Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P4910	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS SPECIALTY CARE AT SOMERBY OF WEST I	901 SOMERBY DRIVE MOBILE, AL 36695

(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 On October 30, 2025, an unannounced inspection of care survey was conducted for this 24 bed Specialty Care Assisted Living Facility (SCALF) with 24 residents. There were no complaints investigated during this survey. There were deficiencies written as a result of the inspection of care investigation. Deficiencies were cited during the 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 placed all facility residents at risk for harm. A plan of correction to address the deficiencies is required.	A 000		
A 302	420-5-20-.03 (e) Administration. (e) Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). All residents shall be informed of new policies or changes in existing policies that may have bearing on the resident. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies shall cover the following: (i) Facility responsibility to protect all residents from abuse, neglect, and exploitation.	A 302		

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A 302	Continued From page 1 (ii) How allegations of abuse, neglect, and exploitation will be handled by the facility. (iii) Resident confidentiality. (iv) Admission and continued stay criteria. (v) Discharge criteria and notification procedures for residents and sponsors. (vi) Facility responsibility when a resident's personal belongings are lost. (vii) What services the facility is capable and not capable of providing. (viii) Medication management. (ix) Infection control. (x) Meal service, timing, menus and food preparation, storage, and handling. (xi) Fire safety and emergency plan, fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness. (xii) Staffing and conduct of staff while on duty. (xiii) Oxygen administration and storage if used in the facility. (xiv) Dietary Policies. The dietitian, with the approval of the administrator, shall develop written policies and procedures for the guidance of all personnel handling food as	A 302		

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A 302	Continued From page 2 outlined by the most current Food and Drug Administration Food Code published by the U.S. Department of Health and Human Services. The facility shall develop and implement dietary policies and procedures to meet the needs of the residents in the facility. In addition to other matters deemed necessary by the facility, dietary policies shall address: (I) Sanitation of dishes, utensils, and service equipment, and sanitary food preparation and handling. (II) The attire and cleanliness of staff members who prepare, handle, or serve food. (III) A schedule of meals, which shall include between-meal nourishment or snacks, and fluids. (IV) Food substitutions or alternatives. (V) Method to ensure an adequate dietary plan is implemented for any resident with a therapeutic diet or special dietary needs. (VI) Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food. (VII) Provision of necessary services to any resident requiring adaptive devices to eat. (VIII) Procedure for the handling of potentially hazardous foods such as meat, milk, ice, and eggs. (IX) Storage of food.	A 302		

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A 302	Continued From page 3 (X) Procedure for food service in the event of a disaster. Disaster menus shall be developed. The policy shall address how food will be obtained and maintained at safe temperatures if electricity is not available. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to implement written policies and procedures. Findings: The facility policy titled, "Investigation Tips Aggressive Behaviors" revealed, "... 18. Has a care plan been completed and the associates updated on it? ... 25. What plan of action has been implemented to keep residents/associates safe? ..." Refer to deficiencies 504 and 611 for additional information. The facility policy titled, "Investigation Form" revealed, "... Immediate actions taken. The extent and description of injury, if any, to the affected resident or residents: .. Outcome resolution. The action taken by the facility to prevent the occurrence of similar incidents in the future. ..." Refer to deficiency 508 for additional information. The facility policy titled, "ABUSE, NEGLECT AND EXPLOITATION" revealed, "... OBJECTIVE: ... Any form of mistreatment of residents including but not limited to abuse, ... is strictly prohibited. ... DEFINITIONS: 1. Physical Abuse - ... intentional use of physical force resulting in bodily injury, pain or impairment, including but not limited to bruising, ... Also includes ... pushing and shoving. ..." Refer to deficiencies 504 and 508 for	A 302	A-302 - The facility failed to implement written policies and procedures. The Administrator was re-educated by the VP of Wellness in the facility's policy on investigation tips for aggressive behavior, the investigation form, abuse, neglect and exploitation, admisssion criteria for memory care, resident discharge and transfer on 11/24/25. Compliance audits will be completed by the VP of Wellness and/or designee two times a week for four weeks, then two times a month for two months, then monthly for 3 months and ongoing as needed. Documentation of the re-education and the audits will be kept in the Administrators' office.	

