STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3733	A. BUILDING: _____ B. WING _____	C 07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RIDGE AT GRANDE VIEW SCALF	700 CORPORATE RIDGE ROAD BIRMINGHAM, AL 35242

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Amended Report on August 28, 2025 On July 17, 2025, an unannounced licensure survey was conducted for this 40 bed Specialty Care Assisted Living Facility (SCALF) with a census of 34. There were seven (7) complaints investigated during this survey. LC#20250626007, LC#20250626006, LC#20250612007 and LC#20240610008 were substantiated. Deficiencies were cited as a result of these complaint investigations. LC#20241126005, LC#20240221011 and LC#20231003002 were unsubstantiated. There were no deficiencies cited as a result of these complaint investigations. 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 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practices resulted in the potential for harm to all residents and require a plan of correction.	A 000		
A 508	420-5-20-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in a specialty care assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the	A 508		

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A 508	Continued From page 1 administrator for review. 1. Incidents which require investigation are: (i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as extensive bruising, pain, or injury that is not consistent with actions necessary in providing day-to-day care to a resident or for which medical treatment was sought. (ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid including but not limited to a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office. (iii) The onset of wandering behavior by any resident who is not fully cognitively intact. (iv) Elopement by a resident. (v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. (vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules. (vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules.	A 508		

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A 508	Continued From page 2 (viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or Staphylococcus aureus). (ix) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (xi) An unplanned occurrence that results in media attention. (xii) A medication error, overdose, or over sedation. (xiii) Ingestion by a resident of a toxic substance that requires medical attention. (xiv) Any indication of malfunction of the sprinkler system, or fire alarm system. 2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following: (i) Names of all residents involved. (ii) Names of all staff involved including	A 508		

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A 508	Continued From page 3 person in charge at the time of the incident. (iii) When the administrator was notified (date and time). (iv) Circumstances under which the incident occurred. (v) When the incident occurred (date and time). (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken. (viii) The extent and description of injury, if any, to the affected resident or residents. (ix) Immediate treatment rendered. (x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified. (xi) Names, telephone numbers, and addresses of witnesses. (xii) Date and time relatives or sponsor were notified. (xiii) Out-of-facility treatment. (xiv) Follow-up care. (xv) Outcome resolution. (xvi) The action taken by the facility to prevent the occurrence of similar incidents in the	A 508		

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A 508	Continued From page 4 future. (xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation. (xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request. (xix) The entire investigative file and documentation of all corrective action taken shall be retained for a period of not less than 3 years after the resident is discharged or dies. (xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff. 3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident: (i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention. (ii) Elopement by a resident. (iii) Suspected, alleged, confessed, witnessed, or actual abuse, neglect, or exploitation of a resident or residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be	A 508		

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A 508	Continued From page 5	A 508		

notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file.

(iv) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility.

(v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident.

(vi) An unplanned occurrence that results in media attention.

(vii) Any medication error, overdose, or over sedation. The incident shall be immediately reported to the attending physician, facility medical director, or back-up physician.

(viii) Ingestion by a resident of a toxic substance that requires medical attention.

(ix) Notifiable diseases and health conditions listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04. shall also be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1-.04. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than three years.

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A 508	Continued From page 6 (x) Any indication of a malfunction of the sprinkler system, fire alarm system, or a door locking device. 4. The report to the Department's Online Incident Reporting System shall include the following: (i) Facility name and direct phone number. (ii) Time and date of the report. (iii) Reporter's name. (iv) Name of resident(s), staff, or visitor(s) involved in the incident. (v) Names of staff on duty at the time of the incident. (vi) Date and time of the incident. (vii) A brief description of the incident. (viii) Any injury or injuries to resident(s). (ix) Action taken by the facility in response to the incident. (i) Vital Statistics Reports. A record shall be kept of all births, deaths, and stillbirths that occur within the specialty care assisted living facility. By the fifth day of each month, the administrator shall make a report of such births, deaths, and stillbirths for the preceding month on such forms as the State Board of Health shall provide to the county health officer, or in counties	A 508		

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A 508	Continued From page 7 without a county health officer, to the State Registrar. This report shall be in addition to the official birth, death, and stillbirth certificates. If there are no births, deaths, or stillbirths in any month, a report shall be made stating that fact to the county health officer. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to report medication errors to the Alabama Department of Public Health's Online Incident Reporting System (OIRS). THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received complaints which alleged residents' medications were not administered on the morning of June 7, 2025 due to no nurse available at the facility. The surveyor was able to substantiate this complaint during the onsite survey. During an interview on the afternoon of July 15, 2025, Employee Identifier (EI)#1 informed the surveyor that there was one morning (June 7, 2025) when residents did not receive any morning medications due to an unfortunate and unavoidable series of events involving nurses who were scheduled to work that morning. This occurred during a brief period of time when no Registered Nurse (RN) and Care Coordinator were employed at the facility who would have	A 508		

