STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 14754 Based on observations, interviews, review of facility policies titled, Management of the Laundry, Interim Recommendations for Routine & Terminal COVID-19 Isolation Room/Unit Cleaning, and review of the facility's Maintenance Repair Logs, the facility failed to ensure a safe, clean, comfortable, homelike environment for residents in the facility. Specifically, the facility failed to ensure: 1. housekeeping services were provided to prevent soiled floors, a soiled over bed table, and/or soiled resident care equipment in Resident Identifier (RI) #80's room; 2. sufficient linens, including bath towels and washcloths, were available for resident care on Units D, E, F, and G; 3. Unit F and Unit G did not have general maintenance items which had not been identified or addressed for repair, which included a torn shower seat, exposed sharp metal edges in a shower room, exposed wires in residents' rooms, overhead lighting in poor repair, missing air conditioner grill covers, and a broken window; and 4. RI #43, RI #61, and RI #70's rooms were maintained at comfortable temperatures. These deficiencies were observed on Units D, E, F, and G, four of six units in the facility utilized as residential areas. Findings included: 1. A review of a facility policy titled Interim Recommendations for Routine & Terminal COVID-19 Isolation Room/Unit Cleaning, dated 02/18/2021 and provided in response to a request for a housekeeping policy, revealed no guidance regarding the general cleaning of nursing units or resident rooms. An observation conducted in RI #80's room on 01/31/2022 at 4:25 PM with Employee Identifier (EI) #19, Registered Nurse (RN), revealed dried tube-feeding formula stains on the floor, the legs of an overbed table, and the legs of the tube feeding pump's pole. The room also had black buildup of grime and dirt along the baseboards in the room. An interview with EI #19 at that time revealed housekeeping only dumped the trash and cleaned handrails, but conducted no deep cleaning of the floors or other items. Per EI #19, the floors on the F Unit (Dementia Unit) had been dirty for months. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/01/2022 at 3:55 PM with EI #49, RN, the nurse stated housekeeping was not cleaning the unit. EI #49 commented that she heard the dayshift housekeeper was lazy and that RI #80's room was always dirty with tube feeding formula dried on the floor. On 02/04/2022 at 10:15 AM, an interview was conducted with EI #56, Housekeeper. EI #56 stated her daily housekeeping role was to sweep/mop the floors, dump trash, wipe down bedside tables and nightstands, and clean the shower rooms after nurse aides completed showers for the day. The surveyor took EI #56 to Room RI #80's room and showed EI #56 the tube-feeding stains that were on the floor, on the over-bed table, and on the tube-feeding pump pole, as well as the black grime along the baseboards since at least 01/31/2022. EI #56 stated housekeepers were not responsible for cleaning tube-feeding poles, noting that was nursing's responsibility. EI #56 stated she had cleaned the floor in the room. EI #56 had no explanation regarding why the floor contained the same stains and dirt if mopped daily. On 02/04/2022 at 10:35 AM, an interview and tour of Unit F was conducted with EI #37, Housekeeping and Laundry Director. EI #37 was shown the soiled floor, overbed table, and tube-feeding pole in RI #80's room. EI #37 stated it was nursing's responsibility to clean resident care equipment such as the tube-feeding pole. Per EI #37, the floors, overbed tables, and furniture such as nightstands were the responsibility of the housekeeping department. On 02/06/2022 at 10:15 AM, an interview was conducted with EI #2, Director of Nursing, regarding housekeeping concerns. EI #2 stated that restorative nursing staff was responsible for cleaning resident care equipment such as tube-feeding poles, scales, and Hoyer lifts. 2. A review of the facility policy titled Management of the Laundry, revised in January of 2016, revealed, . Stage 1: ESTABLISHING LINEN PARS A linen par is the amount of linen needed to satisfy the daily needs of each and every resident . The RULE OF THUMB is that linen pars should be a minimum of 3 times your total linen inventory, 8 times your total inventory for wash cloths. Facilities will be in danger of receiving an F-tag [a federal tag corresponding to a specific regulation with the Code of Federal Regulations] if linen pars are not maintained at this minimum . During an interview with Employee Identifier (EI) #17, Certified Nursing Assistant (CNA), on 01/31/2022 at 6:00 PM, EI #17 stated they had insufficient linens on Unit F almost every day. At 6:20 PM, EI #17 stated and showed the surveyor that there was only one bath towel on the unit, no washcloths, and two pillowcases. Observation of the linen cart and linen room revealed no further towels were available for use. Further interview with EI #17 revealed the unit was frequently short of linens. On 01/31/2022 at 6:15 PM, EI #19, Registered Nurse (RN), confirmed there were not enough towels or washcloths for aides to clean the residents. EI #19 also stated there were never enough linens, particularly bath towels, when she worked over multiple times/shifts. On 01/31/2022 at 6:20 PM, observation of Unit F revealed there were 28 residents on the unit but only one bath towel and a few washcloths available for resident care. On 01/31/2022 at 6:25 PM, observation of Unit G revealed there were five bath towels and two washcloths available for eight residents on the unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/31/2022 at 6:40 PM, observation of a shared linen closet and carts on Unit E for use on Unit D and Unit E revealed there were 14 bath towels and 12 washcloths for the two units. An interview with EI #51, CNA, revealed there were often not enough linens on the unit. EI #51 stated staff made do with what they had, but she had to go to other units on multiple occasions to round up linens to clean incontinent residents. On 02/01/2022 at 7:48 AM, observations conducted of linen carts/rooms revealed: - The shared linen closet for Units D and E had no washcloths and one towel, for approximately 37 residents as indicated by the facility's census listing. -Unit D linen cart had seven towels and four washcloths -Unit E linen cart had no towels or washcloths -Unit G linen closet had six towels and five washcloths, for approximately eight residents as indicated by the facility's census listing. On 02/01/2022 at 7:57 AM, observations were made of Unit F's linen supply. Unit F was observed to have 10 towels and 11 washcloths, for approximately 28 residents as indicated by the facility's census listing. On 02/04/2022 at 10:45 AM, a tour was conducted with EI #37, Housekeeping and Laundry Director, to observe the number of linens available on Units D, E, F, and G. The following was observed: - Unit F had 11 bath towels. - Unit G had three bath towels. - Unit D and Unit E had eight bath towels. An interview with EI #37, conducted at the time of the above observations, revealed he did not believe there were sufficient linens for the number of residents on the units. EI #37 reported having 200 spare towels in a linen closet on the COVID-19 Unit. On 02/04/2022 at 11:42 AM, observation of the spare linen closet revealed there were not 200 towels but only 60 towels available. On 02/28/2022 at 12:20 PM, EI #2, the Director of Nursing, stated she would expect staff to report concerns with linens to unit managers, who were to then follow the appropriate chain of command of notification. EI #2 further stated it was discovered that staff and/or residents had been hoarding linens in resident rooms which resulted in an insufficient linen supply. On 02/28/2022 at 10:15 AM, Resident Identifier (RI) #48 and RI #58 were interviewed about the supply of linens/towels. Both residents stated prior to the survey, there had been issues with not having enough linens. RI #48 said there were a few times the resident had to wait a short time, defined by RI #48 as later in the day, to take a shower when there were no towels on the unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/28/2022 at 11:38 AM, RI #57 stated they did not have towels half the time. RI #57 said the last time he/she took a shower there was only one towel. Per RI #57, the carts did not have linens on them. On 02/06/2022 at 12:00 PM, an interview was conducted with EI #1, Administrator. EI #1 reported he was aware of concerns with insufficient linens and said one of the issues was that the nursing staff were not taking the dirty linens back to the laundry room timely so they could be washed and sent back to the unit. On 02/28/2022 at 11:55 AM, EI #1 stated the concerns with the linens should have been reported to EI #37. EI #1 stated room rounds were recently completed and it was found that staff and residents had been hoarding linens in resident rooms. EI #1 noted linens were available but they were hidden and not in circulation. 3. Random observations of Unit G and Unit F between 01/31/2022 and 02/05/2022 revealed maintenance items which had not been addressed. On 02/05/2022 at 11:15 AM, a tour of Unit G and Unit F was conducted with Employee Identifier (EI) #4, Maintenance Director, and EI #14, Corporate Environmental Life Safety Administrator, which revealed the following: - The Unit G shower room contained a resident shower chair that had a torn plastic seat exposing the upholstery. EI #4 expressed he was unaware the chair required repair. EI #14 stated he planned to order a new seat cover for the shower chair. - The Unit F and Unit G shower room's metal doorway baseboard was rusted with sharp edges. EI #14 stated the doorway would be fixed either by replacing some of the metal or filing down the metal and repainting it. - The Unit F shower room water knobs were not flush and exposed sharp tile edges. EI #14 stated the knobs needed percussion caps applied to make them safer. The shower head was loose from inside of the wall. EI #14 stated the shower fixture needed to be redone and mounted in the wall. - Rooms F16 and F9 had old phone jack wires hanging from the wall. The plastic jack boxes were broken, and wires were hanging from outside of the boxes. EI #14 stated the boxes were no longer in use and they all should be removed. - In Room F17 on the A side of the room, an overbed light was not working, was tilted, and was pulling away from the wall. EI #14 stated it needed to be repaired and mounted securely to the wall. - Rooms F9 and F10 had heat/air conditioning units that had missing grill covers. EI #14 stated the grill covers needed to be replaced. - Room F8 had a broken window that was covered with what appeared to be medical tape. EI #14 stated it appeared the window was broken by a rock when mowing occurred, but was not repaired. EI #14 stated the window needed to be replaced. During this tour, EI #4, the Maintenance Director, indicated he had no rounding tool or checklist to use to monitor for items needing repairs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/06/2022 at 12:00 PM, EI #1, Administrator, stated the building was old and needed many repairs and it was a lot for just one maintenance person. Per EI #1, administration was working with corporate staff for the needed repairs. 4. On 02/02/2022 at 9:34 AM, while in RI #43's room for medication pass observation, the surveyor noted the room was very cold. RI #43 stated his/her heat was not working but, per the resident, maintenance staff was supposed to be working on it. On 02/05/2022 at 10:15 AM, while in RI #43's room, the surveyor noted the interior of the room was still cold. An interview with RI #43 at that time revealed the room's heat had not worked all winter long. Per RI #43, maintenance staff was aware of the heating issues in the room because they had been in the room/bathroom attempting to fix it. The resident was noted to be under five blankets at the time. A review of Maintenance Repair Logs for October 2021 through February 2022 revealed the following entries regarding room temperatures: - On 11/03/2021, it was documented RI #43 indicated heat only made room colder. No documentation on the log revealed the repair was completed. - On 12/19/2021, it was documented RI #43 indicated the heater vent was blowing cold air in his/her room. No documentation on the log revealed the repair was completed. - On 02/04/2022, it was documented RI #43 reported that his/her heat was not working. There was no documentation on the log indicating the repair had been completed. On 02/05/2022 at 11:25 AM, an interview was conducted with EI #4, Maintenance Director, regarding room temperatures. EI #4 stated he was not monitoring resident room temperatures and there were no logs to track room temperatures. EI #4 was not aware of a policy or any regulatory requirement for maintaining room temperatures in a particular temperature range. EI #4 admitted the facility had no way to check room temperatures, since the facility had no thermometers to do so. Initially EI #4 stated he was not aware of heating issues in resident rooms. However, further interview revealed EI #4 was aware the boiler system that provided heat to Units A, D, E, and parts of C and F had not been working correctly, which affected the room temperatures. EI #4 stated when the facility had the boiler issue, there were complaints regarding low temperatures. On 02/05/2022 at 11:30 AM, EI #4 accompanied the surveyor to the office of EI #1, Administrator, where EI #15, Owner, and EI #14, Corporate Environmental Life Safety Administrator, were also present. EI #1 stated that the facility had not been checking the temperature of the rooms, had not kept temperature logs, and had no current way of checking accurate temperatures in residents' rooms due to not having a thermometer capable of that. EI #1 was asked if the facility had a room temperature policy or range in which the room temperatures were to be kept. EI #1 stated it was dependent upon each resident's preference. