan or intervention in place. The MDSC said the concern with not having a plan or interventions in place was even though the hospital said he/she was cleared to return, the facility should have had a plan in place to try to prevent any further occurrence of aggressive behavior toward other residents for the safety of residents and staff. On 06/16/2024 at 4:13 PM an interview was conducted with the Director of Nursing (DON). The DON stated on 06/23/2023, RI #335 was sent to the hospital for physical aggressive behavior and suicidal ideation. The DON said the facility did not complete a nursing assessment when RI #335 returned to the facility on [DATE]. The DON said if a nursing assessment had been done, it would have triggered interventions such as one to one supervision. The DON was asked, what other interventions would you have expected to have been put in place. The DON said interventions for RI #335 and other residents' safety, so one on one supervision and notification of the supervisor, medical director, and resident's family that the resident was having suicidal ideations. ********** On 06/18/2024 at 6:00 PM, the facility submitted an acceptable removal plan, which documented: Immediate Action Removal Plan for F 740 Description: The facility failed to ensure interventions were developed and implemented to address RI#335's physical and verbally abusive behaviors towards staff and suicidal ideations. Safety: 1. Resident #335 was redirected from the Dining room by the Administrator on 6/23/23 after yelling, throwing things and grabbing at staff. 2. Social services made referrals for Psych services on 6/23/23 related to physical and verbally abusive behaviors and suicidal ideation. Charge Nurse sent RI #335 to theER on [DATE] and transported by HEMSI. 3. Resident #335 returned from the hospital by HEMSI on at 3 am on 6/24/23 with no new orders. Labs were drawn at the ER. Per ER records resident denied any complaints, denied suicidality and homicidal ideations. 4. Resident's #334 and #335 were separated by the CNA on 6/24/23. Assessments: (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Resident #334 was assessed by the Charge Nurse on 6/24/23, with no injuries noted. 2. On 6/26/23 the Psychiatric Nurse Practitioner assessed Resident #334 and documented in a provider note with no negative findings. On 6/26/23 Resident #334 was assessed by the Nurse with no negative findings. 3. Resident #335 was placed on one on one by the Charge Nurse on 6/24/23 until resident transferred to the hospital by HEMSI and ultimately discharged . 4. Resident interviews were conducted by the Social Services Director and Activity Coordinator with a BIMS of 13 or greater regarding physical or verbal abuse by another resident on 6/24/23 with no negative findings. 5. Residents with a BIMS of 12 or less, a body audit was completed by the Director of Nursing and Charge Nurse on 6/24/23 with no negative findings. 6. Alabama Department of Health, Adult Protective Services, and law enforcement were notified of the reported events on 6/24/23 by the Administrator. 7. Resident interviews were conducted by the Social Services Director with a BIMS of 13 or greater regarding abuse by anyone on 6/11/24 and 6/18/24 with no negative findings. 8. Residents with a BIMS of 12 or less, a body audit and observation for abuse and behaviors was completed by the Director of Nursing, Staffing Coordinator, and Charge Nurse on 6/11/24 with no negative findings. 9. Resident interviews using a Resident Psychosocial Health Questionnaire were conducted by Social Services Director with BIMS of 13 or greater to determine resident's mood, behaviors, and thoughts such as anxiety, agitation, depression, suicidal and homicidal ideations on 6/18/2024, with no new negative findings. Notification: 1. On 6/24/23 Charge Nurse made notifications to the practitioners and responsible parties for resident #334 and #335. Audits: 1. Clinical Record Review from 3/1/24 to 6/16/24 was initiated on 6/16/24 and completed on 6/17/2024 by the Director of Clinical Education and Regional Nurse Managers to include clinical notes, event notes, and daily skilled notes to identify any potential residents for instances of allegations of potential/actual abuse, aggressive, distress, and combative behaviors, and suicidal and homicidal ideations, with no new unknown findings. In-services: (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. On 6/16/24 Inservice was provided by the Assistant [NAME] President of Operations and the Regional Nurse Manager to the Administrator, DON, Staffing Coordinator, Social Services, and Receptionist/CNA on the Abuse Policy Protocol, updated Behavior Health Services Policy, and interventions related to abuse, aggressive, distress and combative behaviors, and suicidal/homicidal ideation. Education was also provided regarding staff unavailable to receive education will not be permitted to work until required education is completed. The Staffing Coordinator was designated as responsible for ensuring staff are educated n abuse prohibition plan, behavioral health services policy, and list of interventions for behaviors 2. On 6/16/24 Inservice was provided by the DON, Staffing Coordinator, Social Services, and Receptionist/CNA on the Abuse Policy Protocol, updated Behavior Health Services Policy, and interventions related to abuse, aggressive, distress, and combative behaviors, and suicidal/homicidal ideation to all staff. Staff unavailable to receive education will not be permitted to work until the required education is completed. 