Accepted 7/8/25 Theresa Harrison

Village at Cook Springs

07/03/2025

Via email: alfcomplaints@adph.state.al.us

Alabama Department of Public Health
Division of Health Care Facilities
Assisted Living Facilities Unit

Dear Ms. Suniaja Smith:

Please see the attached, requested Plan of Correction for the Village at Cook Springs Assisted Living survey that was conducted on 06/11/2025.

If you have any questions or concerns, please contact me via email (rapickell@nolandhealth.com) or cell phone (205-288-3727).

Respectfully,

Randolph P Pickell Jr, NHA
Executive Director – Village at Cook Springs

415 Cook Springs Road, Pell City, Alabama 35125
(205) 822-0405 Fax: (205) 814-3257

What You Need to Know About Your Plan of Correction

Alabama Department of Public Health
Bureau of Health Provider Standards
Assisted Living Facilities Unit

Your Plan of Correction (POC) must contain the following information:

- ☑ Facility Name: Village at Cook Springs Assisted Living Facility
- ☑ Facility Identification Number: D5802
- ☑ Name of Administrator: Randolph Pickell Sr.
- ☑ Survey Exit Date: 6/11/25

Each deficiency in the statement of deficiencies (SOD) must be separately addressed and include the following five (5) elements:

1. The cited deficiency number from the SOD.
2. The POC must specify the corrective action(s) that you will take in response to each resident or example identified in the SOD.
3. The POC must explain the corrective action(s) that your facility will take to identify other residents or concerns not identified by the survey team that are related to those cited in your SOD. Be sure to include specific timetables and identify responsible facility staff. **DO NOT include resident rosters or any Protected Health Information (PHI) in the POC.** If PHI is included in the POC, corrections to remove that information will be requested.
4. The POC must describe the measures/changes you have put into place or made to ensure the same deficiency will not recur in your facility. Be sure to include specific timetables and identify responsible facility staff; staff training; policy changes; use of consultants; resident input; physical environment modifications; changes or expansion of staffing positions; increase in staff numbers; and improvement of staff qualifications.
5. The POC must explain how you will monitor your corrective action(s) to ensure that they are fully implemented; adequately address the identified problems; and are effective. The POC must also identify positions of staff that will accomplish the monitoring; when and how often the monitoring will take place; and where documentation of the monitoring will be kept. (Monitoring activities may include: oversight by the administrator or other supervisory personnel; ombudsman feedback; and interviews with residents and families.)

Your POC must be signed, dated, and returned by: Saturday, July 5, 2025, at 5pm.

Return to:
Alabama Department of Public Health
Bureau of Health Provider Standards
alfcomplaints@adph.state.al.us

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
	D5802	A. BUILDING: _____ B. WING _____	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE AT COOK SPRINGS ASSISTED LIVING FACIl	415 FERGUSON ROAD COOK SPRINGS, AL 35052

(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 June 10, 2025, an unannounced licensure survey was conducted for this 68 bed Assisted Living Facility (ALF) with a census of 23. There were no complaints investigated during this survey. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities (ALF). The deficiencies cited pose a potential risk of harm to the residents and require a plan of correction.	A 000	A 000 On 06/11/2025 an unannounced survey was conducted. This plan of correction in response to the statement of deficiencies demonstrates our good faith and desire to improve the quality of care and services rendered to our residents.	
A 403	420-5-4-.04 (4) Personnel. (4) Personnel Records. An assisted living facility shall maintain a personnel record for each employee. This record shall contain: (a) An application for employment which contains information regarding the employee's education, training, and experience. (b) Verification of current certification or licensure, if applicable. (c) Record of required physical examinations and vaccinations. (d) Verification the facility has not hired an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry. (e) Date of hire.	A 403	A 403 the facility failed to list the employee initial resident contact date. 1. Staff & EI#1 were educated about the regulations pertaining to new hire orientation process, documentation of initial resident contact date. 2. 100% audit of employee files was immediately conducted. 3. A system of documenting employee orientation including initial resident contact date will be implemented. Monitoring 1. Ed/Designee will audit all new employee files 1 x week x 4 weeks; then 1 x week x 2 weeks then monthly x 1 month, then random audits. 4. The monitoring will be kept in the administrators office for review.	

Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 07/03/2025

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A 403	Continued From page 1 (f) Date of initial resident contact. (g) Date employment ceased. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to list the employee initial resident contact date. Finding: During a review of the employee files on June 10, 2025, at approximately 9:00 AM the following was noted. The facility did not list the employee's initial resident contact date. During an interview with Employee Identifier (EI)#1 later that same day he/she agreed with the surveyors' findings.	A 403		
A 405	420-5-4-.04 (6) Personnel. (6) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained in the facility. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on assisted living facilities.	A 405		

Alabama Department of Public Health

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A 405	Continued From page 2 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire. 5. Identifying and reporting abuse, neglect, and exploitation. 6. Basic first aid. 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environment safety. 10. Special needs of the elderly, mentally ill, and mentally retarded. 11. Safety and nutritional needs of the elderly. 12. Identifying signs and symptoms of dementia. (b) Cardiopulmonary Resuscitation. An assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of an assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must	A 405	A 405 The facility failed to ensure staff had completed required training. Corrective Action 1. 100% audit of the employee files for completion of the required state training requirements 420-5-4- (6). 2. Education of staff including EI #1, 2,3,4, 5,& 6 about requirements for initial training and continuing education specified in the state regulations 420-5-4-.04. (special needs training, diabetes(including individual glucometers or devices), (420-5-4 (6)). 3. 100 % audit of residents files for identification of special needs and need for employee education. Monitor 1. Administrator /designee to review employee files for continuing education, and new hire requirements 1x wk x 4 weeks, then 1 x wk every other week x 1 month, then 1 x month,then random reviews. 2. Administrator /designee to review residents (admissions or change in condition) with special needs identified & staff education. 1x wk x4 weeks then 1 x wk every other week x 1 month, then 1 x month,then random reviews. 3. The monitoring will be kept in the administrators office for review.	

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A 405	Continued From page 3	A 405		

obtain certification in CPR within 90 days of hire. An assisted living facility equipped with an automated external defibrillator (AED) shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or American Red Cross in CPR or AED utilization.

(c) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training.

(d) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure staff had completed required training

Findings:

RI#5 was admitted to the facility on April 25, 2025, with a diagnosis of diabetes mellitus and a Dexcom glucometer (for blood glucose monitoring).

On the morning of June 10, 2025, a review of employee files revealed EI#1 had not completed special needs training to include diabetes

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mellitus, the Dexcom glucometer, hospice, state rules and regulations, advanced directive, safety and nutritional needs of the elderly, resident fire and environment safety and special needs of the elderly and mentally ill.

EI#2 had not completed special needs training to include the Dexcom glucometer.

EI#3 had not completed special needs training to include the Dexcom glucometer.

EI#4 had not completed special needs training to include diabetes mellitus, the Dexcom glucometer, hospice, state rules and regulations, advanced directive, safety and nutritional needs of the elderly, resident fire and environment safety and special needs of the elderly and mentally ill.

EI#5 had not completed special needs training to include diabetes mellitus, the Dexcom glucometer, hospice, state rules and regulations, advanced directive, safety and nutritional needs of the elderly, resident fire and environment safety and special needs of the elderly and mentally ill.

EI#6 had not completed special needs training to include diabetes mellitus, the Dexcom glucometer, hospice, state rules and regulations, advanced directive, safety and nutritional needs of the elderly, resident fire and environment safety and special needs of the elderly and mentally ill.

On the afternoon of June 10, 2025, EI#1 acknowledged the training had not been completed.

Alabama Department of Public Health

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A 507	Continued From page 5 A 507 420-5-4- 05 (3) (g) Records and Reports. (g) Admission Record. A permanent record shall be developed for each resident upon his or her admission to the facility and updated as necessary to remain current. This record shall be typewritten or legibly written in ink. In addition to any information otherwise required by the facility's policies and procedures, it shall include the resident's: 1. Name. 2. Date of birth. 3. Sex. 4. Marital status. 5. Social security number. 6. Veteran status. 7. Name, address, and contact information of the resident's sponsor, responsible party, or closest living relative. 8. Name, address, and contact information of any person or agency providing assistance to the resident. 9. Name, address, and contact information of the resident's attending physician. 10. Preferred pharmacy or pharmacist. 11. Date of admission. 12 Date of discharge.	A 507 A 507	A 507 the facility failed to ensure the admission record included the required veteran staus. Corrective Action 1. 100% audit of resident files for veteran status completed. 2. EI#1 and admission staff was educated about the state regulations for admission record as found in 420-5-4-.05(3) "veterans status". Monitor 1. Administrator /designee to review new admission file 1x a wk x 4 wks, 1x wk x 2 wks, then 1x month, then random audits. 2. The monitoring will be kept in the administrators office for review.	

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13. Facility, setting, or location to which discharged.

