Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 

D4520

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: _____________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED

04/15/2015

NAME OF PROVIDER OR SUPPLIER

ALDRIDGE CREEK TERRACE, A MERRILL GARDENS

10310 BAILEY COVE ROAD

HUNTSVILLE, AL 35803

STREET ADDRESS, CITY, STATE, ZIP CODE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(NAME OF PROVIDER OR SUPPLIER)

ALDRIDGE CREEK TERRACE, A MERRILL GARDENS

10310 BAILEY COVE ROAD

HUNTSVILLE, AL 35803

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(NAME OF PROVIDER OR SUPPLIER)

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Initial Comments

This was an unannounced licensure survey. Complaints LC#90-2014, LC#014-2015, and LC#017-2015 were investigated during the survey and were substantiated.

This is a 51 bed Assisted Living facility with a census of 23 on March 26, 2015.

Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, Assisted Living Facilities (ALF). These deficient practices resulted in actual harm to two residents and placed all residents at risk for harm.

A 301

420-5-4-.03 (1)(a)(b) Administration

(1) The Assisted Living Facility Governing Authority.

(a) An assisted living facility shall have an identified sole proprietorship, corporation, partnership, limited partnership, or other business entity that is its governing authority, or it shall have a designated individual or group of designated individuals who serve as its governing authority. The governing authority shall be responsible for implementing policies for the management and operation of the facility, and for appointing and supervising the administrator who is responsible for overall management and the day-to-day operation of the facility. In family and group assisted living facilities, the governing authority and the administrator may be the same individual. A facility must give complete information to the Department identifying:
### Statement of Deficiencies and Plan of Correction

**DATE SURVEY COMPLETED**: 04/15/2015

**NAME OF PROVIDER OR SUPPLIER**: ALDRIDGE CREEK TERRACE, A MERRILL GARDENS

**STREET ADDRESS, CITY, STATE, ZIP CODE**: 10310 BAILEY COVE ROAD, HUNTSVILLE, AL 35803

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1. Each person who has an ownership interest of ten per cent or more of the governing authority;

2. Each person or entity who has an ownership interest of ten per cent or more in the real property or building used by the assisted living facility to offer its services;

3. Each officer and each director of the corporation if the governing authority is a corporation; and

4. Each partner, including any limited partners, if the governing authority is a partnership.

(b) The governing authority shall submit any changes to the information listed above to the Department within 15 days of the change.

This Rule is not met as evidenced by:

Based on observations, interviews, and record reviews, the governing authority failed to properly supervise the facility's administrator to ensure the facility operated in compliance with the SBOH rules for assisted living facilities. Shannon Powers, Administrator, failed to adequately perform her duties as administrator to ensure the facility was managed responsibly. The administrator's failure to responsibly manage the facility resulted in insufficient staff on duty to meet the residents' care and safety needs, retention of residents whose level of care exceeded the facility's capabilities, poorly developed resident care plans that were not current and did not address resident problem areas with appropriate care actions, failure to follow physicians' orders and lack of physicians' orders for residents' care and medications, lack of health observation and...
A 301 Continued From page 2

supervision, and failure to maintain a safe and
decent environment for all residents. Two
residents {Resident Identifier (RI)#14 and RI#20}
suffered actual harm due to the administrator’s
failure to apply the rules to the day to day
operations of the facility.

Findings:

During an interview on March 26, 2015 at 9:00
AM, the Administrator informed the surveyor that
she did not feel she was properly trained for her
administrator role and she felt that she was being
expected to do multiple jobs since she was also a
nurse. The Administrator stated that she had
performed nursing duties, marketing duties, and
administrator duties at the facility since assuming
the role of administrator. The Administrator also
stated that when calling the governing authority
for advice she was instructed to read the policy.
In an interview on March 25, 2015 at 9:55 AM,
Employee Identifier (EI)#2, Administrative
Designee, stated that the governing authority
visited the facility about every two months for one
day, reviewing files and asking how things were
going at the facility.

On March 26, 2015, a surveyor with the Alabama
Department of Public Health (ADPH) conducted a
licensure survey and complaint investigation at
the facility. The survey was conducted based on
multiple complaints received by the Alabama
Department of Public Health regarding unsanitary
conditions in the facility, ineligible residents, and
resident care issues. Once on site, the surveyor
confirmed that the facility had resident care and
safety issues, as well as maintenance issues
involving the structure and cleanliness of the
facility. The surveyor observed that the
administrator’s failure to provide residents and
Continued From page 3

staff with effective plans of care and the lack of adequate health observation and supervision resulted in harm to two residents and an unsafe environment for all residents.

The following deficiencies were identified as a result of the governing authority's lack of oversight and the administrator's failure to apply the State Board of Health's rules to the day to day operations of the facility.

302 The facility failed to follow its own policies. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JANUARY 6, 2011.

401 There was insufficient staff on duty to meet the care needs of the residents 24 hours a day, seven days a week.

509 Physicians' orders were not present for all residents who administered their own medications.

510 Care plans were not current and did not address all care needs of the residents.

515 An incident of alleged verbal abuse by an employee toward residents was not adequately investigated.

521 A safe and decent environment was not maintained for all residents. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JANUARY 6, 2011.

601 Residents' care was not under the direction and supervision of a physician at all times.

602 Sufficient general observation and health supervision was not provided for all residents.
Alabama Department of Public Health

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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<td>A 301</td>
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<td>A 301</td>
<td>603 Residents were not transferred to a higher level of care when the facility no longer had the capability to meet their care needs.</td>
<td>607</td>
<td>Resident's sponsor was not notified of an incident involving sexual abuse.</td>
<td>611</td>
<td>The facility did not follow proper procedure for disposal of contaminated needles.</td>
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<td>613 Documentation of vaccinations was not present for all pets.</td>
<td>624</td>
<td>Medications were not secured by at least a single lock at all times.</td>
<td>1007</td>
<td>Objectionable odors were present in the facility. This is a repeat deficiency from the survey conducted on January 6, 2011.</td>
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<td></td>
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<td>1008 A sanitary environment was not maintained.</td>
<td>1101</td>
<td>Fire drills were not documented monthly and quarterly on each shift as required.</td>
<td>1203</td>
<td>The building was not maintained in good repair and free of leaks.</td>
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<td>1208 Cleanliness of floors, walls, and ceilings was not maintained.</td>
<td>420-5-.03 (1)(c)(d) Administration</td>
<td>A 302</td>
<td>Administration</td>
<td>(c) Policies. An assisted living facility shall establish and implement written policies and shall be responsible for development of, and adherence to, procedures implementing those</td>
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<td>policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). Policies shall cover the following:</td>
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<td>1. How allegations of abuse, neglect, and exploitation will be handled by the facility.</td>
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<td>2. Admission and continued stay criteria.</td>
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<td>3. Discharge criteria and notification procedures for residents and sponsors.</td>
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<td>4. Facility responsibility when a resident's personal belongings are lost.</td>
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<td>5. What services the facility is capable and not capable of providing.</td>
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<td>6. Medication assistance.</td>
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<td>7. Meal service, timing, menus and food preparation, storage, and handling.</td>
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<td>8. Fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness.</td>
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<td>9. Staffing and conduct of staff while on duty.</td>
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<td>(d) Relationship of Staff to Governing Authority. The administrator, medical staff, facility personnel, and all auxiliary organizations shall be directly or indirectly responsible to the governing authority.</td>
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<td>This Rule is not met as evidenced by: Based on observations, record reviews, and</td>
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**A. BUILDING:**

**B. WING:**

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**NAME OF PROVIDER OR SUPPLIER:**

**ADDRESS:**

**Alabama Department of Public Health**

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**Finding:**

**Falls**

According to Policy 13.1 Suspected Serious Injury and the Fact Sheet under the same policy in the facility's Operations Policy Guide, "Do not assess the seriousness of the injury yourself ... Call 911 for assistance if the fall involves any head or neck injury ... Any time a resident bumps their head, or reports that they bumped their head in a fall, 911 must be called for medical evaluation as soon as a team member becomes aware of it." RI#20 suffered a fall with a bump to the head at the facility on December 18, 2014. Documentation in the facility's incident report written by the Administrator stated that 911 was not called. Refer to deficiency 603 for additional information on RI#20's falls.

**Pet requirements**

According to Policy 43.4 Veterinary Vaccinations in the facility's Operations Policy Guide, "All pets must have current veterinary vaccinations upon entering the Community ... The resident must keep written proof of vaccination in their apartment and make this documentation available to the facility at any time."