73 out of 77 employees have been educated. 3. On 6/16/2024 competency and validation questions were answered by staff currently working to ensure competency verbalized from education received. 4. On 6/17/2024 the Regional Nurse Manager placed signage in break rooms, nurses stations, and behavior communication binders that list interventions for behaviors including abuse, aggressive, distress and combative behaviors, and suicidal/homicidal ideation. This communication binder is used as a communication tool for staff to note resident behaviors, new or changes. This communication binder is brought to morning QA by a member of the Behavior Committee and reviewed during QA to determine appropriate interventions. 5. On 6/18/2024 Regional Nurse Manager inserviced the DON, Staffing Coordinator and Risk Manager that upon return from a transfer when ER deems residents appropriate for return for residents sent out related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations a behavioral assessment should be conducted. This form will help us determine if behaviors are present and require interventions upon return to the facility after a transfer related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations. 6. On 6/18/2024 the DON, Staffing Coordinator, and Risk Manager in-serviced Nursing Staff that upon return from a transfer when ER deems residents appropriate for return for residents sent out related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations a behavioral assessment should be conducted using the Resident Return from Transfer Behavior assessment form. This form will help us determine if behaviors are present and require interventions upon return to the facility after a transfer related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations. Nursing Staff unavailable to receive education will not be permitted to work until the required education is completed. 20 out of 22 Nurses have been educated. QAPI: 1. Adhoc QAPI was conducted on 6/24/23 to include Administrator, Director of Nursing, Senior [NAME] President of Operations, Assistant [NAME] President of Operations, Regional Nurse Manager, Assistant [NAME] President of Clinical Operations, Regional Nurse Manager to discuss resident to resident altercation event, education, root cause, and interventions. (continued on next page)

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	015458	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc Millenium	5275 Millennium Drive Huntsville, AL 35806

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The Medical Director was notified of the immediate jeopardy citations on 6/16/24 by the Assistant [NAME] President of Operations. 3. A Root cause analysis was conducted on 6/16/24 by the Administrator, Regional Director of Operations, Assistant [NAME] President of Clinical Operations, Regional Nurse Manager, Directors of Nursing, Assistant [NAME] President of Quality, Director of Clinical Education. Root cause was identified as ineffective training and education related to behavioral health services. 4. QAPI meeting was conducted on 6/16/24 to include Administrator, Director of Nursing, Staffing Coordinator, Dietary Manager, Activity Coordinator, Treatment Nurse, Receptionist, MDS Coordinator, Social Service Director, Business Office Manager, Maintenance Director, Regional Nurse Manage, Assistant [NAME] President of Operations, Regional Nurse Manager, Medical Director, Assistant [NAME] President of Clinical Operations, Senior [NAME] President, and Director of Clinical Education regarding Immediate Jeopardy citations, Abuse and Behavior Health Services policy review, education, interventions for immediate removal plan, Medical Director notification, facility assessment updated/reviewed and root cause analysis determined. a. Behavior Health Services Policy reviewed with recommendation made to include suicidal and homicidal ideations (Section 5, Subset F) under procedures- to include risk factors, triggering events, examples used to harm self. Definition of Suicidal Ideation added to provide clarification of terminology related to behavioral health services. b. Updated Intervention list attachment included in the updated Behavior Health Policy for behaviors to include immediate action steps to implement related to abuse, aggressive, distress, and combative behaviors, and Suicidal and Homicidal Ideations. c. The facility assessment plan was revised to include suicidal ideations. 