Theresa Hawkins chg

Accepted 1/23/25

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FORM APPROVED

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
	D4946	A. BUILDING: _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVEER AT PORT CITY	4720 MORRISON DRIVE MOBILE, AL 36609

(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 December 6, 2024, an unannounced licensure and complaint survey was conducted for this 83 bed Assisted Living Facility with a census of 56. LC20240409010 was investigated and substantiated. One deficiency was cited as a result of the complaint investigation. 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 risk of harm to the residents and require a plan of correction.	A 000	Preparation, execution and submission of this Plan of Correction does not constitute an admission of fault or liability on the part of Proveer at Port City, nor agreement by Proveer at Port City as to the truth of the facts alleged or conclusions drawn in the Summary Statement of Deficiency or any specific statement of non-compliance and/or findings. Proveer at Port City prepares and submits this Plan of Correction is order to comply with state laws and regulatory provisions. Plan of Correction with supporting documentation of corrective actions and preventive recurrence will be kept in Administrator's office.	
A 302	420-5-4-.03 (1) (e) Administration. 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 residents. 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:	A 302	Corrective Action: Administrator and Wellness Director reviewed and retrained in facility policies: Resident retention in ALF Resident Monthly Assessment ALF Medication Assistance and Competency Reviewed and re-training completed January 7th. R#1 issued 30 days notice to vacate community due to inability to his/her medications. Due to delay in receipt of notice sent via certified mail to resident responsible party; to provide a true 30-day notice, family will relocate resident on or before January 18, 2025. R#3 interventions are in place with resident with eyesight concerns on identification of medications with red stickers on medications as identifiers on medications. Wellness Director is overseeing this	

Susan Stanfield 1/22/25

	(i) Facility responsibility to protect all residents from abuse, neglect, and exploitation.		resident's medication receipt and monitoring of resident's competency of protecting himself from medication errors. Resident will continue to be evaluated weekly for 4 weeks, and then every 30 days thereafter. Steps to Identify Other residents: Record review of ALF resident records by Administrator, Wellness Director and Community RN, for pre-admission screenings, medication assistance competency, behaviors, monthly assessments, care plans.to include resident's ability to protect themselves against a medication error. To be completed by January 24, 2025. Issues identified will be corrected by February 14, 2025. Measures to prevent reoccurrence: Wellness Director and ALL medication staff to be retrained in the resident medication assistance state guidelines and community policies to be completed by January 24, 2025. Administrator, Wellness Director and Community RN to review minimum of 10 resident records weekly until all ALF records have been completed, for pre-admission screenings, medication assistance competency, behaviors, monthly assessments, care plans. to include resident's ability to protect themselves against a medication error. Issues identified will be corrected within 14-day period of issue if any being found. Administrator, and/or Wellness Director / or facility RN will observe medication passes weekly for four weeks and then randomly 90 days. Issues identified through observation will be immediately addressed and additional training will be provided. Implemented January 6, 2025. Wellness Director will be retrained on ALF resident behavior criteria completed January 7, 2025.	

Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Susan Stanford 1/28/25

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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		

1/22/25 Susan Stenkelo

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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 observations, interviews and record reviews, the facility failed to implement written policies and procedures. Findings: The facility policy titled, "Resident Retention in ALF" revealed, "... PROCEDURE: When a resident's care and safety needs exceed what the community can provide or what the regulations allow, the resident is no longer eligible for retention and will be appropriately transferred or discharged. ...." Refer to deficiency 621 for additional information. The facility policy titled, "Monthly Assessments - ALF" revealed, "....POLICY: It is the policy of the community to assess each resident monthly and upon changes in resident status. PROCEDURE: The monthly assessment shall be done by a nurse, physician, or DHW (Director of Health and Wellness). The nurse, physician, or DHW will assess the resident's ability to self-manage medications, medication awareness, and/or self-administer medications with assistance. ... Any decline in resident status requires documentation of interventions. ... " RI#3 was admitted to the facility on May 20, 2024, with diagnoses to include spinal stenosis lumbar region, type two diabetes mellitus and macular	A 302		