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**SUMMARY STATEMENT OF DEFICIENCIES**

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**THIS DEFICIENT PRACTICE WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.**

**THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JANUARY 6, 2011.**

Findings:

Falls

Pet requirements
###Alabama Department of Public Health

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING:** ________________

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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**STREET ADDRESS, CITY, STATE, ZIP CODE:** 10310 BAILEY COVE ROAD HUNTSVILLE, AL 35803

**Alabama Department of Public Health**

**D4520**

**04/15/2015**

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**A 302**

**Continued From page 7**

available to the Community upon request." RI#7 had a pet dog living at the facility, but no proof of vaccination was provided when requested by the surveyor on March 23, 2015. Refer to deficiency 613 for additional information on the pet vaccination.

**Medication assistance documentation**

According to Policy 4.6 Medication Administration Record (MAR) in the facility's Operations Policy Guide, "Refusal should be documented in the block for the medication by circling the med passer's initials ... The physician should be notified during office hours regarding refusal of medication." Documentation in RI#6's medication administration record and an interview with RI#6 revealed that RI#6 refused multiple doses of her medications in March 2015 but there is no documentation to indicate that the physician was aware that the medication doses were refused. Refer to deficiency 601 for additional information on RI#6's medications.

**Ordering medication**

According to Policy 22.4 Ordering Medication in the facility's Operations Policy Guide, "Communities should always have an adequate supply of all centrally stored medication ... It is unacceptable to run out of medication." RI#12 had a physician's order for Zemplar which was not available at the facility on March 23, 2015 at 9:00 AM when the dose was scheduled to be given. Refer to deficiency 601 for additional information on this missed dose of medication.

**Managing controlled medications**

According to Policy 46.3 Counting Controlled...
A 302 Continued From page 8

Medications in the facility's Operations Policy Guide, "Each resident's prescription is entered on a separate page in the book immediately after delivery to the community. The entry should contain the following information ... date of receipt and signature of staff member receiving the medication." Review of Controlled Substance Administration Records revealed the following discrepancies: On March 23, 2015, 60 Lorazepam 0.5 milligram tablets and 30 Clonazepam 0.5 milligram tablets were delivered for RI#22 and there was no signature of the staff member receiving the medication; and a prescription dated February 11, 2015 for 140 Norco 10/325 milligram tablets which was delivered for RI#13 did not show a date received or the signature of the staff member receiving the medication.

Disposal of contaminated needles

According to Policy 7.1 Protection from Exposure to Pathogens: Needles and Sharps in the facility's Operations Policy Guide, "Contaminated needles and other contaminated sharps should not be bent, recapped, or removed from containers unless required by law and appropriate equipment is used ... The Community provides sharps containers to residents who do self-injections in their apartments ... Contaminated sharps are to be placed in sharps containers and transported to an appropriate local medical waste disposal source when full." RI#4 reported to the surveyor that she was placing her contaminated insulin needles in the garbage. A full red plastic sharps container was noted in RI#4's room. Refer to deficiency 611 for additional information on disposal of contaminated needles.
A. BUILDING: ________________________

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ALDRIDGE CREEK TERRACE, A MERRILL GARDENS

STREET ADDRESS, CITY, STATE, ZIP CODE

10310 BAILEY COVE ROAD

HUNTSVILLE, AL  35803

Alabama Department of Public Health

SUMMARY STATEMENT OF DEFICIENCIES

(Each Deficiency Must Be Preceded By Full Regulatory Or LSC Identifying Information)

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<td>420-5-4-.04 (1) Personnel and Training</td>
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(1) General. An assisted living facility shall employ sufficient staff and ensure sufficient staff are on duty to meet the care needs of all residents twenty-four hours a day, seven days a week. This means that an assisted living facility must not only have a sufficiently large number of staff members to meet the care needs of all residents, it must also manage and direct the activities of staff members in a manner that results in adequate care being provided. An assisted living facility shall likewise employ sufficient staff, ensure sufficient staff are on duty, and manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment at all times.

This Rule is not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to maintain sufficient staff on duty to meet the care needs of all residents twenty-four hours a day, seven days a week.

THIS DEFICIENT PRACTICE WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

Findings:

According to employee schedules, the assisted living facility was staffed with only two resident assistants on the 2:00 PM until 10:00 PM shift and on the 10:00 PM until 6:00 AM shift, who were responsible for all resident care including medication assistance, personal care assistance, bathing assistance, housekeeping, and laundry. When interviewed, five employees of the facility who worked these shifts stated they would not have been able to safely evacuate the residents...
Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Alabama Department of Public Health

D4520

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A 401

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from the facility if needed in the event of a fire or other disaster. During record reviews and interviews with staff, the following resident care needs were identified: RI#3 (hospitalized at the time of the survey) was receiving hospice services, required two person assistance for transfers, was incontinent, required oxygen therapy, and was confused at times; RI#14 had very poor vision, had body tremors, was extremely weak, had a history of multiple falls, could ambulate only a very short distance with the assistance of two people, and required the use of a wheelchair when leaving her room (RI#14 fell during the survey and was admitted to the hospital); RI#11 was incontinent of bowel and bladder, was very forgetful, could ambulate only a few feet with the assistance of one and sometimes two people, had a history of falls, and required the use of a wheelchair to leave her room (RI#11 fell during the survey and injured her arm); RI#15 was agitated at times, incontinent of bowel and bladder, and required the assistance of one or two people to get up as well as use of a wheelchair to leave her room; RI#16 was extremely hard of hearing, became agitated and uncooperative at times, and had a history of leaving the facility without notification of staff (documented on March 17, 2015; March 19, 2015; and March 25, 2015). The census at the time of the survey was 23.

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETE DATE

A 406

420-5-4-.04 (3) Personnel and Training

(3) The Administrator. (a) Responsibility.

1. The administrator shall be a direct representative of the governing authority in the management of the assisted living facility and shall be responsible to the governing authority for

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Health Care Facilities

STATE FORM

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the proper performance of his or her duties. Any individual employed as an administrator shall meet all applicable statutory requirements.

2. There must be an individual authorized in writing to act for the administrator during absences.

3. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting.

4. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when needed.

5. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan.

6. The administrator shall ensure that all deficient practices cited by the Department of Public Health are corrected in a timely manner.

(b) The administrator and any individual authorized to act as a substitute shall be at least nineteen years of age.

(c) The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character.

This Rule is not met as evidenced by:

Based on observations, interviews, and record

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SUMMARY STATEMENT OF DEFICIENCIES  

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(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  

Continued From page 12  

A 406  

reviews, the Administrator (who is also a Licensed Practical Nurse) failed to ensure that residents who had health and/or safety needs beyond the capability of the facility were safely transferred or discharged to an appropriate setting; failed to ensure that each resident was observed for changes in health and physical abilities and appropriate medical attention was obtained when needed; failed to ensure that plans of care for all residents were current and appropriate; and also failed to ensure that all deficient practices cited by the Department of Public Health were corrected in a timely manner.

Findings:

During interviews with resident assistants, the surveyor received several reports that the Administrator would not listen when they reported to her changes in residents' conditions. The caregivers also reported to the surveyor that the Administrator did not properly monitor the residents and that she spent most of her time in her office. When the Administrator was interviewed, she (the Administrator) reported to the surveyor that the resident assistants did not report changes and concerns to her and that she was being sabotaged by the caregivers because they called the state and called the facility's corporate office to report concerns about the facility instead of reporting them to her. The Administrator repeatedly reported to the surveyor that she did not feel there was adequate time for her to perform the duties she was expected to perform which she stated included marketing, nursing, and administrator tasks.

Needs beyond the capability of the facility:

Both RI#14 and RI#20 suffered falls and weight
### A. BUILDING: ____________

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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**DATE SURVEY COMPLETED:** 04/15/2015

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** ALDRIDGE CREEK TERRACE, A MERRILL GARDENS

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 10310 BAILEY COVE ROAD

**HUNTSVILLE, AL 35803**

**NAME OF PROVIDER OR SUPPLIER:**

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

**ID**

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<td>A 406</td>
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- **Loss at the facility and had declining physical conditions which required increased care and monitoring. RI#14 required the assistance of one or two people for every transfer and required the assistance of two people to ambulate. A wheelchair was used to transport RI#14 outside her room. According to reports from facility staff and facility records, RI#20 had declining mental status, confusion, and wandering, placing her at increased risk for injury and falls. RI#16 had left the facility on several occasions without notification of staff (once around 4:00 AM) and was uncooperative with care at times. Two staff members were frequently left to provide for the increasing care needs of these three residents as well as the daily needs of all 23 residents. Refer to deficiency 603 for additional information on the care needs of RI#14, RI#16, and RI#20.**

- **Observed for changes in health and physical abilities and appropriate medical treatment obtained:**
  
  RI#14 did not have medication awareness testing documented monthly. Refer to deficiency 510 for additional information on RI#14’s medication awareness testing.