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A 508	Continued From page 8 been available to come to the facility to administer the medications. EI#1 stated that the medications omitted were between the hours of 6:00 AM and 11:30 AM and the residents resumed scheduled medication administration with the 12:00 noon doses. EI#1 added that all physicians were notified, all residents' sponsors were notified, residents were monitored and no adverse effects were observed due to the omission of these medications. When asked if an incident report had been submitted to the OIRS, EI#1 stated that an incident report was submitted. However, an incident report for the medication errors was not located in the OIRS by the surveyor and EI#1 was unable to produce a copy of the incident report.	A 508		
A 604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility RN or care coordinator shall screen prospective residents for eligibility for admission into the specialty care assisted living facility. The screening shall include a clinical history, a mental status examination to include aphasia screening, a geriatric depression screen, a physical self-maintenance screen, and a behavior screen. Appendix A herein, contains the Physical Self Maintenance Scale (PSMS) form and the Behavior Screening form. These forms shall be completed to screen physical functioning and behaviors. The PSMS and Behavior Screen assessments shall be completed by the RN or care coordinator upon admission, annually, and	A 604		

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when there is a change in the resident's status.

The facility RN shall perform a comprehensive assessment of each prospective resident for facility eligibility. This assessment shall document identified care needs and serve as a baseline for the RN plan of care and future assessments.

(b) Monthly Assessments. The RN shall assess each resident monthly and more often when necessary to identify changes in the resident's health status. The monthly assessment shall include a review of monthly weights, falls, incidents, elopements, behavioral symptoms, medications, changes in resident status, and appropriateness of the resident's plan of care.

(c) Comprehensive Assessment. The facility RN shall perform a comprehensive assessment and communicate with the resident's attending physician and with the resident's sponsor or responsible family member when a decline in health status or behavior occurs, or if the resident develops any of the following problems:

1. Weight loss:

(i) Each month, the facility shall accurately weigh and record the weight of each resident.

(ii) A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half percent or greater weight loss in a period of 3 months or less, or a 10 percent or greater weight loss in a period of 6 months or less. Any weight loss shall

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A 604	Continued From page 10 be considered to be an 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. 2. Falls (two or more falls within a 30 day period). 3. Elopement. 4. Any sign and symptom of adverse drug reaction, interaction or over sedation, or circumstances which contraindicate medications that have been prescribed for the resident. 5. Unmanageable, combative, or potentially harmful behavior(s). 6. Any accident with injury. (d) Focused Assessments. The RN or LPN shall conduct focused assessments when necessary to identify changes in resident status. (e) Any change in resident status requires immediate documentation and implementation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility nurses failed to perform health supervision of residents as required. THIS DEFICIENCY WAS CITED AS A RESULT	A 604		

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A 604	Continued From page 11 OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received complaints which alleged residents were not properly assessed for admission. The surveyor was able to substantiate this complaint during the onsite survey. Review of current and discharged residents' facility records, on July 16 and 17, 2025, revealed the following information. Resident Identifier (RI)#1 was admitted to the facility on March 6, 2025 with diagnoses which included dementia, hypertension and cataracts. RI#1 did not have a monthly assessment completed for June 2025. Pre-admission assessments including mental status examination, aphasia screening, depression screening, PSMS, behavior screening and clinical history, for RI#1 were not completed until March 10, 2025, four days after RI#1's admission. RI#2 was admitted to the facility on January 12, 2023 and had diagnoses which included dementia, hypertension, thyrotoxicosis and hyperlipidemia. RI#2 did not have a monthly assessment completed for June 2025. RI#3 was admitted to the facility on March 18, 2025 with diagnoses which included Alzheimer's dementia, anxiety disorder, major depressive disorder, vitamin D deficiency, Parkinsonism, diabetes mellitus, hypertension and hypothyroidism. RI#3 did not have a monthly assessment completed for June 2025. RI#3's initial aphasia screening, behavior screening and PSMS score were not completed until March 19,	A 604		

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2025, the day after RI#3 was admitted.

RI#4 was admitted to the facility on March 7, 2025 and had diagnoses which included hypothyroidism, mixed anxiety and depression, Parkinson's disease and osteoporosis. RI#4 had no monthly assessments documented since admission. The initial comprehensive assessment, mental status examination, aphasia screening, depression screening, behavior screening and PSMS for RI#4 were completed on March 13, 2025, six days after RI#4 was admitted to the facility.