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A 302	Continued From page 4 degeneration. RI#3's inaccurate medication awareness assessments signed monthly by EI#9, a Resident Care Associate, who is not a nurse June through November or 2024. Refer to deficiencies 405 and 604 for additional information. The facility "Medication Assistance Competency Review" revealed, "... Meds (medications) reviewed with resident ... Assistance with self-administration rather than administration provided by unlicensed staff ... Medications not "hidden" in food ... Stays with resident until all meds are swallowed. Meds not left with resident ... Meds are documented immediately after ingestion ..." Refer to deficiencies 504, 613 and 615 for additional information.	A 302		
A 303	420-5-4-.03 (2) (a) Administration. The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the assisted living facility and shall be responsible to the governing authority for 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. 4. There must be an individual with experience in the day-to-day operation of the	A 303	Corrective Action: Administrator has reviewed facility policies and procedures, and State ALF guidelines as follows: Resident Retention in ALF Resident Monthly Assessments in ALF Resident Care Plan in ALF Medication Assistance Competency Personnel training requirements Fire Extinguisher monthly checks Reviewed completed January 7, 2025. Wellness Director and ALL medication staff to be retrained in the resident medication assistance state guidelines and community policies to include resident's ability to protect themselves against a medication error. To be completed by January 24, 2025. Steps to identify other residents Record review of ALF resident records by Administrator, Wellness Director and Community RN, for pre-admission screenings, medication assistance competency, behaviors, monthly assessments, care plans.to include resident's ability to protect themselves against a medication error. To be completed by January 24, 2025. Issues identified will be corrected by February 14, 2025.	

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			Prevention of Reoccurrence Administrator, Wellness Director and Community RN to review minimum of 10 resident records weekly until all ALF records completed for pre-admission screenings, medication assistance competency, behaviors, monthly assessments, care plans. to include resident's ability to protect themselves against a medication error. Issues identified will be corrected within 14-day period of issue if any being found. Administrator, and/or Wellness Director / or facility RN will observe medication passes weekly four weeks and then randomly for 90 days. Issues identified through observation will be immediately addressed and additional training will be provided. Administrator and Business office Director to review all facility personnel for compliance of new hire training and annual training current by January 16, 2025, to include diabetic and oxygen therapy training completed. Issues identified will be addressed immediately with further training. Fire Extinguisher monthly checks- Maintenance Director to take complete inventory of all extinguishers in facility, to place tags of identifier and locations for each on inventory monthly checklist for monthly monitoring. Completed January 7, 2025. Fire extinguishers monthly check verified same day as monthly fire drills ongoing by Administrator monthly. Issues identified will be addressed within 5 days of issue identified.	

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Susan Stanfield 1/07/25

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A 303	Continued From page 5 facility, who is authorized in writing, to act for the administrator during absences. 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 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 setting. 11. The administrator shall ensure that facility staff members observe each resident for	A 303		

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A 303	Continued From page 6 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 perform her duties to ensure the care and safety needs of all residents were met. Findings: The facility did not follow it's own policies and procedures. Refer to deficiency 302 for additional information. Required training was not completed by staff. Also, Employee Identifier (EI)#3, the Health and Wellness Director, failed to exhibit knowledge of the SBOH rules for Assisted Living Facilities. Refer to deficiency 405 for additional information. The Health and Wellness Director shredded pre-admission assessments. Refer to deficiency 501 for additional information. Community standards of care were not followed	A 303		

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A 303	Continued From page 7 for medication assistance when facility staff failed to observe a resident actually take their medications. Refer to deficiency 504 for additional information. Monthly assessments were inaccurate and completed by an unqualified staff member. Refer to deficiency 604 for additional information. Care plans were not developed to address the individual care needs of residents. Refer to deficiency 611 for additional information. Residents were unable or unwilling to protect themselves from a medication error. Refer to deficiency 613 for additional information. Medication was not documented contemporaneously on the resident's Medication Assistance Record (MAR). Refer to deficiency 615 for additional information. The facility retained residents who did not meet the criteria for retention in an assisted living facility. Refer to deficiency 621 for additional information. Fire extinguishers were not visibly inspected each month. Refer to deficiency 1101 for additional information.	A 303		
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	A 405	Corrective Action: Administrator and Business office Director to review all facility personnel for compliance of new hire training and annual training up to date by January 16, 2025, to include diabetic and oxygen therapy training completed. E#1,3,4,5,6,7,8, completed Diabetic and oxygen therapy training completed as of January 9, 2025. E#6 completed new hire retraining as of January 9, 2025. E#3 received retraining on facility policies and procedures,	

