

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/14/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>015454</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/16/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>FAIRVIEW AT REDSTONE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>12000 TURNMEYER DRIVE</b> <b>HUNTSVILLE, AL 35803</b>		
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F 000	INITIAL COMMENTS	F 000			
F 600 SS=D	<p>An abbreviated survey was conducted from 9/14/21 through 9/16/21, for the investigation of complaint/report number AL00041530. As a result of the investigation of complaint/report number AL00041530, F600 and F609 are cited at past non-compliance. Fairview at Redstone Village is in compliance with applicable requirements of 42 CFR Part 483, Health Standard Requirements for Long Term Care Facilities.</p> <p>Free from Abuse and Neglect CFR(s): 483.12(a)(1)</p> <p>§483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews, review of the facility's investigation file and a review of the facility's policy titled, "Abuse, Neglect and Exploitation", the facility failed to ensure a staff member, Employee Identifier (EI) #7, did not verbally abuse Resident Identifier (RI) #1 on 8/29/21.</p>	F 600	Past noncompliance: no plan of correction required.	10/5/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/05/2021

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

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F 600	<p>Continued From page 1</p> <p>This affected RI #1 one of three residents sampled for abuse.</p> <p>Findings Include:</p> <p>A facility policy titled "Abuse, Neglect and Exploitation" dated 11/28/16 documented: "... Each resident has the right to be free from abuse ... Residents must not be subject to abuse by anyone, including, but not limited to; facility staff ..."</p> <p>RI #1 was readmitted to the facility on 9/9/19 with diagnoses to include Dementia and Alzheimer's Disease.</p> <p>A review of RI #1's most recent quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 6/25/21 documented a brief interview of mental status score (BIMS) of 3/15 which indicated RI #1 was cognitively impaired.</p> <p>The facility investigation summary and conclusion documented the following: "... On August 30, 2021 (EI #8), dining room server, reported to EI #9, director of dining, that EI #7, CNA, was interacting inappropriately with (RI #1) in the dining room on August 29 2021 at approx. 5:15 p.m. At approximately 3:15 p.m. on August 30, 2021, EI #9 brought EI #8 to be interviewed by (EI #1), ... (Administrator) and (EI #2), Director of Nursing. After interviewing (EI #8), (EI #7) was put on administrative leave and an immediate investigation was initiated. An initial report of the incident was filed through the ADPH (Alabama Department of Public Health) Online Incident Reporting System ... on August 30, 2021. After more detailed review of the facts and evidence,</p>	F 600			

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F 600	<p>Continued From page 2</p> <p>including an audio recording made by EI #8, four additional employees, ... (EI #6 CNA, EI #4 CNA, EI #10 CNA, and EI #5 Sous Chef) ... were also placed on administrative leave ... Conclusion: ... Based on the interviews conducted and information provided it was the opinion of this investigator that the allegation of mental abuse by (EI #7) is substantiated ... (EI #7) has been terminated due to her role in the incident. (EI #5, EI #10, EI #4 and EI #6) ... were also terminated ..."</p> <p>A witness statement handwritten by EI #6 CNA documented "... On Sunday evening 8-29-21 during dinner time (EI #4 CNA, EI #10 CNA), and (EI #5 Sous Chef) was at the counter talking with our back turned (EI #7 CNA) was sitting at the table with (RI #1) telling (him/her) to touch me inappropriate I turned around and told (RI #1) no don't touch me ... (EI #7) continued to provoke (RI #1) I told her not to do this. ..."</p> <p>A witness statement handwritten by EI #4 CNA documented "... On 8/29/21 during dinner, (EI #7 CNA) was talking reckless and sexual towards resident. (RI #1) Me myself and (EI #6 CNA) was talking to (EI #5 Sous Chef) when (EI #7) kept telling/provoking resident to touch (EI #6) ... (EI #7) continue to tell resident come on (RI #1) touch her. ..."</p> <p>A witness statement handwritten by EI #8 Dining Room Server documented "... Last night, August 29th I worked ... CNA's were all sitting in the corner talking extremely loud. ... (EI #7 CNA) was the main CNA being loud kept ... (RI #1) to play in another CNA's pussy. ... (EI #7) told (RI #1) to grab another CNA's Butt ... (EI #7) grabbed (his/her) arm and lead it to another CNA's butt.</p>	F 600			