5. A Governing Body meeting was held to include the Administrator, Director of Nursing, Assistant [NAME] President of Operations, Assistance [NAME] President for Clinical, Senior [NAME] President of Operations, and Regional Nurse Managers on 6/16/24 at 9pm to discuss the corrective action plans to address the immediate concerns for F 600, F 740, F 741 and F 867 for Resident's #334 and #335 and all current residents in the facility have the potential to be affected. The Medical Director agreed with the current action plan and had no new recommendations. 6. This Behavior Communication binder is brought to morning QA by a member of the Behavior Committee and reviewed during QA to determine any new or changes in behaviors, intervention implementation and appropriateness and will be revised as necessary. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33738 Based on interviews, record review, and a review of a policy titled, Behavioral Health Services, the facility failed to ensure there were sufficient staff who had the knowledge, training, competencies, and skills sets to address the behavioral health care needs of Resident Identifier (RI) #335 after RI #335 was sent to the hospital for aggressive behaviors and suicidal and homicidal ideations. The facility did not develop and implement interventions to ensure resident's safety or to provide additional supervision. On 06/23/2023 during lunch, RI #335 was physically and verbally abusive to staff and had suicidal and homicidal ideation before being sent to the hospital. Upon return from the hospital on 06/24/2023 around 3:00 AM, the facility did not ensure interventions were developed and implemented to ensure residents' safety or to provide additional supervision. Staff identified that RI #335 was acting strange, she was not being herself, she was not being cooperative, she would not listen to what staff were saying when she was redirected to her room as she previously had done. No actions were taken to ensure residents' safety. Around 4:30 AM, RI #335 was witnessed by a CNA in RI #334's room, standing over RI #334's bed with a pillow over RI # 334's face gripping both sides and pushing with force. It was determined the facility's noncompliance with one or more requirements of participation had cause, 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, 483.40 Behavioral Health at F 741-Sufficient/Competent Staff-Behavior Health Needs. On 06/16/2024 at 6:56 PM, the Administrator, Assistant [NAME] President of Operations, Regional Nurse Manager, and the Director of Nursing (DON) were provided the IJ templates and notified of the findings at the immediate jeopardy level in the area of Behavioral Health Services at F 741-Sufficient/Competent Staff-Behavior Health Needs. The IJ began on 06/24/2023 and continued until 06/18/2024 when the survey team verified onsite that corrective actions had been implemented. On 06/19/2024, the immediate jeopardy was removed, and 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. This deficiency was cited as a result of a Facility Reportable Investigation complaint/report number AL00044582. This deficient practice affected one of four residents reviewed for behavioral health services. Findings Include: Cross Reference F 600 and F 740. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Purpose: To ensure that residents receive necessary behavior health services. Policy: It is the policy of this facility that all residents receive care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning. Definitions: Definitions are provided to clarify terminology related to behavioral health services and the attainment or maintenance of a resident's highest practicable well-being. Highest practicable physical, mental and psychosocial well-being is defined as the highest possible level of functioning and well-being-limited by the individual's recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental, and psychosocial needs of the individual . Procedure: . 3. The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. 4. Behavioral health care and services shall be provided in an environment that is conducive to mental and psychosocial well-being. 5. Conditions that are frequently seen in nursing home residents and may require the facility to provide specialized services and supports base upon residents' individual needs, include, but are not limited to: . a. Depression- It is not a natural part of aging, however, older adults in the nursing home setting are more at risk than older adults in the community. e. Aggressive Behaviors-defined as behaviors that cause harm, threaten to harm, or put the health and safety of people risk . 