Susan Stanfield 1/30/25

			and State ALF guidelines as follows: Resident Retention in ALF Resident Monthly Assessments in ALF Resident Care Plan in ALF Medication Assistance Competency Personnel training requirements Resident Rights Resident Behaviors State ALF guidelines Completed on January 7, 2025. E#5-received retraining on medication assistance competency, proper medication documentation completed as of January 7, 2025. Prevention of Recurrence: Facility personnel training records- New hire personnel training record to be completed by hiring manager and approved by either Administrator or Business Office Director prior to new hire being placed on work schedule. Compliance with annual training state rules -5 records randomly selected monthly by Administrator or Business office director for review for compliance of required annual training to include diabetic and oxygen therapy. Identified issues will be addressed immediately with training or re-training. Implemented January 3,2025.	

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Susan Stanfield 1/2/25

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A 405	Continued From page 8 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. 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.	A 405		

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A 405	Continued From page 9 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 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 document review and interview, the facility failed to ensure staff were trained in	A 405		

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A 405	Continued From page 10 diabetes mellitus and oxygen therapy. The facility further failed to ensure EI#3 exhibited knowledge of the SBOH rules for Assisted Living Facilities. Findings: Training Review of the employee files for required training revealed EI#1, EI#3, the Health and Wellness Director, EI#4, a licensed practical nurse (LPN), EI#5, a medication technician (med tech), EI#6, a LPN, EI#7, a Resident Care Assistant (RCA) and EI#8, a RCA, had not received training in diabetes mellitus and oxygen therapy. On the afternoon of December 6, 2024, EI#3 was asked why staff had not been trained regarding diabetes mellitus and oxygen therapy. EI#3 responded the residents are responsible for oxygen therapy and she was not aware staff were supposed to be trained for those needs. EI#3 added Proveer did not require that training. Rules knowledge During the survey from December 3 - 6, 2024, EI#3 1. had not developed care plans for residents. 2. shredded pre admission screening of residents. 3. acknowledged she had not read the state rules. 4, failed to assess the competency of a newly hired nurse. 5. did not accurately assess a resident who could not read their name. 6. failed to address a resident's unmanageable behaviors. 7. failed to identify ineligible residents. 8. did not know the components of a care plan.	A 405		

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A 405	Continued From page 11 On the afternoon of December 6, 2024, EI#2 acknowledged training required by the rules and regulations should have been completed.	S		
A 501	420-5-4-.05 (1) Records and Reports. (1) General. (a) Responsibility for Records. The administrator shall prepare and file all records, or shall oversee the preparation and filing of records. This duty shall be assigned to other employees in the administrator's absence. (b) All records and reports required by these rules shall be completed in a timely manner, and shall be maintained and filed in an orderly manner within the assisted living facility premises. (c) Storage and Safety. Provision shall be made for the safe storage of records within the facility. Records shall be stored in a manner to reasonably protect them from water or fire damage. Records shall be safeguarded from unauthorized access. (d) All facility records, including resident medical records, shall be made readily available for review and copying on demand by representatives of the State Board of Health upon request. This Rule is not met as evidenced by: Based on record review and interview, the facility did not retain pre-admission screenings in the medical record for residents.		Records and Reports Corrective Action Wellness Director received re-training on record retention, all pre-admission paperwork is deemed part of the resident permanent record and will be retained as such. Training completed by Administrator on January 7, 2025. Steps to identify other residents Record review of ALF resident records by Administrator, Wellness Director and Community RN, for pre-admission screenings, medication assistance competency, behaviors, monthly assessments, care plans.to include resident's ability to protect themselves against a medication error. To be completed by January 24, 2025. Issues identified will be corrected by February 14, 2025. Prevention of recurrence: Administrator, Wellness Director and Community RN to review minimum of 10 resident records weekly until all ALF records completed for pre-admission screenings, medication assistance competency, behaviors, monthly assessments, care plans. to include resident's ability to protect themselves against a medication error. Issues identified will be corrected within 14-day period of issue if any being found.	