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F 600	<p>Continued From page 3</p> <p>Then proceeded to do it again to show (RI #1) how to "do it right" while saying "That's not how you treat a woman let me show you."</p> <p>A witness statement handwritten by EI #3 Dining Room Manager documented "... On August 29, 2021 ... (EI #8 Dining Room Server) found me ... and she told me she had a recording for me to hear. It was a recording of a CNA ... and another CNA talking to (RI #1). They were telling (him/her) to "slap her on her Ass" ..."</p> <p>An interview was conducted with EI #2, Abuse Coordinator on 9/15/21 at 1:15 PM. EI #2 was asked when she became aware of an incident involving RI #1 on 8/29/21. EI #2 stated on 8/30/21 when EI #8 and EI #9 came and reported the incident. EI #2 was asked what was done after it was reported. EI #2 stated EI #7 was suspended and an investigation was initiated. EI #2 was asked if EI #7 worked on 8/30/21. EI #2 stated no her last day to work was 8/29/21. EI #2 further stated EI #7 was terminated on 9/2/21. EI #2 was asked what type of abuse RI #1 experienced and who was responsible. EI #2 stated mental abuse and that EI #7 was the main person involved but the other employees heard the abuse and did not report it.</p> <p>An interview was conducted with EI #1, Administrator on 9/15/21 at 2:00 PM. EI #1 was asked when she became aware of an incident involving RI #1. EI #1 stated on Monday 8/30/21 when EI #8 and EI #9 reported the incident and stated there was an audio recording. EI #1 was asked what was done after the report was made. EI #1 stated that she determined who was working by talking to human resources, called EI #7 and told her she was suspended. EI #1 stated</p>	F 600			

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F 600	<p>Continued From page 4</p> <p>after listening to the recording the rest of the employees involved were suspended on 8/31/21. All the employees involved were terminated on 9/2/21. EI #1 was asked what type of abuse did RI #1 experience. EI #1 stated mental due to how he was talked to by the employee.</p> <p>*****</p> <p>Once the facility became aware of the incident on 8/30/2021, the following corrective actions were taken:</p> <p>On 8/30/2021 after the incident the physician and RI #1's sponsor were notified. On 8/31/21 RI #1 was assessed by the Director of Nursing Services to verify extent of injury. Resident had no recollection of events or any change from normal mental status. RI #1 was assessed by the Medical Director on 9/1/21 who reported resident did not appear to have any recollection of the incident or any negative mental or emotional effects.</p> <p>On 8/30/21 EI #7 was placed on suspension and terminated on 9/2/21. EI #'s 4, 5, 6 and 10 were placed on suspension on 8/31/21 and terminated on 9/2/21. EI #3 was placed on suspension on 9/8/21 and terminated on 9/13/21.</p> <p>On 9/2/21 EI #8 was given one on one abuse training (Abuse, Neglect and Exploitation).</p> <p>On 9/3/21 EI #3 was given one on one abuse training (Abuse, Neglect and Exploitation) with focus on reporting guidelines.</p> <p>Beginning 8/30/21-9/2/21 an inservice education program was conducted with direct and</p>	F 600			

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F 600	Continued From page 5 non-direct care staff addressing circumstances that require reporting including appropriate time frames. Inservice education program addressing circumstances that require reporting including appropriate time frames will be provided quarterly.  Beginning on 8/30/21 management staff will conduct random audit five days weekly for four weeks, then weekly for one month and then monthly for three months to monitor dining room during meal times to ensure appropriate conversation and behavior.  The Quality Assurance performance improvement committee will review audit results monthly for 3 months.  *****  After review of the facility's investigation file, in-service/education records, staff and resident interviews, the facility implemented corrective actions from 8/30/21 -9/13/21; thus past noncompliance was cited.  This deficiency was cited as a result of the investigation of complaint/report number AL00041530.	F 600			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		10/5/21	