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A 302	Continued From page 4 additional information. The facility policy titled, "ADMISSION CRITERIA FOR MEMORY CARE" revealed, "... OBJECTIVE: The Community will admit and retain stable residents in Memory Care with health conditions that can be safely cared for by Community staff and are congruent with state regulatory guidelines. ..." Refer to deficiency 621 for additional information. The facility policy titled, "RESIDENT DISCHARGE AND TRANSFER" revealed, "... OBJECTIVE: To ensure resident discharge and transfer in compliance with state regulations, resident rights, and residency agreements. ... Residents requiring a higher level of care shall be discharged to and alternate facility. ..."	A 302		
A 303	420-5-20-.03 (2) (a) Administration. (2) The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the specialty care assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an administrator shall meet all applicable statutory requirements.	A 303		

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A 303	Continued From page 5 4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days. 5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age. 6. The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character. 7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week. 8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment and adequate care actually being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement. 9. The facility administrator is responsible for ensuring that required training is provided to all staff. 10. 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	A 303		

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A 303	Continued From page 6 setting. 11. 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. 12. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan. 13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained. This Rule is not met as evidenced by: Based on observation, interview, and record review, Employee Identifier (EI)#1, the administrator, failed to properly perform her duties to ensure the care and safety needs of all residents were met. Findings: On October 30, 2025, an inspection of care survey was conducted related to a self reported incident of a resident wandering into another resident's room and the occupant/resident of that room did not want him/her in there. The reported incident indicated a resident had been grabbed and was left with a bruise. EI#1 did not identify the physical abuse or address the chronic behaviors of a resident that infringed on other residents' rights, space and belongings.	A 303	A303 - The Administrator failed to properly perform her duties to ensure the care and safety needs of all residents are met. All residents have the potential to be affected. VP of Wellness re-educated the Administrator on 11/24/25 regarding the importance of properly auditing and supervising the overall health and behavior of all the residents. Compliance audits will be completed by the VP of Wellness and/or designees two times a week for four weeks, then two times a month for two months, then monthly for three months and ongoing as needed. The staff of The Arbors will be re-educated by the Administrator, Director of Wellness or the Executive Director by 12/31/25, on reporting on the overall health and behaviors of the residents. Documentation of re-education and audits will be kept in the Administrators office.	

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A 303	Continued From page 7 The administrator did not ensure facility policies and procedures were implemented. Refer to deficiency 302 for additional information. The administrator failed to provide residents' with a decent environment by allowing unmanaged behaviors to continue to infringe on other residents' rights. The administrator further failed to keep a resident free from abuse. Refer to deficiency 504 for additional information. The administrator failed to report an incident of abuse to the ADPH Online Incident Reporting System (OIRS) and failed to investigate the incident. Refer to deficiency 508 for additional information. The administrator failed to develop a current plan of care to identify a resident's behaviors and address the behaviors with interventions to meet the resident's needs and to protect other residents. Refer to deficiency 611 for additional information. The administrator retained residents who had unmanageable behaviors. Refer to deficiency 621 for additional information.	A 303		
A 504	420-5-20-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission, of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The	A 504		

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A 504	Continued From page 8	A 504		

acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate.

1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility.

2. 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.

3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy.

4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time.

5. Every resident shall have freedom to participate in and benefit from social, religious, and community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.

6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the

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A 504	Continued From page 9 premises, an individual account record for each resident shall be maintained by the administrator and an up-to-date record shall be maintained for all transactions. 7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so. 8. Every resident shall have the right to a reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals. 9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident. 10. Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to receive or reject medical care, dental care, or other health care services except those required to control communicable diseases. 11. Every resident shall have the right to at least 30 days prior written notice of involuntary relocation or termination of residence from the facility unless the resident is a patient in a facility providing a higher level of care and no longer meets the eligibility and continued stay requirements in these rules, or for medical reasons the resident is considered by a physician to require an emergency relocation to a facility providing a more skilled level of care, or unless	A 504		

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A 504	Continued From page 10 the resident engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record. 12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person without restraint, interference, coercion, discrimination, or reprisal. 13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file. 14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the facility, provided that: (i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care. (ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation.	A 504		