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/05/2022 at 1:32 PM, a group interview was conducted with EI #1, EI #14, and EI #15 regarding room temperatures. EI #14 explained that different parts of the facility had different heating sources, noting some rooms were heated via a boiler system, some rooms were heated by a central heating system, and yet other rooms were heated by PTAC (packaged terminal air conditioner; a type of self-contained heating and air conditioning system) located in some resident rooms. EI #1 was asked what the expectations were to address multiple entries in the maintenance log regarding resident room heat not working. EI #1 stated that maintenance should have been checking the maintenance log daily or three to four times a day, addressing the concerns, and signing off on the concerns after the items were fixed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14754 Based on record review, interviews, and review of facility policies titled, Care of Fingernails/Toenails, and Shaving the Resident, the facility failed to ensure activities of daily living (ADL) care tasks related to nail care and shaving were provided for Resident Identifier (RI) #67. This deficient practice affected RI #67, one of three residents sampled for ADL care. Findings include: A review of the facility policy titled, Care of Fingernails/Toenails, last revised in October of 2010, revealed, . The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections . General Guidelines 1. Nail care includes daily cleaning and regular trimming .Documentation .The following information should be recorded in the resident's medical record: 1. The date and time that nail care was given. 2. The name and title of the individual(s) who administered the nail care . A review of the facility policy titled, Shaving the Resident, last revised in October of 2010, revealed, .The purpose of this procedure is to promote cleanliness and to provide skin care .Documentation .The following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual(s) who performed the procedure. RI #67 was admitted to the facility on [DATE] with diagnoses to include Sepsis and Dementia with Behavioral Disturbance. A review of RI #67's quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident had severe cognitive impairment according to the Staff Assessment for Mental Status, was not ambulatory, and was totally dependent on staff for personal hygiene needs. A review of RI #67's Care Plan, with a problem onset date of 12/22/2020, revealed the resident was at risk for self-care deficits and needed assistance with ADLs. Per the care plan, the resident was to receive assistance with bathing and grooming by the certified nursing assistants. On 01/31/2022 at 10:54 AM, observation of RI #67 revealed the resident was unshaven (appearing to be multiple days' growth) with long fingernails and brown substances noted under multiple fingernails. On 02/01/2022 at 4:30 PM, an interview was conducted with RI #67's Certified Nurse Aide (CNA)/Restorative Aide, Employee Identifier (EI) #36. EI #36 showed the surveyor a shower book and reported the resident was on the shower schedule for Mondays, Wednesdays, and Fridays during the day shift. EI #36 was unsure the last time the resident received a bath or shower as no such care encounter was documented in the shower book. On 02/03/2022 at 9:24 AM, observation of RI #67 revealed the resident was lying in bed. RI #67 continued to be unshaven with long fingernails with a brown substance underneath multiple fingernails. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 02/03/2022 at 12:15 PM with EI #21, Registered Nurse (RN)/Unit Manager. EI #21 stated every bath schedule was in a book. EI #21 checked a shower book, which revealed RI #67 was to receive showers every Monday, Wednesday, and Friday. EI #21 reviewed the shower book but was unable to find documented entries or initials of staff to indicate they had completed the resident's bath. EI #21 then checked with EI #3, Regional Nurse, and inquired where aides charted baths in the computer system. EI #21 found computer documentation showing staff documented the completion of baths for RI #67 on 01/31/2022, 02/01/2022, and 02/02/2022. However, EI #21 confirmed via observation with the surveyor at that time that RI #67 was unshaven and had long nails with brown substances underneath them, despite documentation in the computer denoting that bathing had occurred over the prior three days. On 02/06/2022 at 10:15 AM, an interview was conducted with EI #2, Director of Nursing. EI #2 stated each resident's shower schedule should be followed by staff and include all ADL tasks, including shaving, nail care, and bathing. Per EI #2, ADL care should also be provided as needed if a resident was dirty.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43016 Based on observations, interviews, review of facility policies titled, Water Temperatures, Safety Of and Management of the Laundry, review of facility Maintenance Repair Log sheets, review of facility Water Temp (temperature) Log Sheets, and review of the laundry department's Dryer Log, the facility failed to: 1) monitor and maintain safe hot water temperatures, which were found to be up to 145 degrees Fahrenheit (F), on all residential wings/units of the facility, including the dementia unit. Further, staff failed to implement the system for reporting and acting upon ongoing concerns related to excessively hot water in resident care areas. Specifically, direct care staff with knowledge of excessively hot water temperatures did not record this information on the facility's Maintenance Repair Log sheets as the concerns were identified. In addition, maintenance staff were not performing weekly routine checks of facility water temperatures to ensure they were within safe ranges, nor did the facility implement any additional checks or safety precautions when they became aware there were concerns with their boiler system. This deficient practice placed all 89 residents in the facility in immediate jeopardy (IJ), as it was likely to result in serious injury, serious harm, serious impairment, or death. On 02/03/2022 at 1:03 PM, Employee Identifier (EI) #1, the Administrator, was notified of the findings of substandard quality of care at the IJ level in the area of Quality of Care/Free of Accident Hazards/Supervision/Devices, F689; and 2) Further, the facility failed to ensure lint was removed from underneath the facility's dryer. These deficient practices had the potential to affect all 89 residents residing in the facility. Findings include: 1) Cross Reference F835 and F908. A review of a facility policy titled, Water Temperatures, Safety of, dated April 2010, revealed: Tap water in the facility shall be kept within a temperature range to prevent scalding of residents. Policy Interpretation and Implementation 1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 110 [degrees] F (Fahrenheit), or the maximum allowable temperature per state regulation. 2. Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log. 4. If at any time water temperatures feel excessive to the touch (i.e., hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff will report this finding to the immediate supervisor. On 01/31/2022 at 10:16 AM, while talking with Resident Identifier (RI) #82 in his/her room on the E Unit, the surveyor turned on the hot water faucet, noting the hot water seemed hotter than expected. The surveyor left the room and returned at 10:29 AM with a thermometer to check the water temperature. RI #82's bathroom sink water temperature was noted to be 124.8 degrees F. After noting this water temperature exceeded 110 degrees F, the surveyors began checking water temperatures throughout the facility. According to the facility's floor plan, the facility consisted of seven units, referred to as the A through G Units. Per the facility's Matrix listing all residents residing in the facility, residents resided on all units, except the B Unit. The following observations were made, listed by unit: A Unit: - On 01/31/2022 at 3:11 PM, observation revealed RI #31 and RI #9's shared bathroom had a hot water temperature at the sink of 131.8 degrees F. - On 01/31/2022 at 3:19 PM, observation revealed RI #23 and RI #52's shared bathroom had a hot water temperature at the sink of 118.2 degrees F. - On 01/31/2022 at 3:23 PM, in the shower room between Hall A and Hall C, the sink hot water temperature was 135.5 degrees F and the shower hot water was 131.0 degrees F. C Unit: - On 01/31/2022 at 2:37 PM in RI #79's bathroom, the hot water temperature was 120.4 degrees F. RI #79 stated the/she used to be a [NAME] and noted that the water from the sink was hot. - On 01/31/2022 at 3:02 PM RI #2's bathroom hot water temperature was 119.2 degrees F. D Unit: - On 01/31/2022 at 2:40 PM, the hot water temperature in the bathroom sink between Rooms D1 and D2 was 133 degrees F. - On 01/31/2022 at 2:40 PM, the hot water temperature in the bathroom sink between Rooms D3 and D4 was 128 degrees F. - On 01/31/2022 at 2:41 PM, the hot water temperature in the bathroom sink between Rooms D9 and D10 was 118 degrees F. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- On 01/31/2022 at 2:41 PM, the hot water temperature in the bathroom sink between Rooms D11 and D12 was 118 degrees F. E Unit: - On 01/31/2022 at 10:34 AM, RI #78 stated that the hot water was warm but acceptable, noting they were able to simply turn on hot and cold water together. The surveyor checked the water temperature with a thermometer and found the hot water in RI #78's bathroom was 127 degrees F. F Unit (Dementia Unit): - On 01/31/2022 at 11:14 AM, the hot water temperature in the bathroom sink shared by Rooms F14 and F15 on the Dementia Unit was found to be 137 degrees F. - On 01/31/2022 at 11:28 AM, the hot water temperature in the bathroom sink shared by Rooms F8 and F9 on the Dementia Unit was found to be 140 degrees F. - On 01/31/2022 at 2:20 PM, the hot water temperature in the bathroom sink shared by Rooms F16 and F17 on the Dementia Unit was found to be 145 degrees F. The two residents in Room F17 were ambulatory and utilized water from the sink. - On 01/31/2022 at 2:42 PM, the Dementia Unit shower room's hot water temperature was found to be 136 degrees F. Per staff, this shower was used for any resident desiring a shower/scheduled for a shower on the unit. G Unit: - On 01/31/2022 at 11:10 AM, RI #139's bathroom sink hot water temperature was found to be 127 degrees F. RI #139, who was cognitively intact, stated the water was hot, but the resident had not gotten burned from the water. - On 01/31/2022 at 11:21 AM, the G Wing shower room water temperature was found to be 136 degrees F. - On 01/31/2022 at 11:35 AM, RI #140's bathroom sink hot water temperature was found to be 136 degrees F. RI #140, who was cognitively intact, stated he/she had been using the hot water from the sink, but had not been burned. On 01/31/2022 at 4:12 PM, Employee Identifier (EI) #1, the Administrator, was informed there was an issue with hot water temperatures. At that time, a request was made to review hot water temperature logs and interview staff from the Maintenance Department. Review of the Water Temp Log Sheets provided by the facility, revealed weekly water temperature checks on each unit of the facility, up until the last entry dated 01/11/2022. There was no evidence the subsequent weekly water temperature monitoring had been performed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 01/31/2022 at 4:17 PM, two maintenance staff were assembled in EI #1's office. EI #1 stated EI #4, the Maintenance Director, had only been at the facility since December of 2021, and EI #5, the Maintenance Assistant, had only been at the facility one week. EI #4, the Maintenance Director, went with a surveyor to verify water temperatures. Hot water temperatures were measured, in degrees F, with EI #4 on 01/31/2022 at the times noted below: -4:21 PM: shower room sink at the beginning of the DEFG wings measured 137.3 per EI #4's thermometer and 138 per the surveyor's thermometer -4:23 PM: shower at the beginning of the DEFG wings measured 136.4 per EI #4's thermometer and 138 per the surveyor's thermometer. -4:25 PM: The shared bathroom for Rooms D1 and D2 measured 133.7 per EI #4's thermometer and 133 per the surveyor's thermometer. -4:27 PM: The shared bathroom for Rooms D3 and D4 measured 130.1 per EI #4's thermometer and 128 per the surveyor's thermometer. -4:29 PM: The shared bathroom for Rooms D9 and D10 measured 114.6 per EI #4's thermometer and 118 per the surveyor's thermometer. -4:31 PM: The shared bathroom for Rooms D11 and D12 measured 115.1 per EI #4's thermometer and 118 per the surveyor's thermometer. -4:38 PM: The shared bathroom for Rooms F8 and F9 measured 140 per EI #4's thermometer and 140 per the surveyor's thermometer. During and after verification of hot water temperatures with EI #4 throughout the facility, surveyors questioned residents as well as staff regarding their knowledge of hot water temperature issues: During an interview on 01/31/2022 at 11:51 AM, RI #57, a cognitively intact resident who resided on the F Unit, stated the hot water temperature was so hot it could have scalded them during their last shower. RI #57 stated the water temperature was uncontrollable. On 01/31/2022 at 2:42 PM, an interview was conducted with EI #27, Certified Nursing Assistant (CNA), regarding water temperatures. EI #27 stated they had worked at the facility since September 2021 and, during that time, the water in the F Unit shower room was always hot or cold and that there seemed to be no in-between. EI #27 stated she was unable to give a decent shower because the hot water temperatures were so hot, it was scalding. EI #27 stated that maintenance