RI#5 was admitted to the facility on February 27, 2024 and had diagnoses which included diabetes mellitus type II, hypertension, congestive heart failure, chronic kidney disease stage III, atrial fibrillation, post traumatic stress disorder, chronic obstructive pulmonary disease, dementia and compensated liver cirrhosis. RI#5 did not have a monthly assessment completed in June 2025, February 2025, October 2024 and August 2024. RI#5 sustained a significant weight loss of 19 per cent for one month in May 2025 (200 pounds in April 2025 and 160.8 pounds in May 2025). No comprehensive assessment, PSMS and behavior screening were completed when this significant decline in RI#5's condition occurred.

RI#7 was admitted to the facility on October 31, 2024 and had diagnoses which included iron deficiency anemia, hypertension, dementia with anxiety and behavioral disturbance, depression and insomnia. RI#7 did not have a monthly assessment completed in June 2025. RI#7's initial assessments including mental status examination, aphasia screening, depression screening, PSMS, behavior screening, clinical history and comprehensive assessment were

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completed on November 5 and 6, 2024, after RI#7's admission to the facility.

RI#8 was admitted to the facility on May 12, 2025 and had diagnoses which included Parkinsonism with cognitive deficits, chronic pain syndrome, hypertension, situational anxiety, asthma, diabetes mellitus type II, insomnia and hypernatremia. RI#5 did not have a monthly assessment completed for June 2025. RI#5's initial mental status examination, depression screening, PSMS, clinical history and comprehensive assessment were not completed until May 13, 2025, the day after RI#8's admission. RI#8's initial behavior screening and aphasia screening were not completed until May 15, 2025, three days after RI#8's admission.

RI#10 was admitted to the facility on April 28, 2023 and discharged from the facility on June 12, 2024. RI#10 had diagnoses which included hypothyroidism, anxiety, vitamin B12 deficiency, dementia with delusional thoughts, insomnia and history of falls and weight loss. RI#10's initial comprehensive assessment, mental status examination, aphasia screening, depression screening, PSMS, behavior screening and clinical history were completed on April 29, 2023, the day after RI#10 was admitted to the facility.

RI#11 was admitted to the facility on February 12, 2024 and discharged from the facility on January 29, 2025. RI#11 had diagnoses which included Parkinson's disease, ataxia, hypertension, polyarthritis, sarcopenia, depression with anxiety, cognitive impairment, hypothyroidism and insomnia. RI#11's initial assessments including mental status examination, aphasia screening, behavior screening. depression screening, PSMS and clinical history were completed on February

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A 604	Continued From page 14 28, 2024, over two weeks after RI#11 was admitted to the facility. EI#1 explained that the facility was without a RN to complete the monthly assessments of residents in June 2025. EI#1 acknowledged that assessments had not been completed as required and stated that the newly hired RN was being trained to complete resident assessments as required.	A 604		
A 611	420-5-20-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. The RN shall develop written plans of care for each resident prior to or at the time of admission. The plans of care shall be based on resident's assessments, diagnoses, and recommendations of the resident's physician. The plan of care shall be developed in cooperation with the resident, if appropriate, and the sponsor. The RN shall identify resident care problem areas and formulate written interventions to address those problems. The RN shall evaluate the implementation of the interventions and the resident's response to the interventions and modify the plan of care as necessary. 1. The plan shall at all times reflect the current condition of the resident. All entries on the	A 611		

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THE RIDGE AT GRANDE VIEW SCALF	700 CORPORATE RIDGE ROAD BIRMINGHAM, AL 35242

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A 611	Continued From page 15	A 611		

plan of care shall be accurately dated. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following:

2. A listing of the resident's individual needs or problems that require intervention by the facility.

3. A listing of interventions provided by the facility to address the resident's identified needs or problems.

4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider.

5. Activities of Daily Living. Residents of a specialty care assisted living facility shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident.

(i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested.

(ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips.

(iii) Hair. Residents' hair shall be kept clean, neat, and well groomed.

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A 611	Continued From page 16 (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be provided assistance with personal safety. 6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain current resident care plans which contained appropriate interventions to meet the care needs of the residents. Findings: RI#1 had resided at the facility since March 6, 2025 and was currently receiving hospice services at the facility. RI#1's hospice care was not addressed on RI#1's facility care plan. RI#4 had resided at the facility since March 7, 2025. RI#4 sustained falls at the facility on June 18, 2025 and again on July 7, 2025. These falls were not addressed on RI#4's facility care plan with appropriate interventions to prevent a recurrence. RI#5 had resided at the facility since February 27,	A 611		