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F 609	<p>Continued From page 6</p> <p>mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews, record review, review of the facility investigative file and review of a facility policy titled, "Abuse, Neglect and Exploitation," the facility failed to report an abuse allegation involving Resident Identifier (RI) #1 to the State Agency when the allegation was reported to the facility on 8/29/21. The facility did not report to the State Agency until 8/30/21.</p> <p>This affected RI #1 one of three residents sampled for abuse.</p> <p>Findings Include:</p> <p>The facility policy titled "Abuse, Neglect and</p>	F 609	Past noncompliance: no plan of correction required.		

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F 609	<p>Continued From page 7</p> <p>Exploitation" dated 11/28/16 documented: "... 13. In response to allegations of abuse ... the facility must: a. Ensure that all alleged violations involving abuse ... are reported immediately, but not later than 2 hours after the allegation is made ..."</p> <p>RI #1 was readmitted to the facility on 9/9/19 with diagnoses to include Dementia and Alzheimer's Disease.</p> <p>A review of RI #1's most recent quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 6/25/21 documented a brief interview of mental status score (BIMS) of 3/15 which indicated RI #1 was cognitively impaired.</p> <p>Review of the Alabama Department of Public Health Online Incident Reporting System revealed the incident of mental abuse as follows: "... associate reported that (EI #7) was interacted with (RI #1) in a demeaning and inappropriate manner. ...", with a date and time of occurrence reported as 8/29/21 at 5:30 PM, was not reported to the State Agency until 8/30/21 at 3:15 pm.</p> <p>A witness statement handwritten by EI #3 Dining Room Manager documented "... On August 29, 2021 ... (EI #8 Dining Room Server) found me ... and she told me she had a recording for me to hear. It was a recording of a CNA ... and another CNA talking to (RI #1). They were telling (him/her) to "slap her on her Ass" ..."</p> <p>The facility investigation summary and conclusion documented on 8/29/21 EI #8 Dining Room Server reported to EI #3 Dining Room Manager, that EI #7 was interacting inappropriately with RI</p>	F 609			

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F 609	<p>Continued From page 8</p> <p>#1 in the dining room. The investigation revealed that EI #8 reported the incident to her supervisor EI #3 immediately after the incident happened on 8/29/21 and advised her that she had made an audio recording of it. EI #3 listened to at least some of the recording but instead of reporting it to any supervisor at that time, she advised EI #8 to report it to another supervisor EI #9 the following day, 8/30/21. When the incident was reported on 8/30/21, EI #9 brought EI #8 to the abuse coordinator, EI #2 and the administrator EI #1 and an investigation was initiated.</p> <p>An interview was conducted with EI #8, Dining Room Server, on 9/14/21 at 4:45 PM. EI #8 was asked what lead to her recording the incident on 8/29/21 involving RI #1. EI #8 stated she saw it happening and wanted evidence that it happened in case no one believed her. EI #8 was asked what she observed on 8/29/21. EI #1 stated RI #1 rolled his/her wheelchair over to where several other employees were by the kitchen. The employees were talking amongst and started to bring RI #1 into it. EI #8 stated that was when she started to record the incident. EI #8 stated EI #7 started talking to RI #1 in sexual manner and telling him/her to touch another employee on the butt. EI #8 was asked what she did after this. EI #8 stated she went downstairs and told her supervisor EI #3 and gave her the recording. EI #8 further stated EI #3 told her that no one was there to report the incident to so she should report it on 8/30/21 to EI #9. EI #8 was asked if she reported the incident the next day. EI #8 stated yes it was reported to EI #9. EI #8 stated after it was reported she went with EI #9 to report to the EI #2, Abuse Coordinator.</p> <p>An interview was conducted with EI # 2, Abuse</p>	F 609			