6. The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-center care . b. Obtaining history from medical records, the family, and the resident regarding mental, psychosocial, and emotional health; c. MDS and care area assessments; d. Ongoing monitoring of mood and behavior; (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident brought by .to facility at 3 AM no new orders given . A review of RI #335's Clinical Notes Report entered by RN #18 dated 06/24/2023 at 5:33 AM, revealed the following: . Resident came back from (name of hospital) went into 200 hall being combative going into other resident rooms, brought him/her back to 100 he/she tried to hit CNA with the hole puncher he/she kept saying we are going to hell and CNA is dead and he/she took a statue from his/her room and tried to hit us with it he/she was throwing the snack tray around trying to hit the nurse. He/She tried to hit the CNA with the pill crusher, he/she tried to smother another resident with a pillow the CNA walked in on him/her and he/she tried to run back to his/her room . On 06/13/2024 at 1:00 PM during an interview, Registered Nurse (RN) #18 stated on the night of the incident, RI #335 was acting strange and was not acting like himself/herself. RN #18 said RI #335 was uncooperative and would not go to his/her room. RN #18 said when RI #335 was asked to go to his/her room, RI #335 got mad and pushed all the snacks off the table. RN #18 said she went to ask for help from another nurse and when she returned to the hall CNA #27 told her what happened. On 06/13/2024 at 6:20 PM a follow-up interview was conducted with RN #18 who said a nursing assessment was not completed when RI #335 returned from the hospital, because he/she was not gone over 24 hours. On 06/14/2024 at 6:52 PM an interview was conducted with the MDS Coordinator (MDSC). The MDSC was asked what training have staff received about residents with suicidal ideation. She said she did not know exactly when they had education or training on suicidal ideation. On 06/16/2024 at 4:13 PM was conducted with the Director of Nursing (DON). The DON stated when RI #335 returned from the hospital on 06/24/2023 a nursing assessment was not completed on resident. She further stated RI #335, was sent to the hospital for physical aggressive behavior and suicidal ideation should have had an assessment completed when he/she returned to the facility. The DON said if a nursing assessment had been done, it would have triggered interventions such as one to one supervision. The DON was asked, what other interventions would you have expected to have been put in place. The DON said interventions for RI #335 and other residents' safety, so one on one supervision and notification of the supervisor, medical director, and resident's family that the resident was having suicidal ideations. In a follow up interview with the MDSC on 06/16/2024 at 12:46 PM, she was asked, when RI #335 returned from the hospital on 06/24/2023 was a nursing assessment completed. The MDSC said, no there was not a nursing assessment done on RI #335, but a nursing assessment should have been done. According to the RI #335's progress notes, when RI #335 returned from the hospital on 06/24/2023 she was still combative and aggressive, did the facility add any interventions or put a plan in place. The MDSC stated, there were no interventions or plan put in place but interventions or a plan should have been put in place. When asked what would be the concern of not having a plan or interventions in place for a resident with aggressive behavior or suicidal ideation. She said the facility should have had a plan in try to prevent any further occurrence of aggressive behavior toward other residents and for the safety of residents and staff. The MDSC was asked did the facility provide training/education on how to manage resident with aggressive behavior and suicidal thoughts, where was the documentation. The MDSC stated she would have to check. ********** (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/18/2024 at 6:00 PM, the facility submitted an acceptable removal plan, which document: Description; On 6/24/23 Resident #335 was observed standing over RI #334's bed with pillow over face gripping both sides with force. Safety: 1. Resident #335 was redirected from the Dining room by the Administrator on 6/23/23 after yelling, throwing things and grabbing at staff. 2. Social services made referrals for Psych services on 6/23/23 related to physical and verbally abusive behaviors and suicidal ideation. Charge Nurse sent R1#335 to theER on [DATE] and transported by HEMSI. 3. Resident #335 returned from the hospital by HEMSI on at 3am on 6/24/23 with no new orders. Labs were drawn at the ER. Per ER records resident denied any complaints, denied suicidally and homicidally. 4. Resident's #334 and #335 were separated by the CNA on 6/24/23. Assessment: 1. Resident #334 was assessed by the Charge Nurse on 6/24/23, with no injuries noted. 