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A 611	Continued From page 17 2024. RI#4 sustained a significant weight loss of 19 per cent for one month in May 2025. RI#4's weight loss was not addressed on RI#5's facility care plan. RI#7 had resided at the facility since October 31, 2024. RI#7 demonstrated aggressive behaviors toward staff when care was provided and would yell out at times. These behaviors were not addressed on RI#7's facility care plan with appropriate interventions for managing the behaviors. EI#2, the current RN had only worked at the facility for a short time and stated she (EI#2) was working on assessing all residents and updating their facility care plans.	A 611		
A 616	420-5-20-.06 (5) (i) (j) (k) (l) (m) Care of Residents. (i) Medications kept under the control or custody of a specialty care assisted living facility shall be packaged by the pharmacy and shall be maintained by the facility in unit dose packaging. Medications kept under the control or custody of the specialty care assisted living facility that are not available in unit dose packaging must be packaged by the pharmacy and administered by a physician, RN, or LPN. (j) Unless a resident can and does self-manage his or her own medications, a specialty care assisted living facility shall require each resident to use a single pharmacy. This does not apply to emergency pharmacy services. All residents need not use the same pharmacy that is used by other residents unless express policy of the specialty care assisted living facility	A 616		

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A 616	Continued From page 18	A 616		

provides otherwise and all residents are informed of such policy and provided a copy of such policy prior to or at the time of admission. The specialty care assisted living facility shall require pharmacies used for medication supply for residents not self-managing their medications to review all ordered medication regimens for possible errors or adverse drug interactions and to advise the facility and the prescribing health care provider when these are detected.

(k) If controlled substances prescribed for residents of any specialty care assisted living facility are kept in the custody of the specialty care assisted living facility, they shall be stored in a manner that is compliant with state and federal laws, 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, under proper temperature and humidity controls and permit only authorized personnel access. 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, under proper temperature and humidity controls and permit only authorized personnel access. 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 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 and secured in the resident's living quarters, if the room is single occupancy and has a locking entrance.

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A 616	Continued From page 19 (l) Medication administration records and written physician orders for all over-the-counter drugs, legend drugs, and controlled substances shall be retained for a period of not less than 3 years. They shall be available for inspection and copying on demand by agents of the State Board of Health. They shall be made available for inspection at reasonable times by residents, anyone authorized by the resident, and by the sponsors of residents. (m) Labeling of Drugs and Medicines. All containers of prescribed medicines and drugs shall be labeled in accordance with the rules of the Alabama State Board of Pharmacy and shall include appropriate cautionary labels, such as, "Shake Well," or "For External Use Only." This Rule is not met as evidenced by: Based on record review and interview, a resident's medications were administered by unlicensed personnel at the facility. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received complaints which alleged residents' medications were administered by unlicensed personnel at the facility. The surveyor was able to substantiate this complaint during the onsite survey.	A 616		

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A 616	Continued From page 20 On the morning of July 17, 2025, the surveyor interviewed EI#7 who was employed as a Medication Technician in the assisted living facility in the same building. EI#7 explained to the surveyor that she (EI#7) also worked as a Care Partner in the SCALF at times. Both EI#1 and EI#2 were present during the interview. EI#7 was asked if she (EI#7) had ever administered medications to residents in the SCALF. EI#7 responded "one time" and explained that a nurse was administering medications that day in the SCALF. EI#7 was working in the SCALF as a Resident Aide. The nurse who was working handed a cup of pills to EI#7 and instructed EI#7 to take the medications to the resident. EI#7 followed the nurse's instructions and administered the medications to the resident. EI#7 did not remember the date the incident occurred or the resident but stated she (EI#7) only administered medications to one resident. When asked who documented the medication administration, EI#7 stated that the nurse documented that the medications were given. EI#7 stated she (EI#7) was aware she (EI#7) was not licensed to administer medications in a SCALF and stated she (EI#7) would not do so again. When asked if she (EI#7) was aware of anyone else who had administered medications in the SCALF without a license, EI#7 replied that she (EI#7) was not aware of any other incidences.	A 616		
A 617	420-5-20-.06 (6) Care of Residents. (6) Disposal of Medications. (a) Controlled substances and legend drugs dispensed to residents, that are expired or unused because the medication is discontinued	A 617		

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A 617	Continued From page 21 or because the resident dies, shall be destroyed within 30 days. Unused legend drugs that are not expired may be donated to a charitable clinic pursuant to Alabama Administrative Code Chapter 420-11-11, et. seq. Under no circumstances shall expired, discontinued, or unused medications be stored or housed in the facility beyond 30 days. (b) Medications of residents who are discharged or transferred to another facility shall be returned to the residents. The responsible party will sign a statement that these medications have been received. The statement shall list the pharmacy, prescription number, date, resident's name, and strength of the medication and the amount. This statement shall be maintained in a file for at least three years. (c) When medications are destroyed on the premises of the specialty care assisted living facility, a record shall be made and retained for at least three years. This record shall include: the name of the specialty care assisted living facility, the method of disposal, the pharmacy, the prescription number, the name of the resident, the name, strength, and dosage of the medication, and the amount and the reason for the disposal. This record shall be signed and dated by the individual performing the destruction and by at least one witness. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to document disposition of medications upon discharge of a resident from the facility.	A 617		