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A 504	Continued From page 11 (iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time without recourse. 15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges. 16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities 17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll-free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll-free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area. 18. All state inspection reports and any resulting corrective action plan from the past 24 months shall be posted in a prominent location. If there has been no inspection in the past 24 months, then the results of the most recent inspection and any resulting corrective action plan shall be posted. 19. Every resident shall have the right to 30 days prior written notice to both resident and	A 504		

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A 504	Continued From page 12 sponsor of any increase of fees or charges. 20. Every resident shall have the right to 30 days prior written notice of any involuntary change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. 21. Every resident shall have the right to wear his or her own clothes, and to keep and use his or her own personal possessions, including toilet articles, except for personal possessions too large to be stored in the resident's room. 22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings. 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide residents' with a safe and decent environment, free from abuse, by retaining residents with unmanageable	A 504	A504 - The facility failed to provide residents with a safe and decent environment, free from abuse, by retaining residents with unmanageable behaviors. All residents have the potential to be affected. VP of Wellness has re-educated the Administrator regarding the importance of properly auditing and supervising the overall health services including behaviors of the residents. All residents of The Arbors have been reviewed and assessed and found to be residing in a safe and decent environment, free from abuse and neglect. Compliance audits will be completed by the VP of Wellness and/or designee two times a week for four weeks, then two times a month for two months, then monthly for 3 months and ongoing as needed. Documentation of re-education and audits will be kept in the Administrators office.	

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A 504	Continued From page 13 behaviors. Findings. RI#1 was admitted to the facility on April 15, 2025, with diagnoses to include senile degeneration of the brain, dementia with mood disturbance, dementia with anxiety, depression and hemiplegia. RI#1's Physical Examination (Exam) dated April 11, 2025, revealed RI#1 had wandering behaviors. A facility documented timeline revealed RI#1 was admitted to hospice on May 15, 2025, only 30 days after admission. On June 7, 2025 RI#1 had a fall in another resident's room. On June 11, 2025, a note on the timeline revealed, "Resident constantly roaming and wandering in other peoples rooms, in and out of (the) wheelchair." On July 17, 2025, RI#1 had a fall in another resident's room. On October 2, 2025, RI#1 went into another resident's room and that resident physically removed RI#1 from the room - state reported. On October 4, 2025, "... resident constantly rolling up and down hallways, nonstop. Frequently, daily, hourly says, "I need help with my much needed speciality care!" On October 5, 2025, "I need help with my much needed speciality care." Constant yelling (of) "Help me with my much needed speciality care!" October 29, 2025, bangs on the exit door. RI#2 was admitted to the facility on November 19, 2024, with diagnoses to include glaucoma, neuropathy and memory impairment. The facility resident profile sheet indicated, "(He/She) has resisted assistance in the independent living." The facility documented timeline for RI#2 revealed, February 7, 2025, resident has outburst about who is running this place. February 8, 2025, resident had a verbal back and forth with another resident and said, "She's a (explicative)."	A 504		

Alabama Department of Public Health

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	P4910	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS SPECIALTY CARE AT SOMERBY OF WEST I	901 SOMERBY DRIVE MOBILE, AL 36695

(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 504	Continued From page 14 Resident was redirected. February 23, 2025, resident became upset after breakfast when the server removed (his/her) plate. (He/She) called her a black (explicative). Resident was redirected. March 8, 2025, loud outburst and resident pulled (his/her) rollator into another resident's chair while at lunch. ... March 30, 2025, the resident became very agitated while the nurse was giving night meds (medications) and was irate and started screaming there is mold and dirt in my room and you aren't doing anything about it. Then he/she hit the nurse in the arm but did not hurt her. April 5, 2025, resident became agitated when another resident greeted (him/her) for breakfast. Later the resident became agitated and shouted my wallet was stolen. Wallet was found. April 9, 2025, resident in the hallway shouting someone stole thousands and thousands of dollars worth of my clothes. Resident was redirected. April 14, 2025, resident irate that (he/she) can't see their (spouse). April 20, 2025, resident became irate and agitated toward a female resident. Resident was redirected when (he/she) called the other resident an (explicative). May 3, 2025, loud outburst from the resident. He/She began hitting his/her glass on the table demanding water. Water was added the glass but he/she continued to bang glass on the table with water in the glass. Resident was redirected. June 14, 2025, resident became combative with staff and peers at breakfast. He began slinging the plates but did not hit anyone. October 2, 2025, resident pushed (RI#1)'s wheelchair with (RI#1) in it down the hallway to the activity room and began yelling that RI#1 was in his/her (RI#2) room. RI#2 then grabbed RI#1's right shoulder and began to shake RI#1. Residents were separated and redirected. RI#1 had a small bruise on front of right shoulder.	A 504		