staff had been aware of the issue for months. Per EI #27, sometimes staff took the F Unit residents to the D Unit shower room for better water pressure, but the water was just as hot in the D shower room as in the F shower room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 01/31/2022 at 04:15 PM, an interview was conducted with EI #17, a CNA working on the F Unit (Dementia Unit). EI #17 stated they had worked at the facility since September of 2021. Per EI #17, water in the F Unit shower was seemingly either hot or cold, stating there was no in-between. EI #17 reported it took forever for the water to heat up but stated once the water warmed up it was super-hot. EI #17 reported it had been like that since she started working at the facility back in September. Per EI #17, staff knew there were water issues, but maintenance never fixed it. On 01/31/2022 at 4:30 PM, an interview was conducted with EI #19, a Registered Nurse (RN) who had worked at the facility since December of 2021. EI #19 stated water temperatures had been an issue since she began working at the facility. Per EI #19, the water on the F Unit would get really hot or cold and, in the shower, there was just a trickle of water at times. Per EI #19, the water concerns had been brought to EI #1's attention for months, but the issue was not fixed. On 01/31/2022 at 4:14 PM, an interview was conducted with EI #57, a CNA who was working on the D Unit. EI #57 said she believed the water temperature between Rooms D1 and D2 was too hot. EI #57 stated that when a resident was brought into the bathroom, the hot water would not be turned on all the way; instead, both the hot and cold water were turned on at the same time and adjusted as needed. However, EI #57 stated the facility had not provided any training addressing how to check if the water was too hot. On 01/31/2022 at 4:21 PM, an interview was conducted with EI #23, LPN, who revealed they had previously noticed water temperatures being too hot and having to regulate it with cold water. EI #23 stated problems with water could be reported via a work order in the maintenance log book located at the nurse's station; however, EI #23 confirmed she had not reported the problem with the water temperature in the maintenance log book. On 01/31/2022 at 5:12 PM, a meeting was attended by EI #1 (Administrator), EI #4 (Maintenance Director), EI #5 (Maintenance Assistant) , EI #6 (Regional Life Safety Director), and the survey team. EI #6 stated he was a resource if the new maintenance staff had any questions or problems. EI #6 stated he would come to the facility to help if needed. EI #6 stated EI #4 and EI #5 were new employees. EI #6 stated the facility had worked on their boiler system twice in January of 2022. He stated the facility saw problems with water temperatures up to 110, 111, and 114 degrees F and the facility had made adjustments. He said water temperatures began getting high, noting he did not like the hot water temperature to rise above 109 degrees F. During the meeting, EI #1 stated the hot water started fluctuating and temperatures were getting high. EI #1 indicated 01/10/2022 was when the facility started to notice the water temperatures fluctuating and getting high. EI #1 further indicated they had outside contractors come to the facility on [DATE] and 01/21/2022, respectively. When asked how often water temperatures were measured, EI #6 stated, one time a week. He further explained that he instructed maintenance staff to take the water temperature in one room on each wing of the facility. During the meeting on 01/31/2022, the survey team asked about the Water Temp Log Sheets that had no log entries recorded after 01/11/2022. It was noted that two routine water temperature monitoring entries were missing for the dates of 01/18/2022 and 01/25/2022 to bring the log up to date, given the expected frequency of measurements, per EI #1 and the facility policy. EI #1 stated if an entry was not on the log, then it was not done. EI #1 stated the dates of the missing entries were around the time that they were identifying issues. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During the meeting, EI #6 explained the facility's boiler and the chiller provided the hot water to the halls. EI #6 indicated if you mess with the boiler temperature, you must adjust the water to the halls. EI #6 stated it was a complicated system, and someone would have to be called in to work on it. EI #6 was asked if he was familiar with the Maintenance Repair Log entry on 11/26/2021 for the G shower room, which documented water temperatures hot enough to scald. EI #6 stated he had not seen it, and that would have been when EI #55, a former employee, was employed as the Maintenance Director. During the meeting, EI #4, the current Maintenance Director, acknowledged signing off on a shower issue and recalled trying to adjust the water temperature. EI #4 stated these issues may have been going on for some time and may have been a valve issue. EI #4 was asked how water temperatures were adjusted. EI #4 stated he had to adjust the temperature with the dial on the hot water heater. EI #4 stated that, after he made adjustments, it was not re-tested to determine what water temperatures it was producing after that. During the meeting, EI #1 stated it was not uncommon for water temperatures to fluctuate; however, too many water temperature issues alerted them to the problem. EI #1 stated they wanted to keep the water temperature between 105 and 110 degrees F and EI #6 concurred, noting the hot water temperature should not exceed 110 degrees F. EI #1 stated they would have to make an adjustment or get an outside contractor to come if the hot water temperature was over 110 degrees F. When questioned why no additional monitoring of water temperatures had been performed after making adjustments to the water heater, EI #1 agreed it would have been critical to check temperatures after maintenance was conducted. A review of the facility-provided Maintenance Repair Logs for 11/2021 through 1/2022 (a log for staff to record concerns/issues requiring maintenance intervention) revealed the following entries related to water temperatures: - an entry dated 11/26 (2021). This entry documented the G shower room had an issue of, water temp is scalding hot + [and] there is standing water that is pooling by the walls. There was no signature of the staff member who made this entry onto the log. In addition, the completion/repair date for this entry was blank. The maintenance signature, indicating this issue had been addressed, was also blank. - An entry dated 12/19 (2021). This entry documented the residents were complaining about the shower room on the F Unit not having water pressure and the temperature going from extreme hot to cold. This entry was not signed by the staff member that made the entry onto the log; however, it was initialed by EI # 4, the Maintenance Director on 1/22/2022. - An entry dated 12/29 (2021). This entry documented a shower water temperature issue in an unspecified shower room. There was no signature of the staff member who made this entry onto the log; however, it was noted EI #4 initialed this entry as completed/repaired with a date of 12/21/2021, indicating a repair date eight days prior to staff reporting the concern. Following the meeting with facility staff regarding the water temperature concerns, the following additional hot water temperatures were measured, in degrees F, with EI #5 on 01/31/2022 at the times noted below: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-5:36 PM: The bathroom of Room E5 measured 116 per EI #5's thermometer and 124.8 per the surveyor's thermometer. -5:38 PM: The bathroom of Room E8 measured 125.2 per EI #5's thermometer and 127 per the surveyor's thermometer. -5:41 PM: The bathroom of Room G11 measured 129.9 per EI #5's thermometer and 127 per the surveyor's thermometer. -5:44 PM: The bathroom of Room G13 measured 131.7 per EI #5's thermometer and 136 per the surveyor's thermometer. -5:47 PM: The shared bathroom of Rooms F14 and F15 measured 136.7 per EI #5's thermometer and 137 per the surveyor's thermometer. -5:49 PM: The shared bathroom of Rooms F16 and F17 measured 136.7 per EI #5's thermometer and 145 per the surveyor's thermometer. -5:50 PM: The F Unit shower measured 135 per EI #5's thermometer and 136 per the survey's thermometer. On 01/31/2022 from 5:57 PM to 6:08 PM, EI #4 measured the following hot water temperatures with the facility's thermometer: -Room C5's sink water was 116.7 degrees F -Room C13's sink water was 116.6 degrees F -Room A3 and A4's bathroom sink water was turned off. EI #4 stated he was unaware why the water was turned off and turned it back on below the sink. The temperature of the hot water was 123.2 degrees F. After obtaining the temperature and turning the water off at the sink, the water kept running, and EI #4 turned the water off below the sink and stated they would need to fix the sink. -Room A7 and A8's shared bathroom sink water was 126.5 degrees F -Room A999's sink water was 123.5 degrees F -While the surveyor accompanied EI #4 to obtain these temperatures, it was noted there were no maintenance logs located on the A/C Units during this time. On 2/01/2022 and 02/02/2022, the following additional water temperature observations and additional resident and staff interviews were obtained by the survey team: On 02/01/2022 at 9:17 AM, the G Unit shower room hot water temperature was found to be 129 degrees F. On 02/01/2022 at 9:20 AM, RI #139's bathroom sink hot water temperature was found to be 126 degrees F. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/01/2022 at 9:27 AM, the hot water temperature in the bathroom sink shared by Rooms F16 and F17 on the Dementia Unit was found to be 139 degrees F. On 02/01/2022 at 9:27 AM, RI #35, a cognitively intact resident, revealed the water in his/her bathroom sink was very hot. Per RI #35, a couple days prior, he/she had burned his/her hands when washing them in the sink. RI #35 reported his/her hands did not blister, but they were very red. RI #35 could not recall the specific day or time the incident occurred. On 02/01/2022 at 9:35 AM, an interview was conducted with EI #28, CNA. EI #28 stated that the water in the resident showers had been too hot. Per EI #28, the hot water had been an issue for a couple of months. On 02/01/2022 at 3:50 PM, an interview was conducted with EI #11, Staff Development Coordinator, who stated an in-service was conducted in the middle of January of 2022 after she noticed the water in the sink behind the nurse's station was too hot. Review of a typed document provided by the facility revealed the following: JANUARY 12, 2022 .ANY EMPLOYEE WHO HEARS OR SEES ANY ISSUES WITH WATER TEMPERATURES SHOULD REPORT THESE FINDINGS TO YOUR SUPERVISOR IMMEDIATELY AND PLACE THESE ISSUES IN THE MAINTENANCE LOG FOR THAT HALL The facility also provided two copies of a Record of Inservice Training and Attendance Form with this document. This form was also dated 01/12/2022 and listed a topic of Temps, and was signed off on by EI #11. These two forms contained only 34 total staff signatures of varying different job titles. During a follow-up interview with EI #11 on 02/03/2022 at 9:40 AM, EI #11 confirmed she had noticed the water temperature was too hot in mid-January of 2022. EI #11 said she reported the concern to EI #4, the Maintenance Director, as well as EI #1, the Administrator. However, EI #11 indicated she did not work the floor, so she was unsure if the water temperatures were actually fixed. On 02/01/2022 at 3:55 PM, an interview was conducted with EI #49, RN. EI #49 had worked at the facility for four to five months. EI #49 stated the water temperatures on the F Unit (Dementia Unit) had been hot. EI #49 was unsure who, if anyone, had reported it to maintenance staff. When asked why EI #49 did not report it to maintenance herself, EI #49 responded that she was too busy on the unit with the residents and had a heavy medication pass and had not taken the time to report it to maintenance. On 02/02/2022 at 8:33 AM, RI #290, identified by the facility as only requiring set-up assistance for bathing, was interviewed regarding his/her showers. RI #290 confirmed he/she had taken a few showers since being admitted to the facility 01/28/2022. RI #290 explained that an aide went with them to shower, but RI #290 turned the shower on and bathed them self. RI #290 stated that the water was too hot, and he/she had to turn on the cold water to 'tweak' it to make it a comfortable temperature. RI #290 stated that they had never been injured from the hot water, but if they were unable to add the cold water, the water would be too hot to shower. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/02/2022 at 8:34 AM, a telephone interview was conducted with the heating and cooling repairman who had provided service to the boiler in January 2022. According to the repairman, he had been contacted to specifically replace the start ignition control board, as it was not sparking to ignite the flame. The repairman stated his company did not usually work on boilers or chillers but did it that time to help the facility out on a late Friday afternoon. On 02/02/2022 at 8:45 AM, a telephone interview was conducted with an electric motor repairman, who also addressed issues with the facility's boiler in January 2022. This repairman also stated he did not usually work on boilers, but the facility's boiler would not fire, and he was able to clean the eye so that it would. The repairman explained that temperature parameters needed to be set so that the water temperatures would remain within that range. He further stated that the temperature of the water needed to be checked frequently. On 02/02/2022 at 10:02 AM, a hired construction manager contacted by the facility during the survey to see what was causing their water temperature issues, stated that he had determined the facility's boiler mixing valve had failed, which was creating the issue with elevated water temperatures. On 02/02/2022 at 10:10 AM, EI #4, Maintenance Director, took the surveyor through the facility to show the location of hot water heaters and boilers for the facility. EI #4 told the surveyor that they never knew where the mixing valve was located. During the tour of the facility's water heaters and boilers, when EI #4 was asked why the temperature logs had not been completed since 01/11/2022, EI #4 said that there were so many things that needed to be fixed and so many issues since he started, that he had not been able to do everything. EI #4 stated that he and EI #5 did not get much training. EI #4 noted he attended 'stand up' (a short, stand-up meeting) every morning and could meet with EI #1 as needed. EI #4 stated that all staff had to go through EI #1 for cost of repairs, noting that some repairs also had to go through corporate for approval. EI #4 explained that there were not a lot of places that used boilers now, and it was not easy to find anyone who worked on them. On 02/02/2022 at 1:05 PM, a Resident Group Meeting was conducted with six (RI #58, #48, #13, #70, #5, and #43) cognitively intact residents in attendance. During the meeting, RI #58 stated, The water is so hot on C Hall. A CNA told me I couldn't take a shower [because] it was so hot. On 02/02/2022 at 1:07 PM, an interview was conducted with EI #2, the Director of Nursing. EI #2 said about three weeks prior, EI #4 told her the sink water behind the nurse's station was too hot. Per EI #2, EI #1 (Administrator) was notified of the concern, and someone came out to look at it. EI #2 noted she took no other actions because EI #1 handled it. EI #2 denied any further knowledge of water temperature concerns. EI #2 further denied any knowledge of residents receiving burns but acknowledged water temperatures that were too hot could be a potential problem. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/02/2022 at 3:24 PM, EI #1 was asked what prompted the work on the boiler on 01/10/2022. EI #1 stated a potential problem had been noticed with the heat (air heating system also associated with the facility's boiler system), noting a contractor had been called to work on it. EI #1 stated the boiler operated both the heating and water systems. EI #1 stated he then called another contractor on 01/21/2022 and this contractor installed a new part. EI #1 stated someone said something about the water temperature around that time, but he could not remember who. EI #1 stated the person who may have first mentioned the hot water was EI #11, but he was not sure. EI #1 stated they checked and did not find issues, so they went on as usual. EI #1 stated they did not have logged temperatures for a week, which he noted he should have caught, but he did not recall anyone having major issues with water during that time. EI #1 was asked what temperature could cause a burn, and he stated, 110 [degrees F]. EI #1 was asked if the facility's water temperatures had exceeded 110 degrees F. EI #1 stated, yes, that has been identified. EI #1 acknowledged they had a hiccup in the facility's system of monitoring and acting upon hot water temperatures. On 02/03/2022 the following additional staff interviews were conducted regarding staff knowledge on how to report maintenance concerns, including excessively hot water temperatures: On 02/03/2022 at 7:54 AM, an interview was conducted with EI #28, a CNA. EI #28 stated water temperatures had been too hot for months and that maintenance staff were aware of the hot temperatures because she had seen maintenance staff working on it. However, EI #28 said she had not reported the concern in the maintenance log, because she thought maintenance staff were already aware. On 02/03/2022 at 9:28 AM, EI #13, LPN, stated that she reported maintenance problems by paging the maintenance department. EI #13 reported that maintenance staff did not check the Maintenance Repair Log books often. EI #13 said she has to chase maintenance staff down and indicated she did not know why they were not keeping a check on the Maintenance Repair Log books. On 02/03/2022 at 9:30 AM, an interview was conducted with EI #33, RN. EI #33 reported she began working at the facility in November of 2021. EI #33 reported she did not know where the maintenance log was kept for the G Unit. On 02/03/2022 at 9:35 AM, EI #63, Housekeeper, reported no knowledge of a maintenance log or its location. On 02/03/2022 at 9:36 AM, EI #8, CNA, stated that she reported maintenance problems to the charge nurse. EI #8 further stated there was supposed to be a book on each hall staff could write down any problems/concerns in but indicated she had not seen one on her hall. EI #8 did confirm having knowledge of hot water concerns and indicated the prior week she had reported to the nurse that the water temperatures were too hot. EI #8 was unable to give a specific date, time, or the name of the nurse she reported the issue to. According to EI #8, the nurse had told her they were handling it. On 02/03/2022 at 9:59 AM, EI #61, a CNA, stated she had heard many complaints from residents about the water being too hot initially, then getting cold and not being warm enough. EI #61 stated she had knowledge of the maintenance logs but had not put anything on it yet, noting she had just been telling someone verbally. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/03/2022 at 9:54 AM, EI #4, the Maintenance Director, was asked about the Maintenance Repair Log books. EI #4 said he was unsure where the maintenance logs were located on the A and C Units. EI #4 stated he did not check off on the log until an issue had been resolved/completed. EI #4 stated that they had not checked the log on the A and C Units and could not provide a date they last checked the logs on those halls. ********** The facility submitted an acceptable Removal Plan on 02/05/2022 for F689 that outlined the following: . 1. When the surveyor informed administration that an abnormal temperature was discovered on January 31, 2022, facility staff were immediately notified of the issue and all 87 residents in house were observed for any burns on January 31, 2022 by Nursing Management, with no burns noted. 2. On January 31, 2022, the facility Administrator educated D.O.N., I.C.P. [Infection Control Preventionist] and Maintenance on water temperature policy. On January 31, 2022 the facility D.O.N. and I.C.P. educated Nurses, CNA's, Business Office Manager, Medicaid Specialist, Human Resource Director Environmental Services and Dietary on identification of water temperatures that should be maintained between 100 - 110 degrees F, and the adverse consequences that can be caused to the resident when water temperatures are outside of the normal range. Education also included the Maintenance Log and location of Maintenance Log. Education started on January 31, 2022 and continued through February 3, 2022. All employees not educated on the water temperature policy will be educated by February 4, 2022. Any facility employee not educated on the water temperature policy, maintenance log, location of maintenance, thermometer use and location of thermometer(s) by February 4, 2022, will not be allowed to return to work until education is received. On February 1, 2022, the facility Administrator educated the I.C.P. on the use of thermometers to check water temperatures, and that thermometers will be located in the shower room and all units. Any facility employee(s) not educated by February 4, 2022 on the use of thermometers to check water temperatures and their location, will not be allowed to work their schedule until education is received. The facility Medical Director was also notified on February 3, 2022 of water temperature issues and that none of the 87 in house residents were burned. 3. Maintenance started checking water temperatures on January 31, 2022 throughout the building in all resident bathrooms, showers, nursing station sinks and visitor bathrooms and determined that water temperatures in the noted areas were in excess of 110 degrees F. On January 31, 2022, direct care staff were educated and instructed to provide assistance to residents with hand washing. On February 1, 2022, contractor shut off all hot tempered water. On February 2, 2022, new mixing valve was installed, and hot water turned on to circulate through pipes. Water temperatures on February 2nd and 3rd were noted to be in the range 75 - 114 degrees F throughout the noted areas. On February 4, 2022, water temperatures were check in the noted areas and ranged from 101 - 107 degrees F and continue to be within normal limits. 4. Contractor was called and on site on 1-31-22 to inspect the boiler and identified an issue with the mixing valve. All hot water was turned off on 2-1-22, until the new mixing valve was installed on 2-2-2 [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 14754 Based on observations, interviews, record reviews, and review of the facility's policies titled, Gastric Tube Feeding via Continuous Pump and Administering Medications through an Enteral Tube, the facility failed to ensure Resident Identifier (RI) #80 and RI #67 received services and treatment to prevent complications. Specifically, the facility failed to ensure: 1. RI #80's head of the bed (HOB) was elevated to a level of 30-40 degrees while the tube feeding pump was running and the Registered Nurse (RN) checked RI #80's tube feeding residual before administering medications through the gastrostomy tube (G-tube) and did not use a syringe to force a medication through RI #80's G-tube that had become clogged. In addition, staff failed to clean RI #80's gastrostomy tubing daily with soap and water and put a clean gauze to the site daily as ordered by the physician; and 2. RI #67's HOB was elevated to a level of 30-40 degrees while the tube feeding pump was running. This deficient practice affected RI #80 and RI #67, two out of three sampled residents reviewed for G-tubes. Findings include: A review of the facility's policy titled, Gastric Tube Feeding via Continuous Pump, dated October 2010, revealed, .4. Always keep resident receiving continuous feedings in semi-Fowlers (in semi-Fowlers position, the patient/resident is usually on their back with the bed angle between 30 degrees and 45 degrees) or higher position . A review of the facility's policy titled, Administering Medications through an Enteral Tube, revised October 2010, revealed, 14. Assist the resident to semi or high-Fowler's position (30-40 [degrees sign]) if tolerated by the resident's physical or medical condition .21. Administer medication by gravity flow 1. A review of RI #80's Face Sheet revealed the facility admitted the resident on 05/14/2014 with diagnoses including Alzheimer's Disease, Intellectual Disabilities, and Contractures. A review of RI #80's Care Plan, dated 08/10/2015, revealed the resident had an altered nutritional status, had a feeding tube, and was NPO (took nothing by mouth). A review of RI #80's February 2022 Physician Orders revealed the resident was receiving all nutrition (tube feeding ran 23 hours a day) and medications via the G-tube. Staff were to clean the G-tube with soap and water and apply new gauze daily and as needed, per an order dated 05/26/2021. An observation of RI #80 on 01/31/2022 at 9:20 AM revealed the resident was lying in bed receiving continuous tube feeding. The head of bed (HOB) was measured to be only 16 degrees (utilizing the iGradient application). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Another observation of RI #80 on 02/01/2022 at 1:10 PM revealed the resident lying in bed receiving continuous tube feeding with the HOB elevated to only eight degrees. Employee Identifier (EI) #20, Registered Nurse (RN), stated the resident's HOB should be 30 degrees or more. On 02/02/2022 at 8:10 AM, a medication pass observation was conducted with EI #20 for RI #80's morning medications. The resident's HOB was elevated to only 17 degrees. EI #20 prepared the medications and placed them on the bedside table. Prior to administering the medications, EI #20 turned the tube feeding off and checked for placement. EI #20 was not observed to check for tube feeding residual in the stomach. EI #20 was then observed to administer two open capsules of medications. EI #20 opened the capsules, which contained beads of medication. EI #20 administered the medication beads (mixed with water-the beads did not dissolve), down the G-tube, which clogged the G-tub. EI #20 was observed attempting to force the medication beads down the G-tube by firmly pushing the plunger of the syringe, instead of using gravity flow as directed by the facility policy. After the medication pass, the surveyor asked to observe the resident's G-tube stoma (a surgical opening into the stomach) area. It was found that the split 4 centimeter (cm) x 4 cm gauze that was supposed to be changed daily had not been changed and was dated 01/31/2022, two days prior. The gauze was half covered with a large amount of yellow-green, dried, crusty drainage. EI #20 stated night shift was responsible for changing the gauze out every night. On 02/22/2022 at 10:00 AM, an interview was conducted with EI #2, the Director of Nursing (DON), regarding RI #80's medication pass observations. EI #2 stated expectations included checking for residual and administering medications via gravity flow, not forced with a syringe. EI #2 stated that the split gauze should have been changed on the night shift. 