  - **Two residents (RI#2 and RI#11) did not have weights documented monthly. Refer to deficiency 510 for additional information on these residents’ weights.**

  - **Five residents (RI#1, RI#7, RI#9, RI#14, and RI#20) had documentation of significant weight loss which was not addressed with appropriate interventions. Refer to deficiency 602 for additional information on these residents’ significant weight loss.**
A 406 Continued From page 14

RI#20 fell at the facility on December 18, 2014, and bumped her head. Although the facility’s policy instructs that 911 is to be called if a resident bumps their head, 911 was not called to evaluate RI#20 when she injured her head. Refer to deficiency 602 for additional information on RI#20’s head injury.

Inadequate care plans:

13 of 21 care plans reviewed did not address resident care problem areas which required monitoring or intervention including blood thinner medication (one resident), significant weight loss (five residents), diabetes mellitus (four residents), hypertension (eight residents), congestive heart failure (three residents), chronic obstructive pulmonary disease (two residents), inappropriate behaviors (two residents), incontinence (two residents), extreme hearing or vision deficits (two residents), falls (two residents), and altered mental status/memory loss/dementia (three residents). The Administrator (and Licensed Practical Nurse) stated that she was responsible for initiating and updating residents’ care plans. Refer to deficiency 510 for additional information on inadequate resident care plans.

Previously cited deficiencies not corrected

THE FOLLOWING DEFICIENCIES CITED DURING THIS SURVEY ARE REPEAT DEFICIENCIES FROM THE SURVEY CONDUCTED ON JANUARY 6, 2011.

The facility failed to follow its own policies. Refer to deficiency 302 for additional information on facility policies.

A safe and decent environment was not provided
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Aldridge Creek Terrace, A Merrill Gardens  
**Street Address, City, State, Zip Code:** 10310 Bailey Cove Road, Huntsville, AL 35803

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<tr>
<th>ID</th>
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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
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<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Complete Date</th>
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| A 406 | | | Continued From page 15  
for every resident. Refer to deficiency 521 for additional information on the environment of the facility.  
The facility was not free of objectionable odors. Refer to deficiency 1007 for additional information on odors in the facility. | A 406 | | | | |
| A 509 | | | 420-5-4-.05 (3)(c) Records and Reports  
(c) Medical Examination Record. Not more than thirty days prior to admission of any resident to an assisted living facility, the resident or prospective resident shall be examined by a physician, who shall report his or her findings in writing to the facility. In addition to any information otherwise required by the facility's policies and procedures, and in addition to any other information the physician believes is pertinent, the medical examination record shall contain the following:  
1. All of the physician's diagnoses, and the resident's baseline weight and vital signs.  
2. A statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact.  
3. Medication presently prescribed (name, dosage, and strength of drug, frequency of administration).  
4. A physician order is required for a resident to manage and have custody of his or her own medications. | A 509 | | | | |
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**

**Date Survey Completed:** 04/15/2015

**Address:**

**Name of Provider or Supplier:** ALDRIDGE CREEK TERRACE, A MERRILL GARDENS

**Street Address, City, State, Zip Code:** 10310 BAILEY COVE ROAD, HUNTSVILLE, AL 35803

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<td>420-5-4-.05 (3)(d) 1. &amp; 2 Records and Reports</td>
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This Rule is not met as evidenced by:

Based on record review and interview, the facility failed to ensure that a physician's order was present for every resident who managed and had custody of his or her own medications.

**Findings:**

According to the resident's facility records and caregivers' reports, RI#5 self-administered his medications including Coumadin, a blood thinner. Further review of RI#5's facility record revealed that the most recent Medical Health Statement dated December 8, 2014 and signed by RI#5's physician read under "Ability to manage medications", "Administer by licensed nurse." There was no current order for RI#5 to self-administer his medications. When interviewed, the Administrator stated she thought the order was in the record. RI#5 was hospitalized during the time of the survey due to gastrointestinal bleeding (which he reported had been going on for two days prior to admission to the hospital) secondary to severe coagulopathy and gastric ulcers.

(d) Plan of Care. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall be based on the medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be developed in cooperation with the resident and, if appropriate, the sponsor. It shall document the personal care...
Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:

D4520

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: ______________________
B. WING ______________________

(X3) DATE SURVEY COMPLETED

04/15/2015

NAME OF PROVIDER OR SUPPLIER

ALDRIDGE CREEK TERRACE, A MERRILL GARDENS

10310 BAILEY COVE ROAD

HUNTSVILLE, AL 35803

STREET ADDRESS, CITY, STATE, ZIP CODE

STATE FORM

STATE FORM

(ID) PREFIX TAG

A 510

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

A 510

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

A 510

(XX) COMPLETE DATE

Continued From page 17

and services required from the facility by the resident. This plan shall be kept current, reviewed and updated when there is any significant change in the resident's condition, after each hospitalization, and at other appropriate times. It shall in all cases be reviewed and updated at least annually by the attending physician. In addition to other items that may be required by the facility's own policies and procedures, it shall contain the following:

1. A listing of the resident's needs or problems that require intervention by the facility, such as behavioral symptoms, weight loss, falls, and therapeutic diets. The facility shall assess the appropriateness of interventions required by each resident monthly. The facility shall on a monthly basis weigh and record the weight of each resident. The facility shall assess residents on a monthly basis and more often when necessary to identify significant changes in health status or behavior to include awareness of medication. Significant change is defined as two or more falls in 30 days or less, a significant weight loss, unmanageable or combative or potentially harmful behaviors, any adverse drug interaction or over sedation or any elopement. A significant weight loss is defined as a 5% or greater weight loss in a period of one month or less, or a 7.5% or greater weight loss in a period of three months or less, or a 10% or greater weight loss in a period of six months or less. Any weight loss shall be considered to be unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician. Any significant change requires immediate implementation and
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<td>A 510</td>
<td>Continued From page 18 documentation of interventions or reassessment of existing interventions.</td>
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<td>2. A description of the assistance with activities of daily living required by the resident including bathing, dressing, ambulation, feeding, toileting, grooming, medication assistance, diet and risk to personal safety. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented.</td>
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<td>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that there was a current written plan of care for each resident which included interventions to adequately address the care needs of the resident; and also failed to ensure that all residents were weighed monthly and assessed for medication awareness, and that interventions were implemented immediately for residents with significant weight loss.</td>
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<td>RI#14 did not have documentation that medication awareness testing was completed in October of 2014.</td>
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A 510 Continued From page 19

Two residents did not have weights documented monthly. RI#2 did not have weights documented for August 2014 and November 2014. RI#11 did not have a weight documented for December 2014.

Care Plans

Review of residents' care plans and facility records revealed multiple resident care needs which were not adequately addressed or not addressed at all. When interviewed, the Administrator and Licensed Practical Nurse, stated that she was responsible for creating and updating resident care plans. The following deficiencies were noted in 13 of the 21 care plans reviewed.

RI#1 had diabetes mellitus and hypertension. According to the facility's weight logs, RI#1 weighed 242 pounds on February 3, 2015 and 220 pounds on March 3, 2015, a weight loss of 9% of her body weight in one month. No diagnoses were listed on RI#1's care plan, there were no instructions for monitoring and reporting symptoms, and her significant weight loss was not addressed.

RI#4 had insulin dependent diabetes mellitus, pulmonary hypertension, and congestive heart failure. No diagnoses were listed on RI#4's care plan and there were no instructions for monitoring and reporting symptoms.

RI#5 had diabetes mellitus, hypertension, and atrial fibrillation and was taking Coumadin (a blood thinner). No diagnoses were listed on RI#5's care plan, there were no instructions for monitoring and reporting symptoms, and there were no precautions for blood thinner medication.
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RI#6 had diabetes mellitus, hypertension, chronic obstructive pulmonary disease, and bowel and bladder incontinence. RI#6 also exhibited inappropriate behaviors at times (such as walking outside her room undressed or inappropriately dressed and refusing baths) which required redirection. No diagnoses were listed on RI#6's care plan, there were no instructions for monitoring and reporting symptoms, no incontinence care was addressed, and there was no plan for interventions when behaviors occurred.

RI#7 experienced frequent back pain which reportedly affected his appetite. According to the facility’s weight logs, RI#7 weighed 179 pounds on January 6, 2015; 171 pounds on February 3, 2015; and 151 pounds on March 3, 2015. RI#7 sustained a weight loss of 11.7% of his body weight in one month (March 2015) and a weight loss of 15.6% of his body weight in two months (March 2015). Although RI#7’s care plan, which was updated on March 3, 2015, stated RI#7 had back pain and read "resident lost weight will call MD to see if we can get orders to weigh weekly," there were no interventions listed to address the back pain and the weight loss and no documentation to indicate the physician was notified of the weight loss.