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A 617	Continued From page 22 Findings: Review of discharged residents' records on July 16, 2025 revealed the following information. RI#11 was admitted to the facility on February 12, 2024 and discharged from the facility to a skilled nursing facility on January 29, 2025. No disposition of RI#11's medications was documented when RI#11 was discharged. EI#1 became the facility administrator in May 2025 and was unable to determine why the disposition of medications was not documented in January 2025 but stated she (EI#1) is aware medication disposition must be documented.	A 617		
A 804	420-5-20-.08 (4) Physical Facilities. (4) Food Service Facilities. (a) Floors. Floors in food service areas shall be of such construction as to be easily cleaned, sound, smooth, non-absorbent, without cracks or crevices, and shall be provided with approved and conveniently located facilities for the disposal of floor wash water. (b) Walls and Ceilings. Walls and ceilings of food service areas shall be of tight and substantial construction, and smoothly finished. The walls and ceilings shall be without horizontal ledges and shall be washable up to the highest level reached by splash and spray. Roofs and walls shall be maintained free of leaks. All openings to the exterior shall be provided with doors or windows, which prevent the entrance of rain or dust during inclement weather. (c) Screens or Outside Openings.	A 804		

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A 804	Continued From page 23 Openings to the outside shall be effectively screened, or suitable provisions made equal to screening (such as fly fans). Screen doors shall be equipped with self-closing devices. (d) Lighting. The kitchen, dishwashing area, and the dining room shall have adequate light. (e) Ventilation. Vent/exhaust hoods, vented to the outdoors, shall be provided over cooking surfaces to aid in removing cooking odors. Group homes with residential stoves may use a residential hood sized for the stove. Commercial exhaust hoods shall be installed when commercial cooking equipment is used. Congregate facilities shall use a commercial exhaust hood system. (f) Employee Toilet Facilities. Toilet rooms, if provided, shall not open directly into any room or space in which food is prepared, stored, displayed, or served, nor into any room in which utensils are washed or stored. Toilet rooms shall include a lavatory with a soap dispenser and disposable towels, and shall be well lighted and ventilated. (g) Hand washing Facilities. Each Group and Congregate specialty care assisted living facility shall provide a hand washing lavatory in the kitchens which shall be equipped with a soap dispenser and a supply of soap, disposable towels, and hot and cold running water through a mixing valve or combination faucet. The use of a common towel and common bar soap is prohibited. Hands shall not be washed in sinks where food is prepared.	A 804		

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A 804	Continued From page 24 (h) Refrigeration Facilities. Adequate refrigeration facilities, automatic in operation for the storage of perishable foods, shall be provided Refrigeration shall be maintained at 41 degrees Fahrenheit or less. All refrigerators shall be provided with thermometers. All refrigerators shall be kept clean. (i) Equipment and Utensil Construction. Equipment and utensils, except single service utensils, shall be so constructed as to be easily cleaned and shall be kept in good repair. No cadmium plated, lead, or readily corrodible utensils or equipment shall be used. (j) Separation of Kitchen from Resident Rooms and Sleeping Quarters. Any room used for sleeping quarters shall be separated from the food service area by a solid wall with no direct openings. Sleeping accommodations shall not be permitted within the food service area. (k) Clean Rooms. Floors, walls, and ceilings of rooms in the food service area shall be clean and free of an accumulation of rubbish, dust, grease, dirt, etc. (l) Clean Equipment. Equipment in the food service area shall be clean and free of dust, grease, dirt, etc. (m) Clean Counters, Tables, Tablecloths, and Napkins. Tables and counters, which are used for food service, shall be kept clean. Tablecloths and cloth napkins shall be laundered after each use. (n) Location and Space Requirements. Food service facilities shall be located in a	A 804		