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A 504	Continued From page 15 On the morning of October 30, 2025, the surveyor observed RI#1 in the activity room with other residents repeating, "Care for the date of the day." RI#1 tried to stop other residents as they walked past and they seem annoyed. Approximately an hour later RI#1 was observed trying to flag residents down saying, "The care for today's date." On the afternoon of October 30, 2025, RI#1 was observed in the dining room. RI#1 was seen leaving his/her table and going to another table attempting to take food off the plates of other residents. Staff redirected RI#1 back to his/her table. RI#1 was observed repeating, "Care for the date of the day " When a resident was walking by, RI#1 tried to stop them, the resident became agitated and had to be redirected by staff. Staff interviews on the morning of October 30, 2025, revealed the following. EI#4, a care associate, reported RI#2 would yell and get angry and started cursing more toward the end of his/her stay at the facility. EI#3 said RI#1 wandered constantly and went through other residents' belongings. EI#2, the activities director/witness, said she was leading an activity when RI#2 came down the hall pushing RI#1 in his/her wheelchair while yelling and cursing. EI#2 said RI#2 said RI#1 was in his/her room going through his/her things. RI#2 was threatening RI#1 by saying he/she would clock him/her. EI#2 ran to RI#2 to try to calm RI#2 down. RI#2 was very agitated. EI#2 said she tried to diffuse the situation but it got worse. RI#2 grabbed RI#1's neck/shoulder area and shook RI#1 back and forth. RI#2 gripped RI#1 at the collar bone area. When the aide came to help, she pried RI#2's hand loose from RI 1' s' shoulder and moved RI#1 away quickly in the wheelchair. EI#2 continued to try to calm RI#2 down. EI#2	A 504		

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A 504	Continued From page 16 reassured RI#2 that it would not happen again. EI#2 said RI#1 constantly wanders and goes through other residents' belongings. Staff try to redirect RI#1. EI#2 said she had reported this behavior to EI#1. EI#2 said RI#1 had a small bruise on the area over his/her collar bone. EI#2 acknowledged RI#1 was physically abused. EI#2 also acknowledged RI#1 had invaded other residents' spaces and belongings since RI#1 was admitted to the facillty. EI#6, a care associate/Certified Nursing Assistant (CNA), reported RI#1 goes in and out of resident rooms and talks to everyone, constantly. EI#6 said RI#1 had these behaviors since admission. EI#6 acknowledged RI#1's behaviors were not managed. EI#7, a Licensed Practical Nurse (LPN), said RI#2 had the behavior of yelling. EI#7 said RI#1 constantly repeats what he/she says, continuously moves, and goes in and out of other residents' rooms. EI#7 acknowledged RI#1 disturbs other residents and the residents tell RI#1 to shut up. EI#7 added if RI#1 was not asleep, RI#1 was always disturbing others. EI#3, a care associate/witness, was asked about the altercation between RI#2 and RI#1 that resulted in a bruise to RI#1's collar bone area. EI#3 said when EI#2 had distracted RI#2, she (EI#3) quickly moved RI#1 away from RI#2. EI#3 had observed RI#2 pushing RI#1 down the hall, grabbing RI#1 at the neck and shoulder area and pulling RI#1 back and forth. EI#3 said RI#2's actions left an indention on RI#1's collar bone. Later EI#3 showed the resulting bruise to EI#1. EI#3 reported RI#1 would constantly repeat words and ask residents if they were okay. EI#3 added a lot of residents got aggravated with RI#1. EI#3 said RI#1 goes into other residents' rooms and goes through their belongings and that infringes on their rights.	A 504		