RI#8 was the victim of inappropriate sexual contact by another resident on March 18, 2015. No interventions were listed on RI#8’s care plan specific to this occurrence. The care plan read under Special Communication Needs “encourage resident to push pendant if he feels unsafe or uncomfortable.” Caregivers reported to the surveyor that they were instructed to redirect RI#9 if he approached RI#8. There were no adequate
measures in place to protect RI#8 from further incidents or injury. In fact, RI#8's sponsor (power of attorney) reported to the surveyor that she was not notified of the occurrence by facility staff and that she (RI#8's sponsor) had to ask the facility to place the two residents involved at separate dining tables. The last date entered on RI#8's care plan was March 16, 2015, when it was initialed by the Administrator, two days prior to the incident.

RI#9 had dementia and hypertension and also initiated an episode of inappropriate sexual contact with another resident. The care plan entry after this episode occurred read "Redirect resident when you see him having any contact with resident (EI#8's room number). Resident to have separate seating arrangement for all meals with resident (EI#8's room number)." According to facility weight logs, RI#9 weighed 163 pounds on January 6, 2015 and 151 pounds on February 3, 2015, a weight loss of 7.3% of his body weight in one month. RI#9's care plan did not list any diagnoses or instructions for monitoring and reporting symptoms, did not adequately address his inappropriate behaviors to prevent a recurrence, and did not address his significant weight loss.

RI#12 had congestive heart failure, hypertension, and chronic obstructive pulmonary disease. No diagnoses were listed on RI#12's care plan and there were no instructions for monitoring and reporting symptoms.

RI#14 had Parkinson's disease, hypertension, and extremely poor vision and had experienced eight falls while at the facility; two of these falls occurred during the month of March 2015. RI#14's most recent care plan entry on March 19,
A 510 Continued From page 22

2015 read "Remind resident to push her pendant. Resident hesitates. Assist with all transfers," although the same care plan was checked "yes" beside "able to leave community unsupervised." RI#14 sustained significant weight loss in February 2015 and in March 2015, and RI#14 suffered another fall during the survey. Although "Parkinson's" was listed on RI#14's care plan, there were no instructions for monitoring and reporting symptoms, no adequate interventions were listed to address her multiple falls and her poor vision and protect her from further injury, and her significant weight loss was not addressed.

RI#15 had diagnoses of hypertension, heart failure, and adjustment disorder with anxiety and depression. RI#15 was incontinent of bowel and bladder. No diagnoses were listed on RI#15's care plan, there were no instructions for monitoring and reporting symptoms, and there were no interventions for incontinence care.

RI#16 had a diagnosis of altered mental status and was very hard of hearing. In addition, RI#16 had left the facility on more than one occasion (once around 4:00 AM) without staff knowledge of his location. A concern verbalized by staff when RI#16 left the facility was that he walked on the sidewalk very close to a busy highway and was unsteady and confused at times. No diagnoses were listed on RI#16's care plan, there were no instructions for monitoring and reporting symptoms, his hearing deficit was not addressed, and no interventions were in place to address his wandering behaviors.

RI#20 had diagnoses of memory loss and hypertension. RI#20 suffered a fall at the facility on December 18, 2014 causing a bump to her
A 510 Continued From page 23

head. RI#20's facility record contained documentation of a decline in her memory and confusion on December 29, 2014 at 5:00 PM; on October 23, 2014 at 12:11 PM; and on January 2, 2014. RI#20's care plan entry on December 29, 2014 read "some confusion on time of day...fall risk, becomes dizzy recently." RI#20 sustained significant weight loss in January 2015. No diagnoses were listed on RI#20's care plan, there were no instructions for monitoring and reporting symptoms, no interventions were listed to address her significant weight loss in January 2015, and no measures were in place to adequately address RI#20's fall, dizziness, and memory loss and to prevent her from further injury. RI#20 fell again at the facility on February 2, 2015, fracturing her hip and requiring admission to the hospital where she passed away on March 6, 2015.

RI#21 had diagnoses of chronic obstructive pulmonary disease and urinary incontinence. No diagnoses were listed on RI#21's care plan, there were no instructions for monitoring and reporting symptoms, and no incontinence care was listed.

A 515 420-5-4-.05 (3)(f) 1. Records and Reports

(f) Incident Investigation.

1. When an incident, as defined below, occurs in an assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct an investigation, and appropriate interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 24 hours of the incident. The report shall be given immediately upon completion to the administrator for review. The
entire investigative file shall be made available for inspection and copying by representatives of the Alabama Department of Public Health upon request. The entire investigative file means the incident report itself and all records and documents created or reviewed in connection with the investigation. Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff. In addition to other items required by the facility's policies and procedures, the incident report shall contain the following:

(i) Circumstances under which the incident occurred.

(ii) When the incident occurred (date and time).

(iii) Where the incident occurred (for example, bathroom, bedroom, street, or lawn).

(iv) Immediate treatment rendered.

(v) Names, telephone numbers, and addresses of witnesses.

(vi) Date and time relatives or sponsor were notified.


(viii) Symptoms of pain and injury discussed with the physician, and the date and time the physician was notified.

(ix) The extent of injury, if any, to the affected resident or residents.

(x) Follow-up care and outcome resolution.
A 515 Continued From page 25

(xi) The action taken by the facility to prevent the occurrence of similar incidents in the future.

This Rule is not met as evidenced by:
Based on interviews and record review, the Administrator, failed to adequately investigate a report of alleged verbal abuse of residents by a staff member.

Findings:
During a licensure survey and complaint investigation performed by the Alabama Department of Public Health at the facility from March 23, 2015 through March 26, 2015, the surveyor received four complaints from staff members of verbal abuse from one employee toward residents as well as one complaint about the same employee from a resident who was interviewed but would not give specific details of the complaint. The complaints were reported to the Administrator, who submitted an incident report to the Alabama Department of Public Health and initiated an investigation. On April 9, 2015, the Alabama Department of Public Health received a "completed" investigation report from the Administrator. This investigation report did not contain an interview with the accused employee and did not contain statements from all employees; only 12 statements were obtained from a total of 19 employees (based on an employee list provided to the surveyor on March 23, 2015 during the survey). Although the report states that all residents were interviewed and none felt that the accused employee had been abusive toward them, there was no documentation of the interviews with residents. In addition, according to documentation submitted to
### Alabama Department of Public Health

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING:**

**B. WING:**

**STATE FORM**

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| A 515 | Continued From page 26  
the Alabama Department of Public Health, inadequate interventions were performed by the Administrator to prevent the occurrence of similar incidents in the future, as only 12 of the 19 employees of the facility received additional training on the facility's Abuse, Neglect and Exploitation policy. | A 515 | | | |
| A 521 | 420-5-4-.05 (3)(g) 2. Records and Reports  
Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints. | A 521 | | | |

**Findings:**

On March 18, 2015, an incident report form was received by the Alabama Department of Public Health reporting inappropriate sexual contact between RI#8 and RI#9 which was initiated by RI#9. Although the care plan was updated for RI#9 following the incident, the interventions...
Continued From page 27

listed in RI#9's care plan were not adequate to prevent a recurrence of the behavior, placing all residents at risk for harm. RI#8's care plan was not updated at all following the incident. RI#9 was not seen by the physician for evaluation until March 25, 2015, one week after the incident occurred. In addition, RI#8's sponsor stated that she had to ask the facility to change the seating arrangement in the dining room so that RI#8 was separated from RI#9. Refer to deficiency 510 for additional information on RI#8's and RI#9's care plans.

RI#4 had insulin dependent diabetes mellitus and self-administered her medications. The surveyor observed a full red plastic sharps container in RI#4's room. When interviewed on March 25, 2015 at 12:45 PM and asked where she discarded her used needles, RI#4 stated that she recapped them and placed them in the garbage, as she was instructed to do by the facility. When interviewed on March 25, 2015 at 2:55 PM and asked about disposal of used needles for RI#4, the Administrator stated that she was not aware that the contaminated needles were being discarded in the trash can. EI#9 confirmed that RI#4 had been discarding her needles into the trash can. Refer to deficiency 611 for additional information on disposal of contaminated needles.