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A 804	Continued From page 25 specifically designated area and shall include the following rooms and space: kitchen, dishwashing, food storage, and dining room. (o) Equipment. Minimum equipment in the kitchen shall include the following: 1. Range. In a Group specialty care assisted living facility, a residential use range is permitted. A Congregate specialty care assisted living facility shall have a heavy duty range suitable for institutional use with double oven, or equivalent. 2. Refrigerator. A Group specialty care assisted living facility may use a residential refrigerator. A Congregate specialty care assisted living facility shall have a heavy-duty refrigerator suitable for institutional use. 3. Fire extinguisher. Five-pound type BC for residential hoods and K type for commercial hoods. 4. Dishwashing. The dishwashing equipment for Group assisted living facilities shall be either residential type using cold water sanitizers or commercial type with a booster water heater. Dishwashing equipment for all Congregate assisted living facilities shall be commercial type using a booster water heater or an automatic dispensing sanitizing chemical system. 5. A three-compartment sink with a booster heater or chemical sanitizing system for the third compartment shall be provided in Congregate assisted living facilities.	A 804		

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A 804	Continued From page 26 6. Garbage cans with cover. (p) Food Storage. A well-ventilated, cool food storage room, pantry, or cabinets shall be provided. Adequate shelving, bins, suitable cans, and raised platforms shall be provided and kept clean. Perishable food shall be stored at least six inches above the floor. The storeroom shall be of such construction as to prevent the invasion of rodents and insects, the seepage of dust and water, leakage, or any other source of contamination. (q) Dining Room. 1. A resident dining room, or rooms, shall be provided which is large enough to seat not less than 100 percent of the bed capacity. (r) Water Heating Equipment. Equipment for heating an ample supply of water, under pressure, for all washing purposes shall be provided. Hot water shall be piped to all hand-washing facilities, and to each compartment of all dishwashing and laundry sinks. Water heaters shall be of the automatic type. This Rule is not met as evidenced by: Based on observations and interview, kitchen equipment was not properly cleaned and maintained. Findings:	A 804		

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A 804	Continued From page 27 On the afternoon of July 15, 2025, the surveyor toured the facility kitchen with EI#5 and noted the following deficient practices. The oven was in need of cleaning. The water in the basins of the steam table contained food particles and the basins were dirty. EI#5 agreed these areas of the kitchen were in need of cleaning.	A 804		
A1001	420-5-20-.10 (1) Sanitation and Housekeeping. (1) Sanitation. (a) Water Supply. 1. If at all possible, all water shall be obtained from a public water supply. If it is impossible to connect to a public water system, the private water supply shall meet the approval of the local County Health Department. 2. Water under pressure of not less than 15 pounds per square inch shall be piped within the building to all sinks, toilets, lavatories, tubs, showers, and other fixtures requiring water. Tubs, showers, sinks, lavatories, and other fixtures used by residents shall have hot water supplied. Hot water accessible to residents shall in no case exceed 110 degrees Fahrenheit. (b) Disposal of Liquid and Human Wastes. 1. There shall be installed within the building a properly designed waste disposal system, connecting to all fixtures to which water under pressure is piped. 2. All liquid and human waste, including floor wash water and liquid waste from	A1001		

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refrigerators, shall be disposed through trapped drains into a public sewer in localities where such system is available.

3. In localities where a public sanitary sewer is not available, liquid and human waste shall be disposed through trapped drains into a sewage disposal system approved by the local County Health Department. The sewage disposal system shall be of a size and capacity based on the number of residents and personnel housed and employed in the institution. Where the sewage disposal system is installed at an existing facility prior to granting of a license, it shall be inspected and approved by the local County Health Department.

(c) Premises. The premises shall be kept neat and clean. The property shall be free of rubbish, weeds, ponded water, or other conditions, which may create a health, safety, or sanitation hazard.

(d) Control of Insects, Rodents, and other Pests. Each facility shall be kept free of ants, flies, roaches, rodents, and other pests. Proper and lawful methods for their eradication or control shall be used. Droppings shall be evidence of infestation by pests.

(e) Toilet Room Cleanliness. Floors, walls, ceilings, and fixtures of all toilet rooms shall be kept clean and free of objectionable odors. These rooms shall be kept free of an accumulation of rubbish, cleaning supplies, toiletry articles. The use of a common towel and common bar soap is prohibited.

(f) Garbage Disposal.

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A1001	Continued From page 29 1. Garbage must be kept in water-tight suitable containers with tight-fitting covers. Garbage containers must be emptied at frequent intervals and shall be thoroughly cleaned and aired before using again. 2. Garbage and waste shall be disposed of in accordance with local and state regulations. (g) Control of Odors. The facility shall be free of objectionable odors. This Rule is not met as evidenced by: Based on observations and interview, residents' toilets were not kept clean. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged residents' toilets were not kept clean. The surveyor was able to substantiate this complaint during the onsite survey. On the afternoon of July 14, 2025, the surveyor and EI#2 toured residents' rooms. The bathrooms of three resident rooms (312, 319 and 325) contained dirty toilets which were soiled with feces. EI#2 agreed the toilets were in need of cleaning and made arrangements for the toilets to be cleaned immediately.	A1001		

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A1101	Continued From page 30	A1101		
A1101	420-5-20-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All specialty care assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift. 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 Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 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. (d) Roller latches are prohibited on doors separating corridors from adjacent spaces.	A1101		

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(e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that:

1. Minimizes leaks and spills.

2. Adequately protects against inappropriate access.

3. Complies with the requirements of the currently adopted Life Safety Code.

(f) Fire Alarm and Sprinkler System.