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A 501	Continued From page 12 Findings: On the afternoon of December 4, 2024, a review of medical records for RI#2, RI#3, RI#4 and RI#5, revealed no pre-admission screenings. EI#3 said she goes to see residents prior to admission to assess them. EI#3 said she shreds those screenings. On the afternoon of December 6, 2024, EI#1 acknowledged the pre-admission screenings were part of the medical record and should be maintained.	A 501		
A 504	420-5-4-.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 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	A 504	Corrective Action: Wellness Director and ALL medication staff to be retrained in the resident medication assistance state guidelines, residents' rights and community policies on medication assistance to include resident's competency/ability to protect themselves against a medication error. Completed by January 24, 2025. E#3 received retraining on facility policies and procedures, and State ALF guidelines as follows: Resident Retention in ALF Resident Monthly Assessments in ALF Resident Care Plan in ALF Medication Assistance Competency Personnel training requirements Resident Rights Record retention State ALF guidelines Completed on January 7,2025. E5-received retraining on medication assistance competency, observance of resident actually taking medication and proper accurate documentation of medication assistance tasks completion. Completed as of January 9, 2025. Steps to identify other residents: Record review of ALF resident records by Administrator,	

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			Wellness Director and Community RN, for pre-admission screenings, medication assistance competency, behaviors, monthly assessments, care plans.to include resident's ability to protect themselves against a medication error. To be completed by January 24, 2025. Issues identified will be corrected by February 14, 2025. Prevention of recurrence Administrator, Wellness Director and Community RN to review minimum of 10 resident records weekly until all ALF records completed for pre-admission screenings, medication assistance competency, behaviors, monthly assessments, care plans. to include resident's ability to protect themselves against a medication error. Issues identified will be corrected within 14-day period of issue if any being found. Administrator, and/or Wellness Director / or facility RN will observe medication passes weekly four weeks and the n randomly for 90 days. Issues identified through observation will be immediately addressed and additional training will be provided. :	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D4946	A. BUILDING: _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVEER AT PORT CITY	4720 MORRISON DRIVE MOBILE, AL 36609

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A 504	Continued From page 13 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 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.	A 504		

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PROVEER AT PORT CITY	**4720 MORRISON DRIVE MOBILE, AL 36609**

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A 504	Continued From page 14 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 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.	A 504		

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A 504	Continued From page 15 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; and (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	A 504		

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A 504	Continued From page 16 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 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, to keep and use his or her own personal possessions including toilet	A 504		

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A 504	Continued From page 17 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 and to freely come and go from the home. 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 and interview, community standards of care were not followed for medication assistance when facility staff failed to observe that the resident actually took the medications. The facility also failed to ensure a resident received skilled nursing for a dressing of a surgical site. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged a resident's medication was given to a family member to give to the resident. The surveyor was able to	A 504		

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A 504	Continued From page 18 substantiate this complaint during the onsite survey. RI#1 was admitted to the facility April 15, 2022, with diagnoses to include Alzheimer's disease, blindness, and dementia. On the morning of December 3, 2024, (9:51 AM) an observation was made of a private duty sitter giving RI#1 a cup of coffee and the resident making a scowling face. The sitter reported it was because medications were in the coffee and that was the only way he/she would take them. The sitter added the nurse (actually a med tech) brings the crushed meds (medications) to them (she and other sitters) to add to RI#1's coffee. She acknowledged the med tech does not observe the medications being taken by RI#1. Later that morning (10:39 AM), EI#5, med tech, acknowledged she gives RI#1's medications to the sitters to give to RI#1. EI#5 said she would rather the sitters give the medications because she wants to make sure RI#1 takes his/her medicine. EI#5 said she gave the medications to the sitter and the sitter gave them to RI#1 in his/her coffee. RI#5 said she knows the sitter gives the medications because the sitter told her she did and she believes the sitter. EI#5 was asked how she makes sure RI#1 gets his/her medications. EI#5 said she goes by what the sitters tell her, she trusts them and they give it. EI#5 was asked if she observed RI#1 take their medicine and she said, "No, I did not see it." EI#5 acknowledged she had documented the medications were given at 9:00 AM while the surveyor observed what was supposedly the medications being given in coffee at 9:51 AM. On the morning of December 5, 2024, EI#3 was	A 504		