RI#16 was 98 years old and had diagnoses of altered mental status, depressive disorder, abnormality of gait, and muscle weakness listed on his medical exam dated January 6, 2014. RI#16's gait was unsteady, he used a walker to ambulate, and he had a history of falls. RI#16 was extremely hard of hearing which made communication difficult. On at least three occasions between March 17, 2015 and March 19, 2015 there was documentation by caregivers
A. BUILDING: ____________________________  
B. WING ____________________________  

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  
D4520  

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING: ____________________________  
B. WING ____________________________  

(X3) DATE SURVEY COMPLETED  
04/15/2015  

NAME OF PROVIDER OR SUPPLIER  
ALDRIDGE CREEK TERRACE, A MERRILL GARDENS  
STREET ADDRESS, CITY, STATE, ZIP CODE  
10310 BAILEY COVE ROAD  
HUNTSVILLE, AL  35803  

(X4) ID PREFIX TAG  
A 521  

(X5) COMPLETE DATE  

SUMMARY STATEMENT OF DEFICIENCIES  
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PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  

Continued From page 28  
on the Shift Change Information forms that RI#16 was confused and during one of these episodes of confusion, RI#16 was walking down the sidewalk outside the facility and a passerby was concerned enough to stop and recruit a staff member from inside the facility to assist RI#16. In addition, staff members reported to the surveyor that RI#16 had left the facility one night around 4:00 AM and was unable to re-enter the building; the staff was unaware he was outside the building until another resident informed them that RI#16 was knocking on the back door. Refer to deficiency 603 for additional information on RI#16. The facility was located on a busy four lane highway and the front sidewalk was very close to the edge of the highway. In spite of RI#16's repeated episodes of confusion and his unsteadiness, no safety interventions were in place on RI#16's care plan to alert the facility staff of his behaviors and prevent injuries or elopement. However, documentation by the Administrator on March 25, 2015 states that RI#16 was observed by a staff member at 5:45 PM that same date walking too close to the road, and the Administrator approached the resident but he had already turned around and walked back to the facility. On March 26, 2015, resident assistants reported to the surveyor that RI#16 had started 24-hour sitters the evening before. A sitter was observed with RI#16 by the surveyor. This addition of sitters for RI#16 was started on March 25, 2015, during the time of the survey conducted by the Alabama Department of Public Health, but had not been initiated previously during RI#16's episodes of confusion and unsafe behaviors, according to the Administrator. Only two staff members were scheduled to work at the facility between the hours of 2:00 PM and 6:00 AM, and these two staff members were responsible for 23 residents, with at least four of
# Statement of Deficiencies and Plan of Correction

## PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

D4520

## MULTIPLE CONSTRUCTION B. WING _____________________________

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<td>these residents requiring two people to assist them at times, creating an unsafe environment for RI#16, as well as for all residents of the facility, due to the amount of monitoring required for RI#16’s behaviors. RI#20 had been discharged from the facility. However, facility records revealed that RI#20 was 74 years old with diagnoses of depression, tremors, and memory deficit. According to complaints received by the Alabama Department of Public Health and reports received by the surveyor, RI#20 was confused and wandered. Documentation in RI#20's facility record on at least five different dates between October 23, 2014 and January 1, 2015, stated that RI#20 was confused, had memory loss, and was a fall risk. Refer to deficiency 603 for additional information on RI#20. After RI#20 suffered a fall with a bump to the head at the facility on December 18, 2014, the Administrator failed to follow the facility’s policy and did not call 911 for assistance. RI#20's Home Health Certification and Plan of Care dated January 1, 2015 showed a diagnosis of memory loss and abnormal loss of weight. According to the facility's weight logs, RI#20 weighed 140 pounds on December 2, 2014 and 125 pounds on January 6, 2015, a weight loss of 10.7% of her body weight in one month. There were no specific interventions on RI#20's care plan to address her confusion and wandering behaviors and to prevent her from further injury. RI#20 suffered a second fall at the facility on February 2, 2015, resulting in a fractured femur and hospitalization where documentation showed diagnoses of acute kidney injury, encephalopathy, and delirium with underlying dementia. RI#20 passed away at the hospital on March 6, 2015. RI#20 was never issued a 30 day notice of intent to discharge.</td>
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A 521 Continued From page 30

RI#1, RI#7, and RI#9 experienced significant weight loss which was not adequately addressed by the administrator. RI#7 also suffered from back pain which was reportedly affecting his appetite. Although RI#7 reported that he was drinking Ensure, no physician contacts were documented by the facility for these residents and weight loss was not addressed on any of the three care plans. No additional interventions were in place to properly monitor these three residents, placing them at risk for further decline in health and physical abilities.

The assisted living facility was staffed with only two resident assistants on the 2:00 PM until 10:00 PM shift and on the 10:00 PM until 6:00 AM shift. When interviewed, five employees of the facility who worked these shifts stated they would not have been able to safely evacuate the residents from the facility if needed in the event of a fire or other disaster. At least four residents required two people to assist them at times due to various physical and mental limitations. At least three residents required incontinence care. One resident had a diagnosis of altered mental status and had left the facility at least three times without notification of staff. The census at the time of the survey was 23. Refer to deficiency 401 for additional information on inadequate staffing.

The Alabama Department of Public Health received multiple complaints of mold in the facility. During a tour of the assisted living facility on March 23, 2015 with E1#4, Maintenance Director, the surveyor observed a black substance on the ceiling, walls, and floor in the laundry room which appeared to be mold. In addition, there was a strong musty, moldy odor in the laundry room which could also be smelled in the hallway outside the laundry room. When
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<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
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<td>A 521</td>
<td>Continued From page 31 asked about the black areas, EI#4 stated that he thought the black substance on the walls was mold and that he had been cleaning the areas with “A-Tack” cleaning solution for about a month. Also, in the laundry room, there was a very large washing machine on a metal base which had rust and mildew on the base and was dripping water from the front, leaving a puddle of water on the floor. In addition to the laundry room, the surveyor noted less prominent black areas on the ceiling around the vent in the medication room, and also areas around the vents in the kitchen which had been painted over. EI#5, Executive Chef, reported that the areas on the kitchen ceiling also appeared to be mold before they were painted over. The Alabama Department of Public Health received a complaint that the cleaning equipment at the facility needed to be replaced. Once onsite, during interviews, resident assistants reported to the surveyor that they only had one mop to clean the entire 51-bed facility and that it had not been replaced in at least a year. The surveyor observed only one mop in the utility room and also noted that it was very dirty. When asked about the dirty mop, EI#1, Administrator, stated that the staff had not told her that they needed a new mop and that she would obtain one that day.</td>
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<tr>
<td>A 601</td>
<td>420-5-4-.06(1) Care of Residents</td>
<td>A 601</td>
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<td>(1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician. (a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her</td>
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Continued From page 32

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to follow physicians' orders for all residents' care and failed to obtain written physicians' orders for all residents' medications.

THIS DEFICIENT PRACTICE WAS CITED AS A
A 601

Continued From page 33

RESULT OF A COMPLAINT INVESTIGATION.

Findings:

Failure to follow physicians' orders

RI#12 had a physician's order for Zemplar one microgram by mouth daily, which was scheduled at 9:00 AM. On March 23, 2015 at 10:40 AM, EI#13 reported to the surveyor that RI#12 did not receive her Zemplar that morning because the medication was not available on the medication cart. On that same day at 11:45 AM, the surveyor asked EI#3, Administrative Designee, when RI#12 would get her Zemplar. EI#3 stated to the surveyor that the resident would not get the medication that day. When asked who would notify the doctor that a dose was missed, EI#3 stated that the administrator handled that but she was not at the facility that day. On that same day at 2:15 PM, the surveyor asked EI#2, Administrative Designee, about the Zemplar for RI#12. EI#2 stated she would call the administrator. At 3:20 PM, more than six hours after RI#12's medication was due, EI#2 reported to the surveyor that the physician had been contacted and an order obtained to change the time on the Zemplar to 5:00 PM so the resident would receive the medication that evening. When this incident was discussed with the Administrator on March 24, 2015 at 8:50 AM, and the Administrator was informed that her designees were unsure how to handle the situation and the resident would likely have missed a dose of her medication the day before if not for intervention by the surveyor, the Administrator offered no response.

RI#6 had physician's orders for Senna-Plus two tablets by mouth twice a day and Nyamyc topical...
### A. BUILDING:

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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>D4520</td>
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### B. WING _____________________________

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<th>NAME OF PROVIDER OR SUPPLIER</th>
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<td>ALDRIDGE CREEK TERRACE, A MERRILL GARDENS</td>
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<td>10310 BAILEY COVE ROAD HUNTSVILLE, AL 35803</td>
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### SUMMARY STATEMENT OF DEFICIENCIES

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<td>A 601</td>
<td>Continued From page 34</td>
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- **A 601**
  - Powder to affected area under abdominal folds three times a day. According to RI#6's medication administration record for the month of March 2015, all doses of the Nyamyc powder and six doses of the Senna-Plus were refused by RI#6. When interviewed, RI#6 stated that she sometimes did not need these medications. However, there was no documentation in RI#6's facility record that the physician was aware that the medication doses were refused or that the medication was discontinued.