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A 504	Continued From page 17 On the afternoon of October 30, 2025, EI#1 was asked what had been done to deter RI#1 from going in other residents' rooms and rummaging through their things. EI#1 said she just told staff to keep RI#1 out of those rooms. EI#1 acknowledged that was not effective. When asked why she did not resolve this issue for the sake of the other residents, EI#1 said she did not know how. When asked what intervention was put in place regarding the physical abuse of RI#1, EI#1 said more one on one interaction. EI#1 said a bruise was left on RI#1 and that it was abuse. EI#1 said she now realizes RI#1 was abused by RI#2 and that RI#1's behaviors infringe on the other residents rights.	A 504		
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 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	A 508		

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A 508	Continued From page 18 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. (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).	A 508		

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A 508	Continued From page 19 (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 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).	A 508		

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A 508	Continued From page 20 (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 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	A 508		

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A 508	Continued From page 21 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 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	A 508		

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A 508	Continued From page 22 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. (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.	A 508		

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A 508	Continued From page 23 (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 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.	A 508		

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A 508	Continued From page 24 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report an incident of abuse to the ADPH Online Incident Reporting System (OIRS) and failed to investigate the incident. Findings: On October 2, 2025, the ADPH received an incident report of a resident going into another resident's room uninvited and unwanted. The reported incident indicated a resident had been grabbed and was left with a bruise. Refer to deficiency 504 for additional information. According to witness statements and staff interviews RI#1 entered RI#2's room and RI#2 pushed RI#1 down the hallway yelling and threatening RI#1. RI#2 then grabbed RI#1 and shook him/her back and forth leaving an indention on RI#1's collar bone area that later bruised. On the afternoon of October 30, 2025, EI#1 said she did not realize the occurrence was abuse at the time and did not report it as such. EI#1 said she read and spoke with the two witnesses and that was all she had done to investigate the incident. EI#1 said that was not an investigation. EI#1 said she was responsible for identifying and reporting abuse and that had not been done.	A 508	A508 - The facility failed to report an incident of abuse to the ADPH Online Reporting Incident System (ORIS) and failed to investigate the incident. The administrator incorrectly reported the incident to the state ADPH ORIS on 10-2-25. The Administrator was re-educated by the VP fo Wellness on abuse, investigation of an incident, and how to report abuse to ADPD ORIS on 11/24/25. Compliance audits will be completed by the VP of Wellness and/or designee two times a wekk for four weeks, then two times a month for two months, then monthly for three months and ongoing as needed. Documentation of this re-education and audits will be kept in the Administrators' office.	
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	A 604		

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A 604	Continued From page 25 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 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	A 604		

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A 604	Continued From page 26 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 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	A 604		

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A 604	Continued From page 27 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 review and interview, the facility failed to ensure the accuracy of assessments. The facility also failed to ensure a comprehensive assessment was completed after an incident occurred related to unmanaged behaviors. Findings: RI#1 was admitted to the facility on April 15, 2025. Refer to deficiency 504 for additional information regarding RI#1. Review of RI#1's facility record on October 30, 2025, revealed the physician's medical exam dated April 11, 2025, indicated RI#1 had behaviors that included wandering. The admission comprehensive assessment completed by EI#1 indicated RI#1 had no behaviors. On October 2, 2025, RI#1 had been the victim of resident on resident abuse. There was no comprehensive assessment of RI#1 after the incident. On October 20, 2025, EI#1 was asked why she had assessed RI#1 as having no behaviors. EI#1 said she did not know.	A 604	A604 - The facility failed to ensure the accuracy of assessments. The facility also failed to ensure a comprehensive assessment after and incident occurred related to inmanageable behavior. The Administrator was re-educated by the VP of Wellness about the importance of accuracy of assessments, and when assessments per policy and per state regulations are required, on 11/24/25. The Administrator completed all assesments by12-3-25 The administrator will audit 4 charts a week for six weeks and ongoing as needed. Compliance Audits will be completed by the VP of Wellness and/or designee two times a week for four weeks, then two times a month for two months, then monthly for three months and ongoing as needed. All changes in health or behavior will result in a new assessmnet. Documentation of re-education and audits will be kept in the adminiistrators office.	
A 611	420-5-20-.06 (4) (a) (b) Care of Residents.	A 611		