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A 504	Continued From page 19 interviewed regarding mention of a dressing in RI#3's medical record. EI#3 said RI#3 had an out-patient surgery in early October. EI#3 was asked what care RI#3 needed after surgery. EI#3 said nurses changed the dressing for approximately two weeks. EI#3 admitted there was no documentation of that dressing change and no physician's order for the dressing change. EI#3 admitted nurses are supposed to have a physician's order if they provide care beyond first aid. On the morning of December 6, 2024, EI#2, the Chief Executive Officer/Registered Nurse, was informed of the concern of medications being given to family of residents or sitters for them to give to the resident. EI#2 responded, "No, you can't do that."	A 504		
A 604	420-5-4-.06 (3) (a) (b) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility shall assess prospective residents for facility eligibility. This assessment shall document identified care needs and serve as a baseline for future assessments. (b) Monthly Assessments. The facility shall assess each resident monthly and more often when necessary to identify changes in resident's status. In addition to other items that may be required by the facility's own policies and procedures, the monthly assessment shall: 1. Assess the resident's ability to safely self-manage medications or safely self-administer medications with assistance.	A 604	Corrective Action: Wellness Director and ALL medication staff to be retrained in the resident medication assistance state guidelines and community policies to include resident's ability to protect themselves against a medication error. Completed by January 24, 2025. Wellness Director received retraining on facility policies and procedures, and State ALF guidelines as follows: Resident Retention in ALF Resident Monthly Assessments in ALF Resident Care Plan in ALF Medication Assistance Competency Personnel training requirements Resident Rights Record retention State ALF guidelines Completed on January 7,2025. Steps to identify other residents Record review of ALF resident records by Administrator, Wellness Director and Community RN, for pre-admission screenings, medication assistance competency, behaviors, monthly assessments, care plans.to include resident's ability to protect themselves against a medication error. To be	

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			completed by January 24, 2025. Issues identified will be corrected by February 14, 2025. Steps to prevent recurrence: Administrator, Wellness Director and Community RN to review minimum of 10 resident records weekly until all ALF records completed for pre-admission screenings, medication assistance competency, behaviors, monthly assessments, care plans. to include resident's ability to protect themselves against a medication error. Issues identified will be corrected within 14-day period of issue if any being found. Steps to prevent recurrence: Administrator, and/or Wellness Director / or facility RN will observe medication passes weekly for four weeks and then randomly 90 days. Issues identified through observation will be immediately addressed and additional training will be provided. Identified issues or residents will be addressed immediately with interventions put in place and documented.	

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A 604	Continued From page 20 2. Accurately weigh and record the weight of each resident. 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 or greater weight loss in a period of three months or less, or a ten 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. 3. Document identified changes in resident status. 4. Assess the appropriateness of each resident's plan of care. Any decline in resident status requires immediate implementation and documentation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the accuracy of monthly assessments. The facility also failed to complete an assessment of a resident after surgery. Findings: RI#1 On the morning of December 3, 2024, an observation was made of RI#1 not being given	A 604		

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A 604	Continued From page 21 the opportunity to protect themselves from a medication error. RI#1's Monthly Wellness Reviews dated February 2024 through November 2024 indicated RI#1, "... Can Validate Name on Medications and Validate meds have been taken?" RI#1 could not or would not validate his/her name or names of medications during a medication awareness test. RI#3 On the morning of December 3, 2024, RI#3 said he/she is not observed by staff regarding medications because he/she has been doing it too long. RI#3 was admitted to the facility on May 20, 2024, with diagnoses to include spinal stenosis lumbar region, type two diabetes mellitus and macular degeneration. The initial med (medical) exam for RI#3 dated May 20, 2024, revealed the resident could not self administer or store his/her own medications. RI#3's Monthly Wellness Reviews dated May 2024 through November 2024 indicated RI#3, "... Can Validate Name on Medications and Validate meds have been taken?" RI#3's medication awareness assessment titled, "Resident Assistance with Self-Administration of Medications" revealed RI#3 demonstrated the ability to correctly receive medications according to time and route of all medications ordered. (An observation revealed RI#3 was unable to read his/her own name, therefore was unaware of what medication he/she was taking.) On the morning of December 5, 2024, EI#3 was interviewed regarding mention of a wound	A 604		