- **RI#9** had cellulitis of the left foot and swelling of the feet and legs. RI#9's physician had ordered Jobst relief stockings to be applied every morning and removed at bedtime, and this was scheduled daily at 9:00 AM and 9:00 PM on RI#9's medication administration record. Also, listed on RI#9's care plan, was an intervention to "assist with TED hose on and off." During the month of March 2015, documentation showed that RI#9 refused the stockings daily. When interviewed by the surveyor, RI#9 stated that he had the stockings but that he would not wear the stockings. However, there was no documentation that the physician was notified of RI#9's refusal of this treatment or that the stockings were discontinued.

Failure to obtain physicians' orders:

- **RI#12** had glucosamine chondroitin in her room without a physician's order for the medication.

- **RI#14** had Orajel and Cortizone 10 cream in her bathroom without a physician's order for the medications.

- **RI#16** had chest rub nasal decongestant in his bathroom without a physician's order for the medication.
Alabama Department of Public Health

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<td>A 602</td>
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<td>420-5-4-.06(2)(a) Care of Residents</td>
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<td>(a) Observation. Each assisted living facility shall provide general observation and health supervision of the residents sufficient to develop awareness of changes in all residents' health conditions and physical abilities, and awareness of the need for medical attention or nursing services. Whenever a resident requires medical attention, nursing services, or changes in personal care and assistance with activities of daily living provided by the facility, the facility shall arrange for or assist the residents in obtaining necessary services.</td>
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<td>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide general observation and health supervision of all residents sufficient to develop awareness of changes in health conditions and physical abilities, and awareness of the need for medical attention or nursing services.</td>
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<td>THIS DEFICIENT PRACTICE WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.</td>
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<td>Findings: RI#1, RI#7, and RI#9 experienced significant weight loss which was not adequately addressed by the administrator. RI#7 also suffered from back pain which was reportedly affecting his appetite and RI#9 had dementia with recent inappropriate behavior. No additional interventions were in place to properly monitor</td>
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### SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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### PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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**These three residents who were at risk for decline in health and physical abilities.**

RI#14 was thin and frail, had extremely poor vision and difficulty reading her name on medication packets, was unable to safely ambulate without assistance, had suffered significant weight loss, had sustained two previous falls in the month of March, and had body tremors. Resident assistants reported that RI#14 sometimes required two people to assist her and that they used a wheelchair to transport RI#14 out of her room due to RI#14's extreme weakness and poor endurance. Since admission to the facility on October 3, 2013, RI#14 suffered eight falls: one resulted in a fractured arm; one resulted in an eye injury; and one resulted in sutures to RI#14's arm. RI#14's increasing care needs were not adequately addressed by the facility, and RI#14 suffered her third fall in March 2015, during the survey, and was again admitted to the hospital, this time for dehydration and failure to thrive.

RI#16 was 98 years old with diagnoses of altered mental status, depressive disorder, hypothyroidism, vitamin D deficiency, abnormality of gait, and muscle weakness listed on his medical exam, as well as diagnoses of dementia and anxiety documented on a visit note written by a certified registered nurse practitioner on December 14, 2013. RI#16 had at least three episodes of confusion documented on Shift Change Information forms at the facility. In addition, RI#16 had two episodes of wandering outside the facility, one episode occurring around 4:00 AM. In spite of these multiple reports of confusion and wandering behaviors, RI#16 was not evaluated by a physician and remained at the facility with no additional staff available to monitor.
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>A 602</td>
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<td>A 602</td>
<td>RI#16 was safe until another episode occurred during the Alabama Department of Public Health survey on March 25, 2015. Refer to deficiency 603 for additional information on RI#16. RI#20's facility record contained documentation of a decline in her memory and confusion on December 29, 2014 at 5:00 PM; on October 23, 2014 at 12:11 PM; and on January 2, 2014. RI#20 experienced a weight loss of 10.7% of her body weight in January 2015. In spite of repeated documentation of RI#20's declining health and mental condition, RI#20 remained at the facility with no additional measures in place to adequately address her increased care needs. RI#20 fell again at the facility on February 2, 2015, fracturing her hip and requiring admission to the hospital where she passed away on March 6, 2015.</td>
<td>A 603</td>
<td>420-5-4-.06(2)(b) Care of Residents</td>
<td>A 603</td>
<td>(b) Services Beyond Capability of Assisted Living Facility. Whenever a resident requires hospitalization, medical, nursing, or other care beyond the capabilities and facilities of the assisted living facility, arrangements shall be made to discharge the resident to an appropriate setting, or to transfer the resident promptly to a Health Care Facilities</td>
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### State Form TMPY11

#### Alabama Department of Public Health

**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/CLIA Identification Number:**

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<tr>
<th>A. Building:</th>
<th>B. Wing:</th>
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</table>

**Date Survey Completed:** 04/15/2015

**Name of Provider or Supplier:** ALDRIDGE CREEK TERRACE, A MERRILL GARDENS

**Street Address, City, State, Zip Code:** 10310 BAILEY COVE ROAD, HUNTSVILLE, AL 35803

**Summary Statement of Deficiencies**

- **ID:** A 603
- **Prefix:** Continued From page 38

This Rule is not met as evidenced by:

- Based on observations, interviews, and record reviews, the facility failed to promptly discharge or transfer residents who required care beyond the capabilities and facilities of the assisted living facility.

**This Deficient Practice Was Cited as a Result of a Complaint Investigation.**

**Findings:**

RI#14

RI#14 was 81 years old, frail, weighed 101 pounds, and was unable to safely ambulate without assistance due to extreme generalized weakness, very poor vision, and tremors. RI#14 sustained a weight loss of 10.6% of her body weight in two months from January 6, 2015 until March 3, 2015 and had "malnourishment and failure to thrive" when she was admitted to the hospital on March 24, 2015, following a fall at the assisted living facility. That was the third fall she had suffered there since March 5, 2015 and the ninth fall since RI#14 was admitted to the facility on October 3, 2013. RI#14's hospital records from her admission on March 24, 2015 also listed dehydration and advanced Parkinson's disease as diagnoses. According to interviews with resident assistants and observations at the assisted living facility, RI#14 had great difficulty reading her name on the medication packages even with the use of a magnifying glass, and she required the assistance of at least one and
Continued From page 39

sometimes two people to get up. Although RI#14 was able to ambulate a few steps in her room with a walker and assistance, a wheelchair was used to transport RI#14 outside her room for safety due to her poor endurance and extreme weakness. According to a note written by a nurse practitioner who visited RI#14 at the facility on July 26, 2014 at 2:40 PM, RI#14's husband stated to the nurse practitioner that if RI#14 suffered another fall at the facility, she (RI#14) would have to be transferred to a skilled nursing facility. At the time of the survey, RI#14 had suffered three additional falls at the facility; however, no 30 day notice of intent to discharge had been issued to RI#14.

RI#16

RI#16 was 98 years old and had diagnoses of altered mental status, depressive disorder, hypothyroidism, vitamin D deficiency, abnormality of gait, and muscle weakness listed on his medical exam, as well as diagnoses of dementia and anxiety documented on a visit note written by a certified registered nurse practitioner on December 14, 2013. RI#16 was extremely hard of hearing, forgetful, used a walker for ambulation, was unsteady with his gait, and had a history of falls. On March 17, 2015, documentation on the facility's Shift Change Information sheet stated that RI#16 was confused and walking down the sidewalk and someone passing by stopped by the facility to alert the staff. On March 19, 2015, both first and third shifts documented on the Shift Change Information form that RI#16 was confused, and on this same date, the third shift documented that RI#16 went outside during the night and seemed very confused. Interviews with caregivers revealed that RI#16 was unable to get back into the facility when he went outside that
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>A 603</td>
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<td>A 603</td>
<td>night (around 4:00 AM), and another resident had to inform the staff that he was outside when they heard him knocking on the back door. In spite of these multiple reports of confusion and wandering behaviors, RI#16 was not evaluated by a physician and remained at the facility with no additional staff available to monitor and ensure that RI#16 was safe until another episode occurred during the Alabama Department of Public Health survey on March 25, 2015. The Administrator documented on this date that a staff member saw RI#16 walking outside and thought he was getting too close to the road so she (the administrator) approached RI#16 but he had already turned around and walked back to the facility. The Administrator further documented that she contacted RI#16's family, notified RI#16's physician, and set up an appointment with the physician to evaluate RI#16's health and behaviors &quot;for his safety,&quot; and that RI#16's family enlisted sitters for RI#16 until the evaluation could be done by the physician. This incident occurred after the surveyor had discussed with the Administrator that inadequate interventions were in place at the facility to protect RI#16 due to his wandering behaviors and documented confusion, and after the Administrator stated to the surveyor that she did not consider RI#16's behaviors to be &quot;wandering&quot;. No 30 day notice of intent to discharge had been issued to RI#16.</td>
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<td>RI#20 (discharged)</td>
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<td>RI#20 was 85 years old with diagnoses of depression, tremors, and hypertension when she was admitted to the facility on September 18, 2013. According to two separate complaints received by the Alabama Department of Public Health, RI#20 wandered and was confused. Documentation in RI#20's facility record on</td>
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October 23, 2014 at 12:11 PM stated that RI#20 came to the front desk lost and asking for a place to stay. On December 17, 2014, the facility record showed documentation that RI#20 was evaluated by a home health psychiatric nurse. On December 18, 2014 at 1:47 PM, the Administrator, documented that RI#20 had fallen at the facility and hit her head; on December 29, 2014, the Administrator documented that RI#20 was "somewhat confused, but not exit seeking and resident knows herself and her name"; and on December 29, 2014, the Administrator documented on RI#20's care plan "some confusion on time of day ... fall risk, becomes dizzy recently." RI#20's Home Health Certification and Plan of Care dated January 1, 2015 showed a diagnosis of memory loss and abnormal loss of weight. According to the facility's weight logs, RI#20 weighed 140 pounds on December 2, 2014 and 125 pounds on January 6, 2015, a weight loss of 10.7% of her body weight in one month. A Physician Report and Orders written on January 2, 2014 listed a diagnosis of memory deficit. A Progress Note written by North Alabama Home Care on January 2, 2014, documented that RI#20 was experiencing behavioral changes, she was talking about calling family members who were deceased, her hygiene was lacking, and her Mini Mental Status Exam showed a decrease in memory. Although RI#20 had repeated documentation of confusion, memory deficit, weight loss, and declining mental status, she remained at the assisted living facility until she suffered a second fall on February 2, 2015, which resulted in hospitalization due to a fractured femur and multiple other medical diagnoses which included acute kidney injury, encephalopathy, and delirium with underlying dementia. RI#20 passed away at the hospital on March 6, 2015.
Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