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F 609	<p>Continued From page 9</p> <p>Coordinator on 9/15/21 at 1:15 PM. EI #2 was asked when she became aware of the incident on 8/29/21 involving RI #1. EI #2 stated on 8/30/21 at 3:15 PM when EI #8 and EI #9 came to her office and reported the incident. When asked when the incident happened, EI #2 replied, on 8/29/21 in the second floor dining room around 5:00 PM. EI #2 was asked if the incident was reported timely. EI #2 stated no it should have been reported immediately to the supervisor and within two hours to the State Agency. EI #2 was asked what EI #3 should have done when it was reported to her on 8/29/21 by EI #8. She stated EI #3 should have called her or the administrator to report the incident. EI #2 further stated it could have been reported to any nursing supervisor who was working that day or she could have called her supervisor EI #9. EI #2 was asked if the abuse policy was followed concerning reporting abuse. EI #2 stated no. EI #2 was asked why EI #3 thought she had 72 hours to report the abuse. EI #2 stated she did not know, she was trained and should have know.</p> <p>An interview was conducted with EI #1, Administrator on 9/15/21 at 2:00 PM. EI #1 was asked when she became aware of an incident involving RI #1. EI #1 stated on Monday 8/30/21 when EI #8 and EI #9 reported the incident and stated there was an audio recording. EI #1 was asked what type of abuse did RI #1 experience. EI #1 stated mental due to how he/she was talked to by the employee. EI #1 was asked if this incident was reported timely. EI #1 stated no, not on Sunday when it happened, it was reported on Monday when they became aware of it. EI #1 was asked why the incident was not reported timely. EI #1 stated none of the people involved reported the abuse, they should have, they were trained to</p>	F 609			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 609	<p>Continued From page 10 report all abuse immediately. EI #1 was asked why it was important to report abuse timely. EI #1 stated to take care of it and remove the resident from harms way.</p> <p>*****</p> <p>Once the facility became aware of the incident on 8/30/2021, the following corrective actions were taken:</p> <p>On 8/30/2021 after the incident the physician and RI #1's sponsor were notified. On 8/31/21 RI #1 was assessed by the Director of Nursing Services to verify extent of injury. Resident had no recollection of events or any change from normal mental status. RI #1 was assessed by the Medical Director on 9/1/21 who reported resident did not appear to have any recollection of the incident or any negative mental or emotional effects.</p> <p>On 8/30/21 EI #7 was placed on suspension and terminated on 9/2/21. EI #'s 4, 5, 6 and 10 were placed on suspension on 8/31/21 and terminated on 9/2/21. EI #3 was placed on suspension on 9/8/21 and terminated on 9/13/21.</p> <p>On 9/2/21 EI #8 was given one on one abuse training (Abuse, Neglect and Exploitation).</p> <p>On 9/3/21 EI #3 was given one on one abuse training (Abuse, Neglect and Exploitation) with focus on reporting guidelines.</p> <p>Beginning on 8/30/21-9/2/21 an inservice education program on Abuse, Neglect and Exploitation was conducted with direct and non-direct care staff addressing circumstances</p>	F 609			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 609	<p>Continued From page 11 that require reporting including appropriate time frames. Inservice education program addressing circumstances that require reporting including appropriate time frames will be provided quarterly.</p> <p>Beginning on 8/30/21 management staff will conduct random audit five days weekly for four weeks, then weekly for one month and then monthly for three months to monitor dining room during meal times to ensure appropriate conversation and behavior.</p> <p>The Quality Assurance performance improvement committee will review audit results monthly for 3 months.</p> <p>*****</p> <p>After review of the facility's investigation file, in-service/education records, staff and resident interviews, the facility implemented corrective actions from 8/30/21 -9/13/21; thus past noncompliance was cited.</p> <p>This deficiency was cited as a result of the investigation of complaint/report number AL00041530.</p> <p>ANGELA BROWN, SOCIAL WORKER</p>	F 609			