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A 604	Continued From page 22 dressing in RI#3's medical record. EI#3 said RI#3 had an out-patient surgery in early October. EI#3 was asked about the assessment following surgery that should have included the surgical wound. EI#3 responded if a resident is ambulatory, they do not do an assessment. On the morning of December 6, 2024, EI#9 said she had observed EI#3 conduct a medication awareness assessment twice and that was all the training she had before she began doing the assessments. She acknowledged RI#3 could not see or protect himself/herself from a medication error. EI#9 said RI#3's medication awareness assessment was inaccurate. On the afternoon of December 6, 2024, EI#3 acknowledged RI#1's and RI#3's assessments were inaccurate. On the afternoon of December 6, 2024, EI#2 acknowledged assessments should be accurate and completed by a qualified staff member.	A 604	Corrective Action: Wellness Director retrained on the requirement of care plans being developed to meet each individual needs. Care plans created for Residents #1,2,3,4,and 5 as of January 9, 2025.	
A 611	420-5-4-.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. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall	A 611	Steps to identify other residents: Record review of ALF resident records by Wellness Director and Community RN, to identify residents' needs and to develop a care plan to meet those needs. To be completed by January 31, 2025. Steps to prevent recurrence: Administrator will randomly select 3 resident charts per week to review for resident's care plan to be current at time of review. Issues identified to be corrected within 7 days of being identified.	

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A 611	Continued From page 23 be based on the initial medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be reviewed and updated based on the annual examination, and all other physician examinations, diagnoses, and recommendations of the resident's treating physician, and the resident's monthly assessments. The plan of care shall be developed and updated in cooperation with the resident and, if appropriate, the sponsor. All entries on the plan of care shall be accurately dated. 1. The plan shall at all times reflect the current condition of the resident and document the personal care and services required from the facility by the resident. 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 assisted living facilities shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide	A 611		

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A 611	Continued From page 24 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. Resident's 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 shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure care plans were developed to address the individual needs of residents.	A 611		

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PROVEER AT PORT CITY	4720 MORRISON DRIVE MOBILE, AL 36609

(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 611	Continued From page 25 Findings: RI#2 was admitted to the facility on August 23, 2024, with diagnoses to include cellulitis and deep vein thrombosis. Review of the medical record revealed no care plan had been developed. The "Proveer Resident Assessment with Care Tasks" assessment was completed to gauge how much assistance RI#2 required. It did not address needs, goals or interventions for RI#2. RI#3's medical record revealed no care plan had been developed. The "Proveer Resident Assessment with Care Tasks" assessment was completed to gauge how much assistance RI#3 required. It did not address needs, goals or interventions for RI#3. RI#4 was admitted to the facility on October 10, 2023, with diagnoses to include chronic obstructive pulmonary disease (COPD) and essential tremor. The "Proveer Resident Assessment with Care Tasks" assessment was completed to gauge how much assistance RI#4 required. It did not address needs, goals or interventions for RI#4. RI#5 was admitted to the facility on March 28, 2024, with diagnoses to include COPD and neuropathy. The "Proveer Resident Assessment with Care Tasks" assessment was completed to gauge how much assistance RI#5 required. It did not address needs, goals or interventions for RI#5.	A 611		
A 613	420-5-4-.06 (5) (a) (b) (c) (d) (e) Care of Residents.	A 613	Corrective Action: Residents identified as not being able to protect themselves against a medication error will have their medications administered by a licensed nurse. Steps to identify other residents: Wellness Director and Community RN will conduct	

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			medication competency reviews on all ALF residents to determine their ability to protect themselves against a medication error. Any resident identified of not being able to protect themselves against a medication error will have their medications administered by a licensed nurse. Issues identified will be corrected immediately. Steps to prevent recurrence Administrator, and/or Wellness Director / or facility RN will observe medication passes weekly for four weeks and then randomly 90 days. Issues identified through observation will be immediately addressed and additional training will be provided.	

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A 613	Continued From page 26 (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. (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	A 613		

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A 613	Continued From page 27 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 and interview the facility failed to provide nurse administration of medications for two residents who did not have the ability to protect themselves from a medication error. Findings: RI#1 Review of resident records, on December 3 - 6, 2024, as well as interviews with facility staff, revealed RI#1 was resistive to care, cursed staff, "always hollers" and refused medications from staff. On the morning of December 3, 2024, RI#1 was observed drinking coffee that reportedly contained his/her medications. This coffee was served to RI#1 by a private duty sitter because RI#1 hits the med tech when she (the med tech) tries to give RI#1 medications. On the afternoon of December 4, 2024, EI#3 was asked about RI#1's medication awareness screenings. EI#3 said RI#1 acknowledges his/her name but does not know his/her medications or what he/she takes. EI#3 said RI#1's behaviors had been identified in June of 2024, and she had notified the doctor and asked the sponsor to hire sitters. EI#3 acknowledged that RI#1 was unable	A 613		