D4520

A. BUILDING: __________________________ 
B. WING: __________________________ 

DATE SURVEY COMPLETED: 04/15/2015

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

Alabama Department of Public Health

NAME OF PROVIDER OR SUPPLIER: ALDRIDGE CREEK TERRACE, A MERRILL GARDENS
STREET ADDRESS, CITY, STATE, ZIP CODE: 10310 BAILEY COVE ROAD, HUNTSVILLE, AL 35803

SUMMARY STATEMENT OF DEFICIENCIES

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<tr>
<td>A 607</td>
<td>420-4-06(2)(f)</td>
<td>Care of Residents</td>
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(f) Each facility shall develop and implement a policy and procedure to ensure that each resident of the facility is free from abuse, neglect and exploitation. The facility shall ensure that all staff can demonstrate an understanding of what constitutes abuse, neglect, and exploitation and shall ensure that all staff understands his or her responsibility to immediately report suspected incidents of abuse, neglect or exploitation of a resident to the administrator. When abuse, neglect, or exploitation is alleged or suspected, the facility shall conduct and document a thorough investigation and take appropriate action to prevent further abuse. All allegations and suspicions shall be reported to the Assisted Living Unit of the Alabama Department of Public Health and to the victim's sponsor or responsible family member within 24 hours. Suspected abuse, neglect, or exploitation of a resident shall be reported to the Department of Human Resources or law enforcement in accordance with Code of Ala., 1975, Section 38-9-8. At any time that a resident has been the victim of sexual assault or sexual abuse perpetrated by a staff member or visitor, local law enforcement authorities shall be immediately notified.

This Rule is not met as evidenced by:
Based on interview, the Administrator failed to notify the victim's sponsor when an incident of sexual abuse occurred.

Findings:

On March 26, 2015 at 11:30 AM, RI#8's sponsor
Continued From page 43

A 607

(and power of attorney) asked to speak with the surveyor. RI#8's sponsor informed the surveyor that she nor anyone in the family was notified by the facility when an incident of sexual abuse occurred between RI#8 and RI#9 on March 18, 2015. In fact, RI#8's sponsor stated that another family member came to visit RI#8, and RI#8 informed the family member of the incident; the family member then reported it to RI#8's sponsor. According to the facility's incident report which was signed by the Administrator RI#8's sponsor was notified at 2:00 PM on the day of the incident, 5 1/2 hours after the incident occurred. When interviewed on March 26, 2015 at 2:00 PM and asked if RI#8's sponsor was notified of this incident, the Administrator stated "well I'm sure we called her, it may have been later." RI#8's sponsor further stated that she had to ask the facility to provide alternate dining room seating arrangements to separate RI#8 from RI#9 following this incident. Review of RI#8's and RI#9's care plans revealed that no adequate interventions were in place to prevent a recurrence of the inappropriate behavior and to protect RI#8 and all residents from further abuse and potential harm. RI#9 was not evaluated by a physician until March 25, 2015, one week after the incident occurred. At the time of the initial onsite survey, the facility was still awaiting lab results for RI#9 which were ordered at the time of the physician evaluation.

A 611

420-5-4-.06(2)(k) Care of Residents

(k) Laboratory Tests. Any facility conducting or offering laboratory tests for its residents, including routine blood glucose monitoring, shall comply with federal law, and specifically with the applicable requirements of the federal Clinical

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### Laboratory Improvement Act ("CLIA")

Laboratory Improvement Act ("CLIA") as well as with applicable federal regulations. This requirement in some cases would require the facility to obtain a CLIA certificate, and in other cases would require the facility to obtain a CLIA waiver. For more information about CLIA requirements, a facility may contact the Alabama Department of Public Health, Bureau of Health Provider Standards. For testing or monitoring requiring blood, either the resident must draw his or her own blood or the blood must be drawn by a physician ("MD" or "DO"), a physician's assistant ("PA"), a registered professional nurse ("RN"), or a licensed practical nurse ("LPN"). Blood and blood products, needles, sharps and other paraphernalia involved in collecting blood must be handled in a manner consistent with requirements of the federal occupational safety and health administration ("OSHA"). Personnel handling such materials must be vaccinated against blood borne diseases if such vaccinations are required by OSHA. Blood, blood products, needles, sharps and other paraphernalia involved in collecting blood shall be treated as medical waste and shall be disposed of in a manner compliant with the requirements of the State of Alabama Department of Environmental Management.

This Rule is not met as evidenced by: Based on observations and interviews, the Administrator failed to ensure that contaminated needles were properly discarded.

### Findings:

On March 25, 2015 at 12:45 PM, the surveyor noted a full red plastic sharps container in R1#4's room. When the surveyor asked R1#4 where she

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<td>A 613</td>
<td>420-5-4-.06(3)(b) Care of Residents</td>
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### Alabama Department of Public Health

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

| (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION 
A. BUILDING: ______________________ |
| | B. WING __________________________ |

| (X3) DATE SURVEY COMPLETED | D4520 | (X5) COMPLETE DATE |
| | 04/15/2015 | |

**NAME OF PROVIDER OR SUPPLIER**

ALDRIDGE CREEK TERRACE, A MERRILL GARDENS

**STREET ADDRESS, CITY, STATE, ZIP CODE**

10310 BAILEY COVE ROAD
HUNTSVILLE, AL 35803

**SUMMARY STATEMENT OF DEFICIENCIES**

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<tr>
<th>ID</th>
<th>PREFIX</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tbody>
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<td>A 613</td>
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<td>for the dog, El#4 was unable to locate it. The documentation was presented to the surveyor on March 25, 2015 during the survey but had not been verified prior to the pet residing at the facility.</td>
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<td>A 624</td>
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<td></td>
<td>420-5-4-.06(4)(k) Care of Residents</td>
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<td>(k) If controlled substances prescribed for residents of any assisted living facility are kept in the custody of the assisted living facility, they shall be stored in a manner that is compliant with state law, federal law, the requirements of the Alabama State Board of Pharmacy, and any requirements prescribed by the Alabama State Board of Health. At a minimum, controlled substances in the custody of the facility shall be stored using a double lock system, and the facility shall maintain a system to account for all controlled substances in its possession. All other medications in the custody of the facility shall be stored using at least a single lock. This shall include medications stored in a resident's room when the staff and not the resident have access to the medications. Medications may be kept in the custody of an individual resident who is aware of his or her medications and who can safely manage his or her medications. Such medications may be stored in a locked container accessible only to the resident and staff, or may be stored in the resident's living quarters, if the room is single occupancy and has a locking entrance.</td>
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This Rule is not met as evidenced by:

Based on observations and interviews, the facility failed to keep all medications in its custody and in the custody of residents stored using at least a...
### Health Care Facilities

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<tr>
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<td>Findings:</td>
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<td>During a tour of the facility on March 23, 2015 with EI#4, Maintenance Director, the surveyor noted the medication room door was open. The refrigerator in the medication room was not locked and contained the medication Zioptan. EI#4 quickly closed and locked the medication room door.</td>
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<td>On March 23, 2015 at 5:35 PM, the surveyor and EI#2, Administrative Designee, reviewed RI#10’s self-administered medications in her room. Upon entering RI#10’s room, the door was unlocked and all of RI#10’s medications were unsecured. RI#10 was in the dining room eating dinner.</td>
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<tr>
<td>A1007</td>
<td>420-5-4-.10 (1)(g) Sanitation and Housekeeping</td>
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<td>(g) Control of odors. The facility shall be free of objectionable odors.</td>
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<td>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that no objectionable odors were present in the facility. THIS DEFICIENT PRACTICE WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JANUARY 6, 2011. Findings:</td>
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A1007 | Continued From page 48
During a tour of the facility on March 23, 2015 with EI#4, the surveyor noted foul urine odors from RI#11's and RI#15's rooms, and foul body odors from RI#6's room. These odors were also noted by the surveyor in the same rooms at various times during the survey. In addition, a musty, moldy smell was present in the facility's laundry room and in the hallway outside the laundry room door. When asked about the odors EI#4, Maintenance Director, reported to the surveyor that he had the carpet cleaned in RI#11's room at least every two months and that he had been cleaning the moldy areas in the laundry room with "A-Tack."