2. A review of RI #67's Face Sheet revealed the facility admitted the resident on 12/22/2020 with diagnoses including Gastrostomy (G-tube) Infection, Dementia, and Sepsis (A serious infectious condition that could result in the malfunctioning of various organs, shock and death.). A review of RI #67's Care Plan, dated 12/22/2020, revealed the resident had an altered nutritional status, had a feeding tube (gastrostomy tube/G-tube), and was NPO (took nothing by mouth). A review of RI #67's February 2022 Physician Orders revealed the resident was receiving all nutrition (tube feeding ran 23 hours a day) and medications via the G-tube. An observation of RI #67 on 02/01/2022 at 9:10 AM revealed the resident's tube feeding pump was running, but the HOB was not elevated. The HOB was measured to be only 25 degrees (using the iGradient application). The surveyor asked RI #67's nurse, EI #33, a Registered Nurse, what the resident's HOB should be elevated to. EI #33 was not sure what the facility's policy was but stated they would check and get back with the surveyor. On 02/01/2022 at 1:13 PM, EI #33 returned to the surveyor and stated they had found the tube feeding policy which revealed the resident's HOB should be kept at 30-45 degrees. EI #33 stated the nurse aides had probably not raised the resident's HOB high enough earlier. The surveyor and EI #33 then followed-up with EI #29, the Certified Nursing Assistant (CNA) assigned to RI #67. EI #29 was asked how high a resident's HOB should be when receiving tube feeding. EI #29 stated she knew it was supposed to be raised, but was not sure how much. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/03/2022 at 12:00 PM, an observation of RI #67 revealed the resident's HOB was only 18 degrees. The surveyor identified the CNAs caring for the resident at the time, EI #32 and EI #48. An interview with EI #32 and EI #48 revealed both knew RI #67's HOB should be elevated 30 degrees or more. However, when asked how they are able to tell if the bed is elevated enough, they indicated they just 'eye' it. They indicated some of the beds have a gauge under them to indicate the elevation of the HOB, but after looking at RI #67's bed, said it did not have a gauge. On 02/06/2022 at 10:15 AM, an interview with EI #2, Director of Nursing, revealed it was expected that the facility nursing staff follow the policy and procedure and ensure residents on tube feedings had their HOB elevated from 30 to 45 degrees to prevent aspiration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14754 Based on observation, interviews, and record review, the facility failed to ensure Resident Identifier (RI) #139 received Gabapentin (Neurontin) as ordered, due to not having the medication available for administration. This failure affected one out of five sampled residents reviewed for pain management. Findings include: RI #139 was admitted to the facility on [DATE] with diagnoses of Anxiety Disorder, Chronic Migraine, and Fracture of the Medial Wall of Right Acetabulum (pelvis). A review of RI #139's Care Plan, dated 01/20/2022, revealed the resident was at risk for pain related to a recent hospitalization , generalized weakness, and recent hip fracture. To control the resident's pain level, staff were to assess the resident's pain level and provide medications as ordered by the physician. A review of RI #139's admission Minimum Data Set (MDS) assessment, dated 01/27/2022, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which revealed intact cognition. This assessment also indicated RI #139 reported having pain frequently at a pain level of 4 out of 10. A review of RI #139's Physician's Orders, dated 01/22/2022, revealed orders for Gabapentin 300 mg (milligrams) twice a day for pain. An observation conducted on 02/03/2022 at 2:45 PM revealed RI #139 sitting in the hallway by the medication cart. RI #139 reported to the surveyor he/she had not received their Gabapentin medication in days. On 02/03/2022 at 3:00 PM, a review of RI #139's Medication Administration Record (MAR) was conducted with the resident's Registered Nurse, Employee Identifier (EI) #33. The resident was scheduled to receive Gabapentin 300 mg at 9:00 AM and 5:00 PM. It was found that the resident's Gabapentin 300 mg dose had been missed for the following days: - On 02/01/2022, the 9:00 AM dose was documented on the MAR as given by EI #33, but the nurse admitted documenting giving it in error because the medication was not available. The 5:00 PM dose was documented N, which indicated the medication was not given. - On 02/02/2022, the 9:00 AM dose was documented on the MAR as given by EI #33, but the nurse admitted documenting giving it in error because the medication was not available. The 5:00 PM dose was documented N, which indicated the medication was not given. - On 02/03/2022, the 9:00 AM dose was documented on the MAR as given by EI #33, but the nurse admitted documenting giving it in error because the medication was not available. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further interview with EI #33 on 02/03/2022 at 3:00 PM revealed the resident's Gabapentin was not available. EI #33 was asked if the facility had an emergency kit (E-kit) for medication availability. EI #33 knew about an E-kit in the medication room, but said it was for regular medications and not narcotics or scheduled drugs. On 02/03/2022 at 3:15 PM, an interview was conducted with EI #2, Director of Nursing (DON), and EI #11, Infection Preventionist/Staff Development, about a narcotic E-kit. EI #1 and EI #11 both stated the facility did have a narcotic/controlled substance E-kit, and it was kept on EI #33's mediation cart. EI #11 went to the unit and showed EI #33 that the narcotic E-kit had been on the nurse's medication cart locked in the narcotic drawer the entire day, which contained Gabapentin 300 mg capsules available to administer to the resident. EI #11 confirmed that none of the Gabapentin medication was taken out of the E-kit to administer to the resident. On 02/04/2022 at 6:33 PM, a telephone interview was conducted with EI #47, Consultant Pharmacist. EI #47 stated the pharmacy provided narcotic and routine medication E-kits for the facility to ensure they had medications on hand. EI #47 stated that Gabapentin was a medication that was typically in the E-kit and available to give if the prescription refill was delayed. Per EI #47, all staff had to do was call the pharmacy, notify them they were removing the medication from the E-kit, get a code, open the box, retrieve the medication, and administer it to the resident. Per EI #47, the pharmacy monitored the removal of medication from the E-Kits and restocked/refilled the E-kits as supplies depleted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14754 Based on observation, interview, record review, and review of a facility policy titled, End-Stage Renal Disease, Care of a Resident with, the facility failed to ensure Resident Identifier (RI) #140 received care and services related to dialysis that were consistent with professional standards. This deficient practice affected RI #140, one of two residents sampled for dialysis care and services. Findings included: On 02/01/2022, a copy of the facility's dialysis policy was requested. The nursing department provided the facility's policy, titled, End-Stage Renal Disease, Care of a Resident with, dated September 2010. The policy did not specifically indicate how the facility was to provide care and services to residents receiving dialysis. The policy only mentioned, The resident's comprehensive care plan will reflect the resident's needs related to ESRD [end-stage renal disease]/dialysis care. A review of RI #140's Face Sheet, dated 02/04/2022, revealed the resident was admitted to the facility on [DATE] with diagnoses of Hyperglycemia and Acute Pain Due to Trauma. Observation of RI #140 on 01/31/2022 at 9:10 AM revealed the resident was sitting in bed with their shirt off. The resident had what appeared to be a central catheter (intravenous port) in their right upper chest. The catheter was covered with a 4 centimeter (cm) x 4 cm gauze which was partially covered in dry blood. The gauze was not dated. Observation of RI #140 on 02/01/2022 at 8:55 AM revealed the resident was sitting in bed without wearing a shirt. The central catheter in the right upper chest was still covered by the undated 4 cm x 4 cm gauze that had the same dried blood stain as the day before. On 02/01/2022 at 11:07 AM, a review of RI #140's clinical record revealed no physician's order for a central catheter. A review of RI #140's care plan revealed it made no mention of the central catheter or the care and services needed for the catheter. On 02/01/2022 at 1:15 PM, an interview was conducted with RI #140's nurse, Employee Identifier (EI) #33, Registered Nurse (RN). EI #33 was asked about the resident's central catheter. EI #33 stated the resident was a dialysis resident, and the catheter was used for dialysis. Per EI #33, the resident went to dialysis every Tuesday, Thursday, and Saturday. EI #33 did not know what type of central line the resident had, nor did the nurse know what type of care the catheter required. EI #33 reviewed the resident's clinical record and was unable to find a physician's order for dialysis, for the central catheter (permacath; tunneled hemodialysis catheter), or for permacath care. On 02/01/2022 at 1:34 PM, an interview was conducted with EI #2, Director of Nursing. EI #2 reported the resident was receiving dialysis but was not sure what type of central line the resident had. In a follow up interview on 02/01/2022 at 1:44 PM, EI #2 stated the resident had a permacath for dialysis. EI #2 was in the process of getting orders for dialysis and developing a care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/01/2022 at 4:10 PM, an interview was conducted with EI #3, Regional Nurse. EI #3 was asked about expectations when a resident needing dialysis was admitted to the facility. EI #3 stated the expectation was for RI #140 to be assessed from head to toe when admitted , which would have led to identification of the permacath. A care plan should have been developed within 48 hours. EI #3 noted that orders should have been obtained for the permacath care and dialysis. Per EI #3, EI #2 called the dialysis center and they told her the facility would need to have an order to change the dressing if it was soiled between dialysis days. On 02/01/2022 at 4:20 PM, another interview was conducted with EI #2. EI #2 stated when RI #140 was admitted , part of the admission paperwork was completed by EI #2 and part of the paperwork was completed by EI #35, RN. Since the admission was split between the two nurses, obtaining orders for dialysis, the permacath, and developing a care plan for dialysis care was missed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 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** 14754 Based on observation, interview, and record review, the facility failed to ensure medications were available for administration as ordered by the physician for Resident Identifier (RI) #139, one of five sampled residents reviewed for medication availability. Findings include: RI #139 was admitted to the facility on [DATE] with diagnoses of Anxiety Disorder, Chronic Migraine, and Fracture of the Medial Wall of Right Acetabulum (pelvis). A review of RI #139's admission Minimum Data Set (MDS) assessment, dated 01/27/2022, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which revealed intact cognition. A review of RI #139's Physician's Orders, dated 01/22/2022, revealed orders for Gabapentin 300 mg (milligrams) twice a day for pain. There was also an order dated 01/31/2022, for Xanax 0.25 (anti-anxiety medication) milligrams (mg) one tablet twice a day as needed for anxiety due to Anxiety Disorder. An observation conducted on 02/03/2022 at 2:45 PM revealed RI #139 sitting in the hallway by the medication cart. RI #139 reported to the surveyor he/she had not received their Gabapentin medication in days. At this time, RI #139 also stated facility staff had informed them earlier that morning that their Xanax medication was not available. On 02/03/2022 at 3:00 PM, a review of RI #139's Medication Administration Record (MAR) was conducted with the resident's Registered Nurse, Employee Identifier (EI) #33. The resident was scheduled to receive Gabapentin 300 mg at 9:00 AM and 5:00 PM. It was found that the resident's Gabapentin 300 mg dose had been missed for the following days: - On 02/01/2022, the 9:00 AM dose was documented on the MAR as given by EI #33, but the nurse admitted documenting giving it in error because the medication was not available. The 5:00 PM dose was documented N, which indicated the medication was not given. - On 02/02/2022, the 9:00 AM dose was documented on the MAR as given by EI #33, but the nurse admitted documenting giving it in error because the medication was not available. The 5:00 PM dose was documented N, which indicated the medication was not given. - On 02/03/2022, the 9:00 AM dose was documented on the MAR as given by EI #33, but the nurse admitted documenting giving it in error because the medication was not available. Further review of RI #139's MAR revealed the last doses of Xanax had been administered on 02/01/2022 and 02/02/2022. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further interview with EI #33 on 02/03/2022 at 3:00 PM revealed the resident's Gabapentin and Xanax were not available. EI #33 was asked if the facility had an emergency kit (E-kit) for medication availability. EI #33 knew about an E-kit in the medication room, but said it was for regular medications and not narcotics or scheduled drugs. Review of RI #139's Controlled Drug Record (a separate record for signing out narcotics and listing current counts) for the Xanax revealed the facility received 14 tablets of RI #139's Xanax on 01/24/2022, with the last one signed out as given on 02/02/2022. Review of RI #139's :Controlled Drug Record for the Gabapentin revealed the facility had received 14 capsules of RI #139's Gabapentin from the pharmacy on 01/24/2022, with the last capsule signed out on 01/31/2022, leaving no further doses available until the pharmacy delivered it again. This record also indicated RI #139 had 46 capsules remaining on their prescription. Per the Controlled Drug Record for the next Gabapentin delivery, the facility did not have RI #139's Gabapentin available to give until later in the day on 02/03/2022. On 02/03/2022 at 3:15 PM, an interview was conducted with EI #2, Director of Nursing (DON), and EI #11, Infection Preventionist/Staff Development. EI #1 and EI #11 both stated the facility did have a narcotic/controlled substance E-kit, and it was kept on EI #33's mediation cart. EI #11 went to the unit and showed EI #33 that the narcotic E-kit had been on the nurse's medication cart locked in the narcotic drawer the entire day, which contained Gabapentin 300 mg capsules and Xanax 0.25 mg tablets available to administer to the resident. EI #11 confirmed that none of the Gabapentin medication was taken out of the E-kit to administer to the resident. EI #11 also confirmed that no Xanax had been removed from the E-kit for the resident since 01/21/2022. On 02/04/2022 at 6:33 PM, a telephone interview was conducted with EI #47, Consultant Pharmacist. EI #47 stated the pharmacy provided narcotic and routine medication E-kits for the facility to ensure they had medications on hand. EI #47 stated that Gabapentin was a medication that was typically in the E-kit and available to give if the prescription refill was delayed for any reason. Per EI #47, all staff had to do was call the pharmacy, notify them they were removing the medication from the E-kit, get a code, open the box, retrieve the medication, and administer it to the resident. Per EI #47, the pharmacy monitored the removal of medication from the E-Kits and restocked/refilled the E-kits as supplies depleted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14754 Based on observations, interviews, record reviews, and review of facility policies titled, Administering Medication through an Enteral Tube, Administering Oral Medications, Insulin Administration, and review of the manufacturer's instructions for the Novolog insulin pen, the facility failed to maintain a medication error rate less than 5%. There were seven errors in 29 opportunities, which resulted in a 24% medication error rate for Resident Identifier (RI) #43, RI #78, and RI #80, three of four residents observed during medication pass. Specifically, the facility failed to ensure: 1. RI #80, who received medications via gastrostomy tube (G-Tube), was given complete doses of Calcitriol, Cymbalta and Prilosec as ordered by the physician. In addition, staff failed to dilute a liquid potassium chloride dose prior to administration; 2. RI #43 received a physician-ordered dose of D2 (vitamin) and did not receive the wrong dose of an albuterol inhaler; and 3. RI #78 was not administered sliding scale insulin via an insulin pen, not in accordance with the manufacturer's instructions to ensure an accurate dose of insulin. These failures had the potential to affect RI #43, RI #78, and RI #80, three of four residents observed during medication administration. Findings included: A review of the facility's policy titled, Administering Medication through an Enteral Tube, dated October 2010, revealed, .The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube .1. Request liquid forms of medications from the pharmacy, if possible . A review of the facility's policy titled, Administering Oral Medications, dated October 2010, revealed, .The purpose of this procedure is to provide guidelines for the safe administration for oral medications .1. Verify that there is a physician's medication order for this procedure .8. Check the medication dose. Re-check to confirm the proper dose . 1. RI #80 was readmitted to the facility on [DATE] with diagnoses including Dementia, Intellectual Disabilities, and Gastro-Esophageal Reflux Disease. A review of RI #80's February 2022 Physician Orders, revealed the resident had a G-Tube in which all of the resident's medications were ordered to be administered. Orders included the following: Calcitriol 0.25 mcg (micrograms) capsule via G-tube, Cymbalta 60 mg (milligrams) capsule via G-tube, and Prilosec DR 20 mg capsule via G-tube. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/02/2022 at 8:10 AM, Employee Identifier (EI) #20, a Registered Nurse (RN), was observed during medication administration for RI #80 via G-tube. EI #20 was utilizing a 60-cc (cubic centimeter) syringe with gravity flow. EI #20 was observed to dispense a Calcitriol 0.25 mcg gel capsule by cutting the top off the capsule and squeezing the contents of the capsule into a medication cup to administer down the G-tube. The nurse was asked if anyone had asked the physician or pharmacist about an alternate medication that could more accurately and easily be administered via the G-tube. The nurse's response was they just administered the medication that was ordered by the doctor. It was noted that the nurse struggled to squeeze the gel capsule and get all the medication from the capsule. Thus, it was an inaccurate administration of the medication. EI #20 then dispensed potassium chloride liquid (20 milliequivalents/15 milliliters [ml]) 15 ml to administer to RI #80. On the outside of the bottle, it revealed the liquid should be diluted. A review of the prescription label on the bottle revealed it was to be diluted with 4 ounces of water. EI #20 was observed to begin pouring the potassium chloride down the resident's G-tube when the surveyor asked if it needed to be diluted, and EI #20 said no. EI #20 continued to pour the undiluted medication down the G-tube, meanwhile commenting, Honey, it's just like a pill. The nurse failed to follow the manufacturer's recommendation and prescription instructions to dilute the medication prior to administration. EI #20 was observed to open the Cymbalta 60 mg capsule and the Prilosec DR 20 mg capsule. The inside of the capsules were medication beads. EI #20 mixed each opened capsule (beads) with a small amount of water, but they did not dissolve. The nurse administered the opened capsules (beads) and water down the G-tube. After administering the beads of Cymbalta and Prilosec, the G-tube was observed to become clogged. The medications and water flushes would not go down the tube via gravity flow. EI #20 then took the plunger of the syringe and tried to forcibly push the medication beads down the G-Tube. When doing so, the tip of the syringe dislodged from the G-tube port, and multiple beads of Cymbalta and Prilosec sprayed all over the resident's abdomen and sheets. The resident did not receive the full doses of Cymbalta and Prilosec. After the medication pass and reconciliation, a follow-up interview was conducted with EI #20 on 02/02/2022 at 9:55 AM. When asked if the physician had been notified that the resident did not receive the full doses of Calcitriol, Cymbalta, and Prilosec, the nurse admitted to not calling the physician. On 02/02/2022 at 10:00 AM, EI #2, the Director of Nursing (DON), was notified of the medication concerns and errors observed during RI #80's medication pass. EI #2 stated all the medications should be appropriate to be administered down the G-tube and if not, the nurse should have called the physician. 2. A review of RI #43's Face Sheet, dated 02/04/2022, revealed the resident had diagnoses including Chronic Kidney Disease, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease. On 02/02/2022 at 9:34 AM, EI #24, RN, was observed during medication administration for RI #43's morning medications. The observation revealed the resident received an Albuterol HFA (the type of propellant in the inhaler) 90 mcg inhaler dose. EI #24 shook the inhaler and handed it to the resident, instructing the resident to take two puffs of the medication, which the resident completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/02/2022 at 10:15 AM, reconciliation of medication pass was completed with EI #24. A review of RI #43's Physician Orders revealed the resident was to receive Albuterol HFA 90 mcg inhaler (ordered by the physician on 01/04/2022), one puff, not two puffs, which had been administered. The resident was also supposed to receive Vitamin D2 2000-unit tablet which was ordered by the physician on 01/05/2022, which was omitted. An interview with EI #24 at the time revealed the nurse did not realize the Albuterol inhaler was just one dose, and the nurse admitted mistakenly missing the Vitamin D2 dose. 3. A review of the facility's policy titled, Insulin Administration, dated October 2010, revealed generalized insulin administration instructions for nursing staff. The policy did not give specific guidance on how nursing staff were to utilize insulin pens. A review RI #78's Face Sheet, dated 02/04/2022, revealed the resident was admitted on [DATE] with diagnoses of Diabetes Mellitus. A review of RI #78's Physician Orders, dated 12/07/2021, revealed the resident was to have sliding scale Novolog insulin twice a day dependent upon blood sugar glucometer readings. On 02/02/2022 at 5:20 PM, Employee Identifier (EI) #23, Licensed Practical Nurse, was observed to check the resident's blood sugar. The resident's blood sugar was 265. A review of the resident's Physician Orders, dated 12/07/2021, revealed the resident was to receive nine units of Novolog insulin for a blood sugar of 251-300. The observation of the administration of the Novolog insulin revealed EI #23 obtained the Novolog insulin pen, dialed the pen to 9 units, administered the insulin into the resident's abdomen, and left the insulin pen needle in the abdomen for approximately 2-3 seconds before removing the needle. An interview with EI #23 at the time revealed the nurse did not believe the insulin pen needed to be air shot (air bubbles removed) prior to dialing the nine units. When asked about the time required to keep the needle in the skin, EI #23 stated that Novolog pens only required a three-second hold time. On 02/02/2022 at 5:30 PM, reconciliation of medication was completed with a review of the Novolog manufacturer's instructions for the insulin pen. It was found that the pen EI #23 used required a 2-unit air shot before each injection to ensure air in the syringe was expelled prior to administering the injection. The manufacturer's instructions further revealed that the nurse should have kept the needle in the skin for at least six seconds to ensure that the full dose has been given. On 02/02/2022 at 5:30 PM, an interview was conducted with EI #2, the Director of Nursing (DON), regarding the medication pass observation concerns and errors. EI #2 stated the Novolog insulin pen required an air shot and a needle hold time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 14754 Based on observations, interviews, and review of a facility policy titled, Storage of Medications, the facility failed to label and store medications in three of three medication carts and failed to ensure medications were secured in medications carts in accordance with acceptable principles. Specifically, staff failed to label medications upon opening with an open date and expiration date, and failed to ensure the G Unit medication cart did not contain loose pills inside the drawers. This was observed with opened medications belonging to 10 out of 89 residents in the facility. Findings include: A review of the facility's policy titled, Storage of Medications, dated April 2007, revealed: .The facility shall store all drugs and biologicals in a safe, secure, and orderly manner The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner .The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals .Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use .Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems . On 02/02/2022 at 11:20 AM, medication storage observation was conducted on the D Unit medication cart, accompanied by Employee Identifier (EI) #24, Registered Nurse (RN). The medication cart was found to contain the following: -RI #14's NovoLog insulin vial was opened and not dated, only good 28 days after opening. -RI #15 had two NovoLog insulin vials opened and not dated, only good 28 days after opening. -RI #15 had a Lantus insulin pen opened and not dated, only good 28 days after opening. -RI #79 had a Lantus insulin pen opened and not dated, only good 28 days after opening. -RI #48 had a NovoLog insulin pen opened and not dated, only good 28 days after opening. -RI #20 had a Lantus insulin pen opened and not dated, only good 28 days after opening. -RI #24 had a Breo inhaler opened and not dated, only good for 28 days after opening. -RI #4 had ipratropium albuterol nebulizer ampules with foil packaging opened and not dated, only good for two weeks after opening. An interview with EI #24 revealed the nurse was not aware that the ampules had a limited shelf life after the foil package was opened. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/02/2022 at 1:25 PM, medication storage observation was conducted on the E Unit medication cart, accompanied by EI #33, RN. The medication cart was found to contain the following: -RI #22 had a Lantus insulin pen and a Novolog vial, both opened and undated, good for 28 days after opening. -RI #21 had a Levemir insulin pen opened and not dated, good for 42 days after opening. -RI #78 had a Novolog vial opened and undated, good for 28 days after opening. On 02/02/2022 at 1:35 PM, medication storage observation was conducted on the G Unit medication cart, accompanied by EI #33. The medication cart was found to contain the following: -The drawers of the medication cart had multiple loose white tablets. EI #33 was unsure what the medication was or how it had gotten dumped into the drawers of the medication cart. -There was a bottle of Prostat protein supplement which had been opened and not dated, only good for three months after opening. EI #33 did not realize the bottle needed to be dated or that it had a limited shelf life after being opened. On 02/02/2022 at 1:53 PM, an interview was conducted with EI #2, the Director of Nursing (DON). Per EI #2, all insulins should be dated when opened EI #2 further stated that pharmacy staff would come out and audit medication carts for any concerns needing to be addressed, but EI #2 could not recall how often or when they were last audited.