1. Fire Alarm System. Where fire alarm systems are required, a corridor smoke detection system shall be installed on each floor, including areas open to the exit access corridor, to comply with NFPA 72, connected to the facility's fire alarm system. In lieu of corridor smoke detection, smoke detectors connected to the building fire alarm system may be installed in each resident's room, open areas, and at smoke doors (except that corridor smoke detection shall not be deleted when its use is dictated by other requirements).

2. Fire alarm and sprinkler system outages of more than 4 hours require evacuation of the facility or the establishment of a continuous fire watch. The fire watch procedure must be coordinated with the Department and the local Fire Marshal. Outages and fire watch documentation shall be reported to the Department within 12 hours or no later than the next duty day, and shall be corrected expeditiously.

3. The fire alarm system and the sprinkler system shall be inspected by licensed,

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trained, and qualified personnel at least semiannually for compliance with the respective codes. Inspection and Testing reports shall be maintained in the facility for a period of at least 3 years.

This Rule is not met as evidenced by:
Based on record reviews and interview, the facility failed to conduct fire drills as required. In addition, the fire evacuation route was not posted in the facility at the time the surveyor entered.

Findings:

Fire Drills

Review of fire drill reports on the afternoon of July 15, 2025 revealed the following information. No fire drill was documented for April 2025 and fire drills were not documented quarterly on each shift for the second quarter (April-June) of 2025. No fire drill was documented for January 2024. The fire drill reports for February through July 2024 did not contain times of the drills and one did not contain a date. The surveyor was unable to determine when the fire drills were conducted to verify compliance. EI#1 agreed the fire drills had not been conducted as required but stated she (EI#1) is working with the new Maintenance Director to bring the facility into compliance.

Fire Evacuation Route

On July 14, 2025, while touring the facility with EI#2, the surveyor noted that fire evacuation routes were not posted. EI#2 agreed with the surveyor's finding. EI#4, Maintenance Director, was notified and immediately located and posted

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A1101	Continued From page 33 the fire evacuation routes.	A1101		
A1203	420-5-20-.12 (5) Physical Environment. (5) General Building Requirements - 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. (b) Temperature to be Maintained. The facility shall maintain a comfortable temperature. A comfortable range is between 71-81 degrees Fahrenheit. (c) Lighting. Each resident's room shall have artificial light adequate for reading and other uses as needed. All entrances, hallways, stairways, inclines, ramps, cellars, attics, storerooms, kitchens, laundries, and service units shall have sufficient artificial lighting to prevent accidents and promote efficiency of service. Night lights shall be provided in all hallways, stairways, and bathrooms. (d) Screens. All screen doors and operable windows shall be equipped with tight-fitting, full-length 16 mesh screens. Screen doors shall be equipped with self-closing devices. (e) Emergency Lighting. 1. All specialty care assisted living facilities shall provide an emergency artificial lighting system to adequately illuminate halls,	A1203		

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corridors, and stairwells in case of electrical power failure. As a minimum, dry cell battery-operated lighting shall be provided to light such spaces.

2. Emergency lighting must provide illumination in accordance with the currently adopted Life Safety Code for at least 90 minutes.

(f) Floors.

1. All floors shall be level, smooth and free of cracks, and finished so as to be easily kept clean. 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.

2. Any differences in floor levels shall not prevent a resident from navigating safely throughout the facility.

(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. Operable windows shall be so constructed and maintained so that they fit snugly, and are capable of being opened and closed easily. Windows in specialty care facilities may have devices which prevent full opening of the window.

(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 eight feet shall be acceptable when the height complies with the codes.

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A1203	Continued From page 35 (j) Handrails. If handrails are installed in halls or corridors, the handrails shall be mounted at 30 - 36 inches above the floor and returned to the wall at each end. (k) Stairways. Stairways shall be well lighted, kept in good repair, and have handrails. Open space under stairs shall not be used for storage purposes. All walls and doors under stairs shall meet the same fire rating as the stairwell. (l) Doors. 1. In each new specialty care assisted living facility, doors of resident bathrooms connected to resident bedroom shall swing into the bedroom. 2. Bedroom and bathroom doors may be equipped with hardware that will permit a resident to lock himself within the room, provided a master key is readily accessible for the staff at a central location. 3. Resident bedroom and other exit access doors in specialty care assisted living facility shall be at least three feet wide. 4. Exterior egress doors except the main entry/exit door, may be equipped with a delayed egress locking system installed in accordance with NFPA 101. Other exterior egress doors may be arranged to prevent free and unhindered egress from specialty care assisted living facilities, in accordance with the Special Requirements portion of this section.	A1203		

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5. Exit doors swinging outward shall swing out over a landing having a minimum length and width equal to the door's width at the same level as the floor level, except existing doors shall not have more than a four inch step down.