A1008 | 420-5-4-.10 (2) (a)(b)(c) Sanitation and Housekeeping
(2) Housekeeping and Physical Plant Maintenance. The facility must provide a safe, functional, sanitary and comfortable environment for residents, staff, and the public.

(a) Equipment and Supplies. The home shall maintain an adequate quantity of housekeeping and maintenance equipment and supplies.

(b) Bathtubs and Lavatories. Bathtubs and lavatories shall be kept clean and in proper working order, and shall not be used for laundering.

(c) Resident Bedrooms. Resident bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance.
A1008 Continued From page 49

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to maintain a sanitary environment for all residents, failed to maintain lavatories in proper working order, and failed to maintain adequate housekeeping equipment.

THIS DEFICIENT PRACTICE WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

Findings:

Unsanitary environment

The carpet in R1#11’s room was badly stained and smelled strongly of urine. The carpet in R1#15’s room also smelled strongly of urine. There was rust and black areas on the base of the washing machine in the laundry room as well as black areas on the ceilings and walls in the laundry room and on the ceiling in the medication room. Room 403 had piles of cat hair in the closet area.

Lavatory not working properly

On March 23, 2015, during a tour of the facility with EI#4, Maintenance Director, the surveyor noted that the lavatory in Room 304 was not draining properly and once filled, was very slow to empty.

Adequate quantity of housekeeping equipment

The surveyor received multiple complaints from resident assistants that the facility only had one mop for 51 rooms and that it was over a year old. Only one mop was observed by the surveyor in the utility room and it was very dirty. When interviewed, EI#1, Administrator, stated that the
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<td>A1101</td>
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<td>resident assistants had not asked her for a new mop and that she would obtain one that day.</td>
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<td>A1101</td>
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<td>420-5-4-.11 Fire Safety</td>
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(a) Evacuation Plan. All assisted living facilities shall maintain a current written fire control and evacuation plan. In facilities which have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. Fire control and evacuation plans shall be kept current. Written observations of the effectiveness of the fire drill plan shall be filed and kept for at least three years.

(b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days, quarterly on each shift of Group and Congregate facilities. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the Code.

(c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9:00 PM and 6:00 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs.
A1101  Continued From page 51

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to maintain adequate documentation of required monthly and quarterly fire drills.

Findings:

On March 25, 2015 at 1:00 PM, the surveyor reviewed fire drill reports for the facility provided by EI#4, Maintenance Director. Fire drill reports were not present for May 2014, September 2014, October 2014, November 2014, and December 2014, and were not documented monthly as required. In addition, fire drills were not documented quarterly on each shift. When asked about the missing fire drill reports on March 25, 2015, both EI#1 and EI#4 stated that the fire drills were done but they were unable to locate the reports.

A1203  420-5-4-.12 (3)(a) Physical Plant

(3) General Building Requirements - Family, Group and Congregate.

(a) Structural Soundness and Repair. The building shall be structurally sound, free from leaks and excessive moisture, in good repair, and painted with sufficient frequency to be reasonably attractive inside and out. The interior and exterior of the building shall be kept clean and orderly.
Alabama Department of Public Health

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<td>B. WING ____________________</td>
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| A1203              | Continued From page 52
This Rule is not met as evidenced by:
Based on observations and interviews, the facility structure was not maintained in good repair, free from leaks and excessive moisture, and was not kept sufficiently clean.

THIS DEFICIENT PRACTICE WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

Findings:

During a tour of the facility on March 23, 2015, the surveyor observed a badly stained, sagging ceiling tile in the hallway outside the activity room door. When asked about the tile and if a leak had occurred, EI#14 reported that it leaked every time there was rain and they had to put a garbage can in the hall to catch the water. When EI#4, Maintenance Director, was asked about this leak, he stated he had obtained an estimate for repair, but the repairs had not been done due to rainy weather.

On March 26, 2015, the surveyor observed a large area of the ceiling which had fallen in Room 104. Also, in Room 410, a strip of the ceiling extending across the room had partially fallen, with fragments hanging from the ceiling and some pieces on the carpeted floor. When asked about these fallen ceilings, both the Administrator and resident assistants reported to the surveyor that they had leaks when the sprinkler system had malfunctioned which caused the ceiling damage.

Large holes were noted in the wall and in the bathroom door in Room 403. Also noted in this room were large scraped areas and missing paint on the baseboards and bathroom door. When asked about the condition of this room, EI#4,
**A. BUILDING:** 

**B. WING:** 

**NAME OF PROVIDER OR SUPPLIER:** ALDRIDGE CREEK TERRACE, A MERRILL GARDENS  
**STREET ADDRESS, CITY, STATE, ZIP CODE:** 10310 BAILEY COVE ROAD, HUNTSVILLE, AL 35803  

**ID** | **PREFIX** | **TAG**  
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A1203 | | Continued From page 53  
A1208 | 420-5-4-.12 | (3)(f)(g)(h)(i) Physical Plant  

(f) Floors. All floors shall be level, smooth and free of cracks and finished so that they can be easily cleaned. The basic requirement for floor finishes shall be wall-to-wall with such finishes as paint, stain, sealer, carpet, sheet vinyl, vinyl tile, hard tile, or other appropriate floor finish. Floors shall be kept clean.  

(g) Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface and shall be kept clean and in good repair.  

(h) Windows. Non-stationary windows shall be so constructed and maintained so that they fit snugly, and are capable of being opened and closed easily.  

(i) Ceiling Height. Each room occupied by residents shall have a ceiling height of eight feet or more. Existing facilities with ceiling heights less than 8 feet shall be acceptable when the height complies with the codes.  

This Rule is not met as evidenced by:  
Based on observations and interviews, the facility's walls and ceilings were not kept clean and in good repair.
**Summary Statement of Deficiencies**

This deficient practice was cited as a result of a complaint investigation.

Findings:

Blackened areas were noted on the walls and ceilings in the laundry room as well as on the ceiling in the medication room. Although EI#4, Maintenance Director, reported to the surveyor that he had been cleaning these areas for a month, the black areas were still present. Refer to deficiency 521 for additional information on the unclean walls and ceilings.

On March 23, 2015, the surveyor observed a badly stained, sagging ceiling tile in the hallway outside the activity room. When asked about the tile and if a leak had occurred, EI#14 reported that the leak had been there for some time and that it leaked every time there was rain, and they had to put a garbage can in the hall to catch the water. When EI#4, Maintenance Director, was asked about this leak, he stated he had obtained an estimate for repair, but the repairs had not been done due to rainy weather.

During a tour of the facility with EI#4 on March 23, 2015, the surveyor observed Room 403, which had been unoccupied since January 22, 2015. The carpet was dirty, cat hair was piled up thickly on the carpet in the closet area, there were large holes in the wall beside the door as well as in the bathroom door, and the baseboards and bathroom door were badly scraped and in need of paint. When asked about the appearance of Room 403, EI#4, Maintenance Director, stated that the resident used a power wheelchair which she had trouble driving causing her to run into the walls, and that she owned a cat.
On March 26, 2015, the surveyor observed a large area of the ceiling which had fallen in Room 104. Also, in Room 410, a strip of the ceiling extending across the room had partially fallen, with fragments hanging from the ceiling and some pieces on the carpeted floor. When asked about these fallen ceilings, both the Administrator and resident assistants reported to the surveyor that they had leaks when the sprinkler system had malfunctioned which caused the ceiling damage.

CONNIE CHERRY, REGISTERED NURSE