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A 613	Continued From page 28 to protect themselves from a medication error. EI#3 was asked what was supposed to be done when a resident refused medications from staff or was unable to protect themselves from a medication error. EI#3 said the doctor, family and her supervisor should be notified and she had not done that. On the morning of December 6, 2024, EI#3 attempted a medication awareness test to determine if RI#1 could protect themselves from a medication error. When EI#3 asked RI#1 to tell her the name on the medication cards, RI#1 said, "No." EI#3 put the medication cards in front of RI#1 and RI#1 looked away. EI#3 attempted to administer the medications without obtaining a physician's order first and RI#1 spit the medicine out on EI#3. EI#3 said the resident was refusing medications and she was going to notify the doctor and family. EI#3 was asked what had been done since December 3, 2024, regarding RI#1's unmanageable behaviors that she (EI#3) had been made aware of. EI#3 responded, "(He/She) is on hospice and we are letting them manage those issues." On the afternoon of December 6, 2024, EI#3 was asked why nothing was done for the unmanageable behaviors after they were identified. EI#3 said she had no answer. RI#3 Review of resident records on December 3 - 6, 2024, as well as interviews with facility staff, revealed RI#3 was unable to read the card. On the morning of December 5, 2024, EI#3 attempted a medication awareness test to determine if RI#3 could protect themselves from a medication error. EI#3 passed medication cards	A 613		

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A 613	Continued From page 29 to RI#3. RI#3 complained about his/her vision then said, "I can't read." RI#3 said when staff bring his/her medications, he/she does not know what the name of the medicine is because he/she cannot read the card. EI#3 acknowledged RI#3 failed the medication awareness test. On the morning of December 6, 2024, EI#9 was asked about RI#3's medication awareness monthly screening she had completed. EI#9 was asked how RI#3 could identify his/her name or the name of the medication. EI#9 said, "(He/She) can't see." EI#9 said RI#3 could not protect themselves from a medication error. On the afternoon of December 6, 2024, EI#2 agreed residents should be able to protect themselves from a medication error.	A 613		
A 615	420-5-4-.06 (7) (j) Care of Residents. (j) All medications administered to residents and all medications self-administered with assistance of facility staff in an assisted living facility shall be contemporaneously recorded on a standard medication administration or medication assistance record. "Contemporaneously recorded" means recorded at the same time or immediately after medications are administered. The medication administration or medication assistance record shall include at least the following: 1. The name of the resident to whom the medication was administered or assisted. 2. The name of the medication administered or assisted.	A 615	Corrective Action: E#5 retrained on medication documentation must occur contemporaneously on Medication Administration Record. As of January 9, 2025. Wellness Director and ALL medication staff to be retrained in the resident medication assistance state guidelines and to record/document medication contemporaneously on the resident's mediation administration record. Completed by January 24, 2025. Steps to identify other residents: Administrator, and/or Wellness Director / or facility RN will observe medication passes weekly for four weeks and then randomly 90 days. Residents identified through observed medication passes MAR will be review for contemporaneously documentation. Issues identified through observation will be immediately addressed and additional training will be provided. Steps to prevent recurrence: Administrator, and/or Wellness Director / or facility RN will observe medication passes and contemporaneously	

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			documentation weekly for four weeks and then randomly 90 days. Issues identified through observation will be immediately addressed and additional training will be provided.	

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A 615	Continued From page 30 3. The dosage of the medication administered or assisted. 4. The method of administration or assistance. 5. The site of injection or application, if the medication was injected or applied. 6. The date and time of the medication administration or assistance. 7. Any adverse reaction to the medication. 8. The printed name, initials, and written signature of the individual administering the medication or assisting the resident with self-administration of the medication. This Rule is not met as evidenced by: Based on observation, interview and record review, a resident's medication was not documented contemporaneously on the resident's Medication Assistance Record (MAR). Findings: On the morning of December 3, 2024, (9:51 AM) an observation was made of a private duty sitter giving RI#1 a cup of coffee and the resident making a scowling face. The sitter reported it was because medications were in the coffee and that was the only way he/she would take them. Later that morning (10:39 AM), EI#5 acknowledged she had given RI#1's medications to the private sitter to give to RI#1 in his/her	A 615		