2. On 6/26/23 the Psychiatric Nurse Practitioner assessed Resident #334 and documented in a provider note with no negative findings. On 6/26/23 Resident #334 was assessed by the Nurse with no negative findings. 3. Resident #335 was placed on one on one by the Charge Nurse on 6/24/23 until resident transferred to the hospital by HEMSI and ultimately discharged . 4. Resident interviews were conducted by the Social Services Director and Activity Coordinator with a BIMS of 13 or greater regarding physical or verbal abuse by another resident on 6/24/23 with no negative findings. 5. Residents with a BIMS of 12 or less, a body audit was completed by the Director of Nursing and Charge Nurse on 6/24/23 with no negative findings. 6. Alabama Department of Health, Adult Protective Services, and law enforcement were notified of the reported events on 6/24/23 by the Administrator. 7. Resident interviews were conducted by the Social Services Director with a BIMS of 13 or greater regarding abuse by anyone on 6/11/24 and 6/18/2024 with no negative findings. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. Behavior Health Services Policy reviewed with recommendation made to include suicidal and homicidal ideations (Section 5, Subset F) under procedures- to include risk factors, triggering events, examples used to harm self. Definition of Suicidal Ideation added to provide clarification of terminology related to behavioral health services. c. Updated Intervention list attachment included in the updated Behavior Health Policy for behaviors to include immediate action steps to implement related to abuse, aggressive, distress, and combative behavior, and Suicidal and Homicidal Ideations. d. The facility assessment plan was revised to include suicidal ideations. 5. A Governing Body meeting was held to include the Administrator, Director of Nursing, Assistant [NAME] President of Operations, Assistance [NAME] President for Clinical, Senior [NAME] President of Operations, and Regional Nurse Managers on 6/16/24 at 9pm to discuss the corrective action plans to address the immediate concerns for F600, F740, F741, and F867 for Resident's #334 and #335 and all current residents in the facility have the potential to be affected. The Medical Director agreed with the current action plan and had no new recommendations 6. This Behavior Communication binder is brought to morning QA by a member of the Behavior Committee and reviewed during QA to determine any new or changes in behaviors, intervention implementation, and appropriateness and will be revised as necessary. 7. Upon return from a transfer when ER deems resident appropriate for return for residents sent out related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations a Resident Return from Transfer Behavior assessment will be conducted. This will help us determine if behaviors are present and require interventions upon return to the facility after a transfer related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations. For any resident discharged and readmitted a readmission assessment already part of the readmission process is completed to include an abuse and behavior section. On 6/18/2024 Nursing Staff educated that upon return from a transfer when ER deems residents appropriate for return for residents sent out related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations a behavioral assessment should be conducted using the Resident Return from Transfer Behavior assessment form. This form will help us determine if behaviors are present and require interventions upon return to the facility after a transfer related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations. Nursing Staff unavailable to receive education will not be permitted to work until the required education is completed. 20 out of 22 Nurses have been educated. Facility implemented all corrective actions by 6/18/2024. ********** After review of documentation supporting the above corrective actions, including the facility's investigation file, in-service/education records, QAPI documentation, and staff intervention, the survey team verified the facility implemented corrective actions including ongoing monitoring on 06/18/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015458	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc Millenium	5275 Millennium Drive Huntsville, AL 35806