14. Date of death.

15. Cause of death, if known.

16. Religious preferences.

17. Information from insurance policies regarding funeral arrangements and burial provisions.

18. Written documentation that the facility has devised a plan to transfer the resident to a hospital, nursing home, specialty care assisted living facility, or other appropriate setting if and when the facility becomes unable to meet the resident's needs. The resident's preference, if any, with respect to any particular hospital, nursing home, or specialty care assisted living facility shall be recorded. The facility shall keep written documentation that demonstrates the transfer plan has been thoroughly explained to the resident or sponsor, as appropriate, and that the resident or sponsor understands the transfer plan.

19. The written documentation of the procedure to follow in case of serious illness, accident, or death to the resident (including the name and telephone number of the physician to be called, the names and telephone numbers and addresses of family members or sponsor to be contacted, the resident's or, if appropriate, the sponsor's wishes with respect to disposition of personal effects, and the name and telephone number of the funeral home to be contacted).

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the admission record included the required veteran status.

Findings:

On the afternoon of June 10, 2025, resident records were reviewed for required information. RI#s 4, 5 and 6 had no indication of their veteran status. EI#1 was asked where the veteran status could be found and he acknowledged it was not documented.

A 613	420-5-4-.06 (5) (a) (b) (c) (d) (e) Care of Residents.	A 613		

(5) Medications.

(a) Medications as defined in these rules, may be administered to a resident of an assisted living facility only after the drugs have been prescribed specifically for the resident by an individual currently licensed to prescribe medications in Alabama. A currently licensed physician in good standing with the Medical Licensure Commission of any state may prescribe medications to a resident of an assisted living facility only during the initial physical examination.

(b) A physician order is required for a resident to manage and have custody of his or her own medications.

Alabama Department of Public Health

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A 613	Continued From page 8 (c) A resident may have custody of and manage over the counter topical medications with the written approval of a physician. A physician order is not required for over the counter topical medications that are self-administered by residents and approved by the physician for resident possession. (d) Nothing in these rules shall preclude a facility from using a licensed nurse employed by the facility or nursing agency to administer medication to any resident. An RN or LPN shall administer medications to residents in the assisted living facility only in accordance with physician orders and the Nurse Practice Act. (e) A resident who is incapable of recognizing his or her name, or understanding the facility unit dose medication system, or does not have the ability to protect himself or herself from a medication error shall require medication administration. Medication administration shall be provided only by a physician or by an RN or LPN. If the resident cannot understand or be trained to understand the unit dose medication system used by the facility or cannot protect himself or herself from medication errors by facility staff, the resident will be appropriately discharged. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to obtain a physician order for a resident to have custody of his/her own prescription/over the counter (OTC) medications. Also, the facility allowed unlicensed staff to administer medication to residents who were incapable of protecting themselves from a medication error.	A 613	A 613 The facility to obtain a physician order for a resident to have custody of his/her own prescription/OTC. The facililty allowed unlicensed staff to administer medication to residents who were incapable of protecting them selfs from medication error. The facility reported that they did not have any residents that self medicated. Corrective Action 1. 100% room audit for any medication including OTC was immediatly conducted. 2. Staff education to include the regulations for medication awareness, & self managing as described in 420-5-4-.06 (5). 3. 100% Resident medication awareness testing was conducted. Action 1. The administrator/designee will observe med pass for med awarenss 3x wk x1 wk, 2x wk x1 wk 1x wk x 2 wk, then monthly random audits. 2. The administrator/designee will conduct room audits for medications 1x wk x 4 wks then monthly audits. 3. The monitoring will be kept in the administrators office for review.	

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Findings:

Prescription medication

RI#1 was admitted to the facility on March 4, 2019, with diagnoses that included benign prostatic hyperplasia, hyperlipidemia, pain, vitamin D deficiency, chronic obstructive pulmonary disease (COPD), inflammatory disease of prostate, ocular manifestation, atherosclerotic heart disease, osteoarthritis, major depressive disorder, gastroesophageal reflux disease, Parkinson's disease, edema, and hypokalemia. During a facility tour on June 9, 2025, the surveyor observed Fluticasone Propionate sitting on a counter in RI#1's room. According to RI#1's Medical Examination Record dated June 3, 2025, there was no physician order for RI#1 to have custody of prescription medications. Also, according to the plan of care dated February 28, 2025, it does state that RI#1 may have cough lozenges at bedside but not any prescription medication. Upon entering the facility, it was told to the surveyors that the facility did not have any residents that self-medicated.

OTC

RI#3 was admitted to the facility on July 12, 2024, with a diagnosis that includes hypokalemia, insomnia, chronic pain, constipation, hyperlipidemia, dementia, hereditary and idiopathic neuropathy, hypertension, osteoarthritis, and edema. During a facility tour on June 9, 2025, the surveyor observed a bottle of Clearlax Polyethylene Glycol in RI#1's bathroom. According to RI#3's Medical Examination Record dated June 26, 2024, there was no physician order for RI#3 to have custody of OTC

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A 613	Continued From page 10	A 613		

medications. Also, according to the plan of care dated March 15, 2025, it states that resident is not to have any medications at bedside.