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A 615	Continued From page 31 coffee. EI#5 reviewed the Medication Administration Record (MAR) with this surveyor. EI#5 had documented RI#1's medications had been administered at 9:00 AM. EI#5 was asked if she observed RI#1 take their medicine and she said, "No, I did not see it."	A 615		
A 621	420-5-4-.06 (11) (b) Care of Residents. (b) Retention 1. An assisted living facility shall not allow any resident to return to the assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the facility is licensed to provide or the facility is capable of providing. 2. An 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. 3. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in an assisted living facility. 4. An 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	A 621	Corrective Action: : Resident #1- issued 30 -day notice and will vacate apartment #104 by January 18, 2025. Resident #3- has had interventions(red stickers) put in place for his sight issues in recognizing his medications being administered by licensed nurse. Administrator and Wellness Director to review all AL residents for any physical or cognitive issues as in relation to not meeting ALF criteria of being appropriate for community. Review to be completed by January 24, 2025. Issues identified will be addressed immediately with interventions and/or discharge notices within 7 days of review. Steps to prevent recurrence. Wellness Director to monitor all residents for appropriateness in meeting criteria physically and cognitively to be in Assisted Living. Any concerns or issues are to be brought to the Administrator. Issues or concerns will be addressed within 5 days of notification.	

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A 621	Continued From page 32 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 others and does direct others 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. 5. If a resident of an assisted living facility is diagnosed with a terminal illness other than dementia 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 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. 6. All skilled services provided in the facility, such as but not limited to wound care or insertion of a urinary catheter, shall be provided	A 621		

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A 621	Continued From page 33 by the staff of properly licensed or certified agencies. Skilled services shall not be delegated to facility staff. 7. Residents that develop acute infectious pulmonary disease, such as active tuberculosis, or other diseases capable of transmission to other individuals through normal person-to-person contact shall be immediately transferred to an appropriate level of care until certified by a physician to be free of a contagious condition. 8. No assisted living facility shall be operated in whole or in part in a manner that prevents free and unhindered egress from the facility by any of its residents. 9. An assisted living facility shall not retain any resident who cannot safely reside in the facility unless his or her egress from the facility is restricted. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility retained two residents who did not meet the criteria for retention in an assisted living facility. Findings: RI#1 was admitted to the facility April 15, 2022, with diagnoses to include Alzheimer's disease, blindness, and dementia. RI#1 had unmanageable behaviors that were identified in June of 2024. RI#1 was unable to protect themselves from a medication error and staff acknowledged they gave medications to sitters because the sitters were able to get RI#1 to take	A 621		

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A 621	Continued From page 34 them. RI#3 was admitted to the facility on May 20, 2024, with diagnoses to include spinal stenosis lumbar region, type two diabetes mellitus and macular degeneration. RI#3 was unable to see his/her name on medication cards or read the name of the medication. Therefore RI#3 could not protect themselves from a medication error. Note: No accommodations had been made by facility staff to enable RI#3 to identify his/her medications. On the afternoon of December 6, 2024, EI#2 agreed ineligible residents should not be retained in the facility if they do not meet the criteria for retention in an assisted living facility.	A 621		
A1101	420-5-4-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All 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 of Group and Congregate facilities. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior	A1101	Corrective Action: Administrator reviewed state rule regarding fire extinguisher monthly checks requirement. Completed January 7, 2025. Maintenance Director has been retrained and reviewed state rule regarding fire extinguisher monthly check requirement. Completed January 7 2025. Steps to prevent occurrence: Maintenance Director to establish community fire extinguisher inventory list, to place identifier and location for each community fire extinguisher on monthly check list to be completed monthly. Completed January 7, 2025. Monitoring of implementation: Administrator will review community fire extinguisher monthly check list for compliance during monthly community fire drill exercises. Issues identified will be addressed immediately, further training or interventions will be implemented.	

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A1101	Continued From page 35 as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the currently adopted 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. (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	A1101		

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A1101	Continued From page 36 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, 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 observation, document review and interview, the facility failed to ensure fire extinguishers were visually inspected monthly. Findings: On the morning of December 3, 2024, sixteen fire extinguishers were found to have not been visually inspected each month.	A1101		

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A1101	Continued From page 37 On the morning of December 5, 2024, EI#10, the maintenance director, said the fire extinguishers had not been inspected monthly because he did not know they had to be. EI#10 said they would be inspected monthly going forward. THERESA HARRISON, REGISTERED NURSE	A1101		

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