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 26764 Based on observations, interviews, review of the Food and Drug Administration (FDA) Food Code, and review of the facility's policies titled, Food: Preparation, Food Storage: Dry Goods, Food Storage: Cold Foods, Dispose of Garbage and Refuse, Warewashing, and Proper Hand Hygiene: Dining Services Employees, the facility failed to ensure: 1) one item was properly labeled and dated, and two items were used or disposed of by date on package; 2) five boxes of food were stored off the walk-in freezer floor; 3) soap was available for staff to wash hands at the only handwash sink in the kitchen; 4) opened bags of food in dry storage were closed, labeled, and dated; 5) the floor and shelves in dry storage are were clean from foods; 6) sanitizing buckets contained the appropriate concentration of sanitizer for cleaning the kitchen; 7) kitchen staff maintained clean and dirty areas in the dishwasher area to prevent contamination of clean dishes with unclean gloved hands; and 8) the dishwasher contained chemicals needed for washing and sanitizing the dishes. This had the potential to affect all residents who received meals from the kitchen. Findings included: 1) A review of a facility policy titled, Food: Preparation, with a revised date of 09/2017, revealed, .All TCS (Time/Temperature Control of Safety) food that are to be held for more than 24 hours at a temperature of 41 degrees Fahrenheit or less, will be labeled and dated with a prepared date (Day 1) and a use by date (Day 7) . On 01/31/2022 at 8:54 AM, Employee Identifier (EI) #41, Certified Dietary Manager (CDM), accompanied the surveyor during the initial tour of the kitchen. In the walk-in cooler, the surveyor and EI #41 observed the following: (1) a bag containing ham with no label to indicate the use-by date; (2) a bag with hamburger steak dated 01/30/2022; and (3) a bag of chicken patties dated 01/29/2022. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview with EI #41 was conducted at 8:54 AM on 01/31/2022. EI #41 was asked if those items should be in the walk-in refrigerator and the reply was no. EI #41 immediately took the bags and threw them in the garbage. EI #41 said that probably over the weekend, staff had not checked dates on the refrigerated items. 2) A review of the facility policy titled, Food Storage: Cold Foods, revised 04/2018, noted that All food items will be stored at least 6 inches above the floor and 18 inches below the sprinkler unit. On 01/31/2022 at 8:54 AM, Employee Identifier (EI) #41 accompanied the surveyor during the initial tour of the kitchen, which included the walk-in freezer. A box of frozen breaded fish was found sitting directly on the freezer floor. EI #41 stated that the food should not be on the floor and moved it onto a crate to get it off the floor. On 02/04/2022 at 11:13 AM, during a return visit to the kitchen, the surveyor found a box of thawed and refrozen ice cream on the floor of the walk-in freezer. A box of biscuits that had burst open was found on the freezer floor. An unopened box of Mighty Shakes (supplements) and potatoes were also on the freezer floor. Two additional boxes of frozen foods were noted to be stacked on top of the frozen supplements. EI #42, Dietary Cook, took the box of biscuits and ice cream to the outside dumpster. EI #42 stated that those items should not have been on the floor. 3) A review of the policy dated (revised) 09/2017, titled, Food: Preparation, began with, .All staff will practice proper hand washing techniques and glove use . On 02/04/2022 at 10:40 AM, the surveyor found that the only handwashing sink in the kitchen contained no soap in the soap dispenser. EI #42 was unaware that it was empty and contacted housekeeping to replace the soap in the dispenser. Employee Identifier (EI) #43, a Certified Dietary Manager from a sister facility, stated that the soap dispenser should never be empty. 4) A review of the facility policy titled, Food Storage: Dry Goods, revised 09/2017, stated that .All packaged and canned food items will be kept clean, dry and properly sealed . It also stated that it would be .date marked as appropriate . On 02/04/2022 at 12:43 PM, a plastic bag containing dry cereal was observed in the dry storage area with no label to indicate open date or use-by date, and the plastic bag was open. EI #42 stated that the bag should have been closed and labeled. 5) The surveyor noted on 02/04/2022 at 12:43 PM that there was dry cereal on three of the shelves and also on the floor in various areas of the dry storage room. EI #43 stated on 02/04/2022 at 1:20 PM that food should not be on the floor because it could attract rodents and pests. 6) On 02/04/2022 at 1:09 PM, the surveyor asked EI #42 to check the concentration of the chemicals in the sanitizing bucket in the food preparation area and at the three-compartment sink. The bucket under the food prep table was found to be at 150 parts per million (ppm), and EI #42 stated it should be at least 200 ppm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7) A review of the policy titled, Warewashing, which had been revised on 09/2017, stated that the .Dining Staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine and proper handling of sanitized dishware . On 02/04/2022 at 1:38 PM, Employee Identifier (EI) #44, Dietary Aide, washed their hands and donned gloves to begin washing dishes. EI #44 stated that usually it was their responsibility to empty the dirty trays but that day they would be filling the empty trays with dirty dishes and running them through the dishwasher. EI #44 took one of the trays and filled it with dirty cups from lunch. When it was full, EI #44 pulled it into the dishwasher and started the cycle and then started filling the next tray with dirty dishes. When the first load was washed and rinsed, EI #44 opened the dishwasher and pulled the clean tray of dishes with their dirty (gloved) left hand. EI #44 then continued placing dirty dishes in the next tray to be washed. When that tray was full, EI #44 pulled it into the dishwasher and pulled the handle down to begin the wash cycle. After the dishwasher had completed the two trays of dishes, the surveyor asked EI #44 about using the dirty gloved hand to remove the clean tray of dishes. EI #44 stated that it was not their usual job to fill the dishwasher, but to empty dirty dishes as they were returned from the residents. EI #43, the certified Dietary Manager from a sister facility, stated that staff needed to keep clean dishes clean and not touch them with dirty hands, or gloved hands, because the gloves are dirty. 8) During an observation on 02/04/2022 at 1:38 PM, as EI #44 and EI #43 were washing dishes with the dishwasher, the surveyor asked EI #44 how often the dishwasher sanitizing solution was checked, and EI # 44 promptly answered during each meal. When asked if it could be checked at that time, EI #44 asked EI #43 to test with the strips. EI #43 came over to the dishwasher to retrieve the strips and then tried to test in the water below the rack when the lid was open and the strip did not change colors. So EI #43 tried another strip on the dishes which had just been washed and were still wet, and there was no change in color. EI #43 then told the surveyor that the machine was different than the one at the facility where EI #43 usually worked. EI #43 then made a telephone call to EI #41 and found that the correct place to check the water was below where the water was released from the dishwasher. After checking a strip in that location, there was still no change in the color of the strip. EI #43 moved the chemical buckets under the dishwasher and found that the bucket containing the sanitizing agent was empty.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 43016 Based on interviews and review of the facility's, Administrator Job Description, administration failed to provide training and oversight to ensure the facility was free from the potential for injury related to identified concerns regarding elevated hot water temperatures. During the survey, the survey team identified hot water temperatures throughout all residential units/wings of the facility, including the Dementia Unit, that exceeded 110 degrees Fahrenheit (F). Temperatures were found to be as high as 145 degrees F in resident bathroom sinks, as well as resident shower rooms. This deficient practice placed all 89 residents in the facility in immediate jeopardy (IJ), as it was likely to result in serious injury, serious harm, serious impairment, or death. On 02/03/2022 at 1:03 PM, Employee Identifier (EI) #1, Administrator, was notified of the findings of IJ in the area of Administration/F835. Findings include: During the survey, concerns were identified with hot water temperatures in excess of 110 degrees Fahrenheit (F). Hot water temperatures exceeding 110 degrees F were noted on all residential wings/units of the facility, including the Dementia Unit, despite prior staff knowledge about water temperature concerns. In addition, it was determined facility staff were not implementing the facility's system for reporting identified concerns requiring Maintenance intervention, nor was Maintenance staff consistently monitoring and addressing reported concerns related to hot water temperatures. Cross Reference F689 and F908. A review of the facility's Administrator Job Description, dated 06/01/2017, revealed: .Summary .Lead and direct the overall operation of the facility in accordance with resident needs, government regulations and Company policies so as to maintain care for the residents while achieving the facility's business objectives . On 02/01/2022, a review of the facility's maintenance staff members EI #4's (Maintenance Director) and EI #5's (Maintenance Assistant) personnel and training files was conducted. A review of competency documentation revealed maintenance staff received no specific training for water temperature monitoring to protect residents. A review of EI #4's and EI #5's job descriptions, which were signed by the staff members, revealed they would be responsible to conduct preventive maintenance, including keeping facility logs of water temperatures. EI #4 and EI #5's signed job descriptions also indicated their Supervisor was EI #1, the facility Administrator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/01/2022 at 12:20 PM, an interview was conducted with EI #1, the Administrator, regarding orientation for maintenance staff. EI #1 stated that the maintenance staff received general orientation like all employees. EI #1 was not aware of specific maintenance competency check-offs or requirements. EI #1 stated that most of the training was on-the-job training with another maintenance supervisor or regional maintenance staff. On 02/02/2022 at 3:24 PM, EI #1 was asked what prompted work on the facility's boiler on 01/10/2022. EI #1 stated a potential problem had been noticed with the heat (air heating system), noting a contractor had been called to work on it. EI #1 stated the boiler operated both the heating and water systems. EI #1 stated he then called another contractor on 01/21/2022 and this contractor installed a new part. EI #1 stated someone said something about the water temperature around that same time, but he could not remember who. EI #1 stated the person who may have first mentioned the hot water was EI #11, Staff Development, but he was not sure. EI #1 stated they checked and did not find issues, so they went on as usual. EI #1 stated they did not have logged temperature monitoring for a week, which he noted he should have caught. EI #1 was asked what temperature could cause a burn, and he stated, 110 [degrees F]. EI #1 was asked if the facility's water temperatures had exceeded 110 degrees F. EI #1 stated, yes, that has been identified. EI #1 acknowledged they had a hiccup in the facility's system of monitoring and acting upon hot water temperatures. During this same interview, EI #1 was asked to describe maintenance staff training. EI #1 stated maintenance staff went through orientation. EI #1 stated EI #6, the Regional Life Safety Director, assisted with some of the maintenance training and was available by phone to answer any questions. EI #1 stated EI #14, the Corporate Environmental Life Safety Administrator, had now begun to assist with some of the training. EI #1 stated the maintenance staff had changed more than once since he started at the facility in April or May of 2021. EI #1 described how it was difficult to find people who knew how to work on boiler systems. EI #1 stated EI #4 was maintenance savvy but was not a boiler expert, so the facility relied on outside help. EI #1 stated they had no boiler-certified person on staff and were limited on the training that could be provided about boilers. EI #1 acknowledged training could be better, but indicated staff turnover made training difficult. EI #1 stated nursing homes were not the easiest place to work, and people got tired of being called on the weekends. During the same interview, EI #1 was asked if there was a check-off list used when training maintenance staff that included the things they would be responsible for. EI #1 stated EI #4 was an MDS nurse prior to taking the maintenance position and was aware of a lot of protocols for long-term care. EI #1 stated EI #4 had expressed an understanding of what needed to be done, but he had not had any help until about one week ago. EI #1 stated EI #5 was hired as a Maintenance Assistant about one week prior. He stated he had not had any time to spend with EI #5 yet. During the same interview, EI #1 was asked if he did environmental rounds himself. EI #1 stated most of the rounds were conducted informally. EI #1 stated he would get a notebook and pen, grab a maintenance person, and hit the floor. EI #1 stated they were not formal-type rounds and were not officially documented anywhere. During the same interview, EI #1 was asked what was on the top of the list that EI #4 was working on before the survey team entered. EI #1 stated the list could change day to day and was just whatever was needed for him to do, including blowing off debris from the parking lot or looking at the smoking area. EI #1 stated EI #4 had been there a month, running around by himself, and had to do a lot of things on his own. EI #1 stated EI #4 had not had help. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During the same interview, EI #1 was asked how he provided oversight to the maintenance staff. EI #1 replied, in morning meetings. EI #1 stated he asked maintenance if their logs (Maintenance Repair Logs) were up to date, but indicated he did not ask them to bring the logs with them each day for him to review. EI #1 stated if he had inspected the Maintenance Repair Logs, he would have known about the hot water temperatures. EI #1 stated that at the end of the day, 'the buck stopped' with him. EI #1 stated he needed to look at logs daily or establish a system to review the logs weekly or biweekly. ********** The facility submitted an acceptable Removal Plan on 02/05/2022 for F835 that outlined the following: . 1. On January 31, 2022, when the surveyor informed administration that an abnormal temperature was discovered, contractor was immediately notified to inspect the boiler. 2. Contractor was called on 1-31-22 to inspect the boiler and identified an issue with mixing valve. On 2-1-22, hot water to the facility was turned off and remained off until a new mixing valve was installed on 2-2-22. No further issues noted with excessive hot water temperatures in resident bathroom, showers, nursing station sinks and visitor bathrooms. 3. On January 31, 2022, Administrator instructed Maintenance staff to immediately check water temperatures in resident bathrooms, showers, nursing station sinks and visitor bathrooms, and identified additional abnormal water temperatures. At that time, the administrator educated Maintenance staff on correct water temperatures that should range between 100 - 110 degrees F. The Regional Environmental Director educated Administrator and Maintenance staff on monitoring water temperatures February 4, 2022. The Regional Environmental Director also educated on water temperature logs, maintenance logs, follow up of monitoring water temperatures and prioritization of entries in Maintenance Repair Log on February 4, 2022. Maintenance will also bring Repair Log to the daily morning meeting for review beginning February 4, 2022 for 60 days. 4. Maintenance will assess and do water temperature audits on 1 different unit weekly. The Regional Environmental Director will come to the facility 1 x per week for 2 months and 1 x per month for 3 months to provide oversight to Maintenance Department, education, checking water temperatures, reviewing the Maintenance Repair Log and inspection of boiler. The likelihood and/or potential of injury to all 87 in house residents began to be negated on January 31, 2022 r/t [related to] staff education on water temperatures policy along with additional education that included use and location of thermometers to check water temperatures, Maintenance Repair Log, and location of Maintenance Log on February 1, 2022 that will continue until all facility staff are educated by February 4, 2022. After this date, staff will not be allowed to work their schedule until education is completed. Member of Governing Body met with Administrator and is in agreement with the steps of the removal plan on February 4, 2022. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/06/2022 at 6:30 PM, after review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations of safe hot water temperatures in the facility, the survey team determined the facility implemented the immediate corrective actions as of 02/04/2022 and the scope and severity was lowered to an F level, to allow the facility time to further address and monitor the deficient practice in order to achieve compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43016 Based on observations, interviews, review of a facility policy titled, Water Temperatures, Safety Of, review of facility Maintenance Repair Log sheets, and review of facility Water Temp Log Sheet documents, the facility failed to monitor and maintain the water heating/boiler system in safe operating condition to prevent hazardous hot water temperatures. Water temperatures were observed in excess of 110 degrees Fahrenheit (F) on all residential wings/units of the facility, including the Dementia Unit. Temperatures as high as 145 degrees Fahrenheit (F) were observed in resident bathrooms and shower rooms throughout the facility. This deficient practice placed all 89 residents in the facility in immediate jeopardy (IJ), as it was likely to result in serious injury, serious harm, serious impairment, or death. On 02/03/2022 at 1:03 PM, Employee Identifier (EI) #1, the Administrator, was notified of the findings of IJ in the area of Essential Equipment/Safe Operating Condition, F908. Findings included: During the survey, concerns were identified with hot water temperatures in excess of 110 degrees Fahrenheit (F). Hot water temperatures exceeding 110 degrees F were noted on all residential wings/units of the facility, including the Dementia Unit, despite prior staff knowledge about water temperature concerns. Cross Reference F689 and F835. A review of a facility policy titled, Water Temperatures, Safety of, dated April 2010, revealed: Tap water in the facility shall be kept within a temperature range to prevent scalding of residents. Policy Interpretation and Implementation 1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 110 [degrees] F (Fahrenheit), or the maximum allowable temperature per state regulation. 2. Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log. 3. Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log. 4. If at any time water temperatures feel excessive to the touch (i.e., hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff will report this finding to the immediate supervisor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Water Temp Log Sheets provided by the facility, revealed weekly water temperature checks on each unit of the facility, up until the last entry dated 01/11/2022. There was no evidence the subsequent weekly water temperature monitoring had been performed. A review of the facility-provided Maintenance Repair Logs for 11/2021 through 1/2022 (a log for staff to record concerns/issues requiring maintenance intervention) revealed the following entries related to water temperatures: - an entry dated 11/26 (2021). This entry documented the G shower room had an issue of, water temp is scalding hot + [and] there is standing water that is pooling by the walls. There was no signature of the staff member who made this entry onto the log. In addition, the completion/repair date for this entry was blank. The maintenance signature, indicating this issue had been addressed, was also blank. - An entry dated 12/19 (2021). This entry documented the residents were complaining about the shower room on the F Unit not having water pressure and the temperature going from extreme hot to cold. This entry was not signed by the staff member that made the entry onto the log; however, it was initialed by EI # 4, the Maintenance Director on 1/22/2022. - An entry dated 12/29 (2021). This entry documented a shower water temperature issue in an unspecified shower room. There was no signature of the staff member who made this entry onto the log; however, it was noted EI #4 initialed this entry as completed/repaired with a date of 12/21/2021, indicating a repair date eight days prior to staff reporting the concern. On 01/31/2022 at 5:12 PM, a meeting was attended by EI #1 (Administrator), EI #4 (Maintenance Director), EI #5 (Maintenance Assistant) , EI #6 (Regional Life Safety Director), and the survey team. EI #6 stated the facility had worked on their boiler system twice in January of 2022. He stated the facility saw problems with water temperatures up to 110, 111, and 114 degrees F and the facility had made adjustments. He said water temperatures began getting high, noting he did not like the hot water temperature to rise above 109 degrees F. During the meeting, EI #1 stated the hot water started fluctuating and temperatures were getting high. EI #1 indicated 01/10/2022 was when the facility started to notice the water temperatures fluctuating and getting high. EI #1 further indicated they had outside contractors come to the facility on [DATE] and 01/21/2022, respectively. When asked how often water temperatures were measured, EI #6 stated, one time a week. He further explained that he instructed maintenance staff to take the water temperature in one room on each wing of the facility. During the meeting on 01/31/2022, the survey team asked about the Water Temp Log Sheets that had no log entries recorded after 01/11/2022. It was noted that two routine water temperature monitoring entries were missing for the dates of 01/18/2022 and 01/25/2022 to bring the log up to date, given the expected frequency of measurements, per EI #1 and the facility policy. EI #1 stated if an entry was not on the log, then it was not done. EI #1 stated the dates of the missing entries were around the time that they were identifying issues. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During the meeting, EI #6 explained the facility's boiler and the chiller provided the hot water to the halls. EI #6 indicated if you mess with the boiler temperature, you must adjust the water to the halls. EI #6 stated it was a complicated system, and someone would have to be called in to work on it. EI #6 was asked if he was familiar with the Maintenance Repair Log entry on 11/26/2021 for the G shower room, which documented water temperatures hot enough to scald. EI #6 stated he had not seen it, and that would have been when EI #55, a former employee, was employed as the Maintenance Director. During the meeting, EI #4, the current Maintenance Director, acknowledged signing off on a shower issue and recalled trying to adjust the water temperature. EI #4 stated these issues may have been going on for some time and may have been a valve issue. EI #4 was asked how water temperatures were adjusted. EI #4 stated he had to adjust the temperature with the dial on the hot water heater. EI #4 stated that after he made adjustments, it was not re-tested to determine what water temperatures it was producing after that. During the meeting, EI #1 stated it was not uncommon for water temperatures to fluctuate; however, too many water temperature issues alerted them to the problem. EI #1 stated they wanted to keep the water temperature between 105 and 110 degrees F, and EI #6 concurred, noting the hot water temperature should not exceed 110 degrees F. EI #1 stated they would have to make an adjustment or get an outside contractor to come if the hot water temperature was over 110 degrees F. When questioned why no additional monitoring of water temperatures had been performed after making adjustments to the water heater, EI #1 agreed it would have been critical to check temperatures after maintenance was conducted. ********** The facility submitted an acceptable Removal Plan on 02/05/2022 for F908 that outlined the following:: The facility failed to monitor and maintain the water heating / boiler system in safe operating condition to prevent hazardous hot water temperatures On January 31, 2022, the state surveyor notified administration of water temperatures in the range of 124 - 145 degrees F. [Fahrenheit] D.O.N. [Director of Nursing], I.C.P. [Infection Control Preventionist] and Nurse Management educated Nursing and CNAs [certified nursing assistants] on January 31, 2022 on the water temperature policy, Maintenance Repair Logs, and location of Repair Log. On January 31, 2022, when the surveyor informed administration that an abnormal temperature was discovered contractor was immediately notified and came to the building on January 31, 2022 to inspect the boiler. Administrator educated Maintenance staff on correct water temperature policy on January 31, 2022. The Regional Environmental Director educated Maintenance staff on monitoring and preventative maintenance of boiler operations on February 4, 2022. The Regional Environmental Director educated Maintenance on, Repair Maintenance Log, and follow up on monitoring water temperatures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Contractor was called on 1-31-22 to inspect the boiler and identified an issue with mixing valve and a new mixing valve was installed on 2-2-22 with no further issues noted with excessive hot water temperature. The hot water to the boiler was cut off on 2-1-22 and remained disconnected until mixing valve was replaced on 2-2-22. The likelihood and/or potential of injury to any of the 87 in house residents began to be negated on January 31, 2022 r/t [related to] staff education on water temperatures and new mixing valve installed on February 2, 2022. Employees not educated on water temperature policy, thermometer usage and thermometer location by February 4, 2022 will not be allowed to work their schedule until education is received. Member of Governing Body met with Administrator on February 4, 2022 and is in agreement with these steps of the removal plan. On 02/06/2022 at 6:30 PM, after review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations of safe hot water temperatures in the facility, the survey team determined the facility implemented the immediate corrective actions as of 02/04/2022 and the scope and severity was lowered to an F level, to allow the facility time to further address and monitor the deficient practice in order to achieve compliance.