Incapable of protecting themselves

RI#2 was admitted to the facility on March 22, 2025, with diagnoses that included iron deficiency anemia, diabetes mellitus type 2, hyperlipidemia, acute pain, hypertension, atrial fibrillation, and benign prostatic hyperplasia. During an interview with RI#2 on June 9, 2025, he/she was very confused. RI#2 did not know how old he/she was or what year RI#2 was born. While the surveyor was speaking with EI#5, RI#2 came up to the surveyor and stated, " can you let me in my room because the door is locked, and RI#2 did not know how it was locked". The surveyor requested to EI#2 for RI#2 to have a medication awareness test performed. On June 10, 2025, at approximately 3:00 PM EI#2 gathered two sets of medication unit dose packs. One pack stated, "test patient one" and the other was RI#2's own medications. EI#2 presented the "test patient one" unit dose pack to RI#2 and he/she stated RI#2 could not read the name. RI#2 was given his/her glasses to assist with identifying the medication unit dose packs. RI#2 read the word "test" but could not read the rest of the name. RI#2 was presented with his/her medication packs, and he/she read RI#2's last name on the pack. EI#2 attempted to help RI#2 read the labels but it was unsuccessful. RI#2 suddenly left and went to his/her refrigerator. EI#2 presented again the "test patient one" unit dose pack to RI#2 and EI#2 asked if he/she would take the medication and RI#2 stated, "yes RI#2 would take them because EI#2 would give them to RI#2". RI#2 was not aware of what medications to take and was unable to protect him/herself from

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A 613	Continued From page 11 medication error. According to the facility schedule there was not a licensed staff currently giving RI#2 medication. Afterward the surveyor interviewed EI#2 about RI#2's confusion and the facility elected to get a physician order for a urine analysis. Currently, the facility did not have any medication awareness tests performed for RI#2. During an interview on June 10, 2025, with EI#1 he/she agreed with the surveyors' findings.	A 613		
A 618	420-5-4-.06 (9) Care of Residents. (9) Oxygen Therapy. (a) A resident of an assisted living facility that requires oxygen therapy shall self-manage his or her own oxygen therapy or self-administer his or her own oxygen therapy with assistance of facility staff. A resident that cannot safely self-manage or self-administer his or her own oxygen therapy with assistance shall have oxygen administered only by a physician, RN, or LPN. A resident that cannot direct his or her administration of oxygen and cannot be taught to direct his or her administration of oxygen shall be appropriately discharged. (b) Oxygen use including date, time, rate, and proper function of the equipment shall be documented on the medication administration or medication assistance record at least once per shift unless oxygen therapy is self-managed by the resident. (c) If a resident receives oxygen therapy in a facility: 1. All oxygen equipment, such as	A 618	A 618 The facility failed to safely maintain and store oxygen bottles. Corrective Action 1. The oxygen was immediately secured. 2. 100% audit of all residents with oxygen. 3. RI#1 and staff were educated on the state regulations for the proper storage of oxygen. Monitoring 1. The administrator/designee will inspect the oxygen tanks for proper storage 1x wk x 4wks the 1x wk x 2 wks then 1 x month then random audits. 2. The monitoring sheets will be kept in the administrators office for review.	

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	D5802	A. BUILDING: _____ B. WING _____	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE AT COOK SPRINGS ASSISTED LIVING FACI	415 FERGUSON ROAD COOK SPRINGS, AL 35052

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A 618	Continued From page 12 tubing, masks, and nasal cannula shall be maintained in a safe and sanitary condition. 2. All oxygen tanks shall be safely maintained and stored. 3. The facility shall require safe use of oxygen therapy. No smoking and appropriate precautionary signs shall be posted. 4. The facility shall ensure that each resident using oxygen therapy maintains an adequate supply of oxygen. Refer to National Fire Protection Association (NFPA) 99 for oxygen storage requirements. This Rule is not met as evidenced by: Based on observation and interview the facility failed to safely maintain and store oxygen bottles. Findings; RI#1 was admitted to the facility on March 4, 2019. During a facility tour on June 9, 2025, the following was observed. RI#1 had an oxygen bottle that was standing beside a refrigerator unsecured. During an interview later that same day EI#1 agreed with the surveyors' findings.	A 618		
A 804	420-5-4-.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	A 804		