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	P4910	A. BUILDING: _____ B. WING _____	10/30/2025

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A 611	Continued From page 28 (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 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.	A 611		

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A 611	Continued From page 29 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. (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	A 611		

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A 611	Continued From page 30 shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop a current plan of care to identify a resident's behaviors and address the behavior with interventions to meet the care and safety needs of the resident. Findings: Review of RI#1's care plan revealed. " - BEHAVIORAL -No behaviors to report at this time. ..." No updates were made to this plan of care although a facility documented timeline identified behaviors since admission. Refer to deficiency 504 for additional information. On the afternoon of October 30, 2025, EI#1 was asked why RI#1 was not care planned for behaviors. EI#1 said it was an oversight.	A 611	A611 - The facility failed to develop a current plan of care to identify a resident's behaviors and address the behavior with interventions to meet the care and safety needs of the resident. The Administrator was re-educated by the VP of Wellness on plans of care and care plan updates on 11/24/25. All changes in condition including behaviors will result in a new plan of care with interventions up to and including a 30-day notice of discharge. The administrator completed audits of all plans of care before 12/3/25. The Administrator will audit 4 plans of care a week for six weeks and ongoing as needed. Compliance audits will be completed by the VP of Wellness and/or designee two times a week for four weeks, then two times a month for 3 months and ongoing as needed. Documentation of re-education and audits willl be kept in the administrators' office.	
A 621	420-5-20-.06 (9) (b) Care of Residents. (b) Retention. 1. A specialty care assisted living facility shall not allow any resident to return to the specialty care assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the specialty care assisted living facility is licensed to provide or the facility is capable of providing. 2. A specialty care assisted living facility shall not retain a resident that has a PSMS score	A 621		

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A 621	Continued From page 31	A 621		

greater than 23 or a score of five in feeding, dressing, grooming, bathing or a score of four or five in physical ambulation.

3. A specialty care assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility.

4. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in a specialty care assisted living facility.

5. A specialty care assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless:

(i) The individual is capable of performing and does perform all tasks related to his or her own care; OR

(ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity but the individual has sufficient cognitive ability to direct his or her own care and the individual is able to direct facility staff and does direct facility staff to provide the physical assistance needed to complete such tasks, and the facility staff is capable of providing such assistance and does provide such assistance. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff.

6. If a resident of a specialty care assisted living facility is diagnosed with a terminal

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A 621	Continued From page 32 illness and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90 days. If the facility is unable or becomes unable to meet the needs of a resident receiving hospice care, or if a resident receiving hospice care requires care beyond what the facility may lawfully provide pursuant to this section, then the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for specialty care assisted living facilities. The facility would in all cases remain responsible for ensuring the appropriate delivery of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility retained residents who had unmanageable behaviors. Findings: On October 30, 2025, the surveyor was told by five staff members, that RI#1 would wander into other residents' rooms and rummage through their belongings. RI#1 constantly repeated words and phrases directed at other residents. Those same five staff members said RI#2 would get angry, yell, and curse others. Refer to	A 621	A621 - The facility retained a resident who had unmanageable behaviors. Resident #2 moved out of The Arbors on 10/17/25. Resident #1 moved our of The Arbors on 11/15/25. The Administrator was re-educated by the VP of Wellness in resident retention and unmanageable behaviors on 11/24/25. On a daily basis the Administrator and/or the community staff will monitor the behavior of all the residents residing in The Arbors. This monitoring will be discussed in our weekly one-on-one meeting. All staff members of The Arbors will be re-educated by the Administrator and/or de-signee in identifying and reporting behaviors before 12/31/25. Documentation will be kept in the Admin-istrators' office.	

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A 621	Continued From page 33 deficiency 504 for additional information. RI#2 had discharged home prior to the survey. On the afternoon of October 30, 2025, EI#1 was asked why RI#1, who had unmanageable behaviors, had not been discharged. EI#1 said she could not say why that had not been done yet. After speaking with other management, EI#1 provided a 30-day notice of discharge for RI#1. THERESA HARRISON, REGISTERED NURSE	A 621	Hope Bagley, Administrator, 12-9-25	