(m) Ventilation. The building shall be well ventilated at all times to prevent accumulation of objectionable odors. Kitchens, laundries, service rooms, toilets, and bathrooms shall be ventilated by windows, gravity vents, or mechanical means as necessary to prevent offensive odors from entering other parts of the facility.

(n) Fire Extinguishers. Fire extinguishers shall be provided for each hall, kitchen, and laundry, of type and capacity appropriate to the need.

1. Each fire extinguisher shall receive an annual inspection with maintenance, and recharging when necessary, by a fire equipment servicing representative. An annual servicing tag shall be attached to the extinguisher reflecting the name of the servicing company, representative, day, month, and year of maintenance.

2. A visual inspection of each fire extinguisher shall be conducted monthly by a designated staff of the facility and documented on the attached extinguisher tag by the designated staff person.

(o) Call System. A central electric or electronic call system shall be conveniently provided for each resident, usable in bedrooms

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and bathrooms. The call system shall be certified to meet the applicable Underwriters Laboratories standard.

(p) Manufactured homes/mobile homes are not permitted.

(q) Fireplaces and inserts shall be inspected and cleaned annually, and shall comply with the currently adopted building code. Openings shall be protected with screens or doors.

(r) Exit marking. In all facilities, a sign bearing the word "EXIT" in plain legible block letters shall be placed at each exit. Additional signs shall be placed in corridors and passageways wherever necessary to indicate the direction of exit. Letters of signs shall be at least four inches high. All exit and directional signs shall be kept clearly legible by continuous internal electric illumination and have battery back-up or emergency power.

(s) Heating, Lighting, and other Service Equipment.

1. Central or individual room gas heating systems shall be of the enclosed flame type equipped with automatic flame shut-off control and shall be vented directly to the outside. Heating units of any type shall be located to avoid direct contact with any combustible material and shall be maintained in accordance with manufacturer's recommendation.

2. Open flame and portable heaters are prohibited in specialty care assisted living facilities. This does not apply to a fire place with

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A1203	Continued From page 38 gas logs protected as noted elsewhere in these rules. 3. Lighting shall be restricted to electricity. Electric wiring, motors, and other electrical equipment in all specialty care assisted living facilities shall be in accordance with local electrical codes and the NFPA National Electrical Code. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide a usable call system for each resident. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received complaints which alleged residents' call lights were not answered timely. The surveyor was able to substantiate this complaint during the onsite survey. On July 15, 2025, the surveyor reviewed a log of calls received and answered through the facility's call system. The system currently used contained a call pull cord in each resident's bedroom and bathroom and an optional pendant. A list of calls received was provided by EI#1 for July 9-13, 2025. The facility did not currently have a policy for expected timeframes for answering call lights but staff who were interviewed informed the surveyor that they were trained to strive to answer call lights within 5 minutes. The following calls were received and not answered within a timely	A1203		

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A1203	Continued From page 39 manner. *July 9, 2025 - call received from room 307 bathroom pull cord at 6:56 AM; call was closed at 7:25 AM for a total time of 29 minutes. *July 9, 2025 - call received from Memory Care spa bath at 10:26 AM; call was closed at 12:04 PM for a total time of 1 hour and 38 minutes. *July 11, 2025 - call received from room 330 pendant at 3:00 AM; call was closed at 5:03 AM for a total time of 2 hours and 3 minutes. *July 12, 2025 - call received from room 307 bedroom pull cord at 1:36 PM; call was closed at 2:12 PM for a total of 36 minutes. *July 13, 2025 - call received from room 301 bathroom pull cord at 5:53 AM; call was closed at 6:58 AM for a total time of 1 hour and 5 minutes. *July 13, 2025 - call received from room 330 pendant at 6:54 AM; call was closed at 8:10 AM for a total time of 1 hour and 16 minutes. *July 13, 2025 - call received from room 307 bathroom pull cord at 3:51 PM; call was closed at 4:22 PM for a total time of 31 minutes. EI#1 agreed the timeframes for answering these calls were not acceptable and stated she (EI#1) would investigate. CONNIE CHERRY, REGISTERED NURSE	A1203		