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A 804	Continued From page 13 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. 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. Existing recirculating vent hoods in Family facilities may remain in use when filters are cleaned or replaced regularly to prevent excess grease accumulation. Group assisted living facilities 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	A 804	A 804 Physical Facilities: the facility failed to ensure the ice machine was cleaned . Corrective Action 1. EI#8 immediately emptied and cleaned the ice machine. 2. The ice machine was serviced by the rep. 3. The administrator/ designee educated staff about the regulations for keeping equipment clean. 4. The administrator/ designee set up a cleaning schedule. Monitoring 1. The administrator designee will cheek the ice machine 2xs a wk for 2 wks, 1x wk x 2 wks then 1x month, then random ice machine checks. 2. The monitoring will be kept in the administrators office for review.	

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A 804	Continued From page 14	A 804		

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 and shall be well lighted and ventilated.

(g) Hand Washing Facilities. Each Group and Congregate 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. Existing Group and Congregate facilities that enlarge or renovate kitchens shall install a hand wash sink.

(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

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A 804	Continued From page 15	A 804		

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 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 Family or Group assisted living facility, a residential use range is permitted. A Congregate assisted living facility shall have a heavy-duty range suitable for institutional use with double oven, or equivalent.

2. Refrigerator. A Family or Group assisted living facility may use a residential refrigerator. A Congregate assisted living facility shall have a heavy duty refrigerator suitable for institutional use.

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A 804	Continued From page 16	A 804		

3. Fire extinguisher. A five-pound type BC for residential hoods, and K type for commercial hoods.

4. Dishwashing. The dishwashing equipment for Family and 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.

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. 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.

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A 804	Continued From page 17 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 automatic type. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure the ice machine was clean. Findings: On the morning of June 10, 2025, an observation was made of the ice machine with EI#8, a kitchen staff member. A row of pink and black substance was observed across the top of the inside of the ice holding compartment. EI#8 was asked to wipe across the line of pink and black substance found in the ice machine above the ice. Black flakes and brown residue was on the napkin that could have contaminated the ice. EI#8 said what she wiped away was dirty.	A 804		
A 901	420-5-4-.09 (1) (2) Laundry. (1) General. (a) Direction and Supervision. Responsibility for laundry services shall be assigned to an employee. (b) Linen. Linens shall be handled, stored, processed, and transported in a manner consistent with generally accepted infection control practices.	A 901		

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A 901	Continued From page 18	A 901	A901	

(2) Location and Space Requirements.

(a) Each assisted living facility shall have laundering facilities unless commercial laundries are used. An on-site laundry shall be located in a specifically designated area, and there shall be adequate rooms and spaces for sorting, processing, and storage of soiled material. Laundry rooms in Group and Congregate facilities shall not open directly into resident rooms or food service areas. Domestic washers and dryers which are for the exclusive use of residents may be provided in resident areas, provided they are installed in such a manner that they do not cause a sanitation problem or offensive odors.

(b) Each assisted living facility shall have a system in place to keep clean linen and dirty linen separated and to prevent the reuse of dirty linen before it is cleaned. Dirty linens and clothing shall not be stored, even temporarily, in the area set aside for clean linen.

(c) Ventilation of Laundry. Provisions shall be made for proper mechanical ventilation of the laundry, if located within the assisted living facility. Provisions shall also be made to prevent the re-circulation of air in commercial equipment laundries into the heating and air conditioning systems outside the laundry area.

(d) Lint Traps. Adequate, effective, and clean lint traps shall be used in all dryers.

A 901 Laundry
The facility failed to provide proper mechanical ventilation of the laundry dryer.

Corrective action
1. EI#6 immediately cleaned the dryer vent to allow air flow.
2. Administrator/designee educated staff about the removal of lint from the dryer vents.
3. Administrator/designee to assigned/ schedule staff to check and remove lint if needed.

Monitoring
1. Administrator/designee to check vents 3xs week x 2 weeks, then 2xs week x1 weeks, then random audits x 3 months
2. The monitoring sheets will be kept in the administrators office for review.

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A 901	Continued From page 19	A 901		

This Rule is not met as evidenced by:
Based on observation and interview, the facility failed to ensure dryer lint traps were clean.

Findings:

On the afternoon of June 9, 2025, an observation was made with EI#6, the laundry manager, of the dryer lint traps. Three dryers were found with excessive amounts of lint build up on the lint traps. EI#6 acknowledged she had found less lint build-up the previous day and had sent pictures to staff to make them aware of what she had seen. EI#6 said the issue of excess lint would be corrected.

THERESA HARRISON, REGISTERED NURSE
TROY BLACK, REGISTERED NURSE