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33739 Based on record review, interview, a review of Facility Reported Incidents, the facility's investigative files, and review of a facility policies Medication Administration, and AMPharm Delivery Service, the facility failed to ensure controlled medications records were maintained and able to be reconciled when licensed staff failed to add medication to the control sheets and failed to place the controlled medications in the narcotic drawer after receiving from the pharmacy for Resident Identifier (RI) #57 and RI #47. This affected RI #47 and RI #57 and was cited as a result of the investigation of complaint/report AL00045923. Findings Include: A review of a facility policy AMPharm Delivery Services with an effective date of 11/2021 documented Policy: Nightly delivery is provided to each facility on a preset schedule. Procedure: . c. The delivery person shall present the nurse with a delivery manifest for signature . For narcotic deliveries, the receiving nurse shall verify the medications and counts with the delivery person prior to signing the manifest. 1. Immediately upon receipt scheduled medications shall be secured in the medication cart . RI #47 was admitted to the facility on [DATE]. RI #57 was admitted to the facility on [DATE]. The Facility Reported Incident submitted on 10/18/2023 at 7:06 PM indicated Registered Nurse (RN) #5 identified RI #47 and RI #57 had missing oxycodone tablets. The facility's investigative summary indicated . Incident type: Misappropriation of resident property Suspected Offender: Unknown 10/18/23 it was found that (RI #47) had Oxycodone/APAP 5/325 tablets 60 pills were unaccounted for. 10/18/23 it was found that (RI #57) had Oxycodone 5 milligram tablets 30 pills were unaccounted for. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is substantiated that the pills are missing. But we don't know for sure what happened to them at this point. On October 18th at approximately 12:45 PM 100 hall charge nurse (RN #5) reported to the DON (Former Director of Nursing (FDON)) that she called the pharmacy . to inquire about oxycodone for (RI #57's room number). The (pharmacy) reported that the medication had been delivered the night before and was signed off by two individuals. Nurse managers initiated search . No Oxycodone was found that belonged to (RI #57). On October 18th at approximately 4:30 PM . (RN #5) notified (pharmacy) that (RI #47) was completely out of oxycodone despite (RN #5) faxing the script (prescription) to (pharmacy) the previous day. (Pharmacy) informed (RN #5) the last oxycodone script was filled and delivered . on 10/13/23 of 60 tablets.After a thorough search of the building no medications were found. An order to (pharmacy) was called in requesting to replace the residents missing medications - replacement provided by Millennium. Multiple attempts via phone calls and text messages to contact (RN #7) the charge nurse that signed for both cards of oxycodone were left unanswered. (RN #7) was scheduled to work night shift on October 18th . She arrived late . stated her phone was dead . (RN #7) provided a statement . but denied any involvement in the missing medications. However, she did agree that she was the only nurse that signed for the medications that were delivered . During an interview with RN #5 on 06/12/2024 at 11:58 AM, she said she had ordered RI #57's oxycodone on 10/17/2023. RN #5 said on 10/18/2023 she checked the cart to confirm delivery and did not find it. RN #5 said she called the pharmacy and was told it had been delivered the night before and signed by RN #7. She said she and other nurses searched and did not find the medication, so she reported to the Director of Nursing (DON). She said she told the DON she counted with the RN #18, because RN #7 had left early. RN #5 said the counts were accurate. She said later the same day when RI #47 asked for pain medication, she went to the cart for oxycodone and there was none there, she again called the pharmacy and was told the medication delivered on 10/13/2023 and was also signed by RN #7. RN #5 said the facility was unsure about what happened to the medications and that neither resident missed a dose of the pain medication. An unsuccessful attempt was made to contact RN #7 on 06/12/2024 at 12:15 PM. On 06/12/2024 at 12:20 PM an interview was conducted with RN #18. RN #18 said she worked the same night as RN #7 but worked the other side of facility. RN #18 said when medications were delivered RN #7 received them and signed for them. RN #18 said she went over and got the medications for her hall later in the shift. RN #18 said RN #7 left before her shift was over and RN #7 and herself counted the medications and the count was accurate. RN #18 said she became aware of the missing medications when she did her statement. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/14/2024 at 6:44 PM during an interview with the Regional Nurse Manager (RNM), he said RN #5 identified that RI #47 and RI #57's oxycodone was missing. The RNM said RI #47's was delivered and signed by RN #7 on 10/13/2023 and RI #57's was delivered and signed also by RN #7 on 10/17/2023. When asked what happened to the medications, he said they did not have evidence other than RN #7 signed the delivery sheet. The RNM said RN #7 failed to follow the pharmacy processes of documenting and recording the medication when received. The RNM said RN #7 said she left the medications unattended and was terminated.