STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P0702	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE MEMORY CARE OF GREENVILLE	3108 LUVERNE HIGHWAY GREENVILLE, AL 36037

(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 November 7, 2024, an unannounced licensure and complaint survey was conducted at this 16 bed Specialty Care Assisted Living Facility (SCALF) with a census of 16. One complaint was investigated during this survey. LC20230531012 was investigated and was 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 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practices resulted in the potential for harm to residents and require a plan of correction.	A 000		
A 303	420-5-20-.03 (2) (a) Administration. (2) The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the specialty care assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an administrator shall meet all applicable statutory requirements.	A 303		

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A 303	Continued From page 1	A 303		

4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days.

5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age.

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

7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week.

8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment and adequate care actually being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement.

9. The facility administrator is responsible for ensuring that required training is provided to all staff.

10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely

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A 303	Continued From page 2 transferred or discharged to an appropriate setting. 11. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when needed. 12. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan. 13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained. This Rule is not met as evidenced by: Based on observation, interview, and record review, Employee Identifier (EI)#1, the administrator, failed to properly perform her duties to ensure the care and safety needs of all residents were met. Findings: On May 31, 2023, a complaint was received in the ALF unit regarding a resident not allowed to have visitors. The complainant reported he/she was not allowed to visit their parent. On November 6 - 7, 2024, a surveyor with the ADPH conducted an onsite survey and complaint investigation and substantiated the complaint for a resident not being allowed to have visitors.	A 303 A 303	420-5-20-.03 (2) (a) Administration 1) The Administrator will properly perform all duties to ensure the care and safety needs of all residents are met. 2) (11.12.24) Administrator in-serviced with governing authority to review resident rights with specific regard to visitation rights. Additional training and ins-service was completed with regards to policies and procedures related to investigation practices for elopement, proper practices in screening for resident admissions, discharging a resident to an appropriate setting when a higher need of services is required, appropriate supply of emergency foods, proper cleaning of kitchen equipment, and providing appropriate amount of trash receptacles.	Date

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A 303	Continued From page 3 The administrator failed to ensure a resident's right to visit with a person of their choice was not denied. Refer to deficiency 504 for additional information. The administrator failed to investigate an elopement incident. Refer to deficiency 508 for additional information. The administrator failed to ensure the Registered Nurse or care coordinator screened a prospective resident prior to admission. Refer to deficiency 604 for additional information. The administrator failed to make arrangements for discharge of a resident to an appropriate setting when the resident required a higher level of care than the SCALF could provide. Refer to deficiency 606 for additional information. The administrator failed to ensure a resident's plan of care addressed a wound that required dressing changes. Refer to deficiency 611 for additional information. The administrator retained a resident who required skilled nursing care which had exceeded 90 days. Refer to deficiency 621 for additional information. The administrator failed to ensure a three day emergency supply of non-perishable food was on site. Refer to deficiency 703 for additional information. The administrator failed to ensure the ice machine was cleaned. Please refer to deficiency 804 for additional information. The administrator failed to ensure refuse	A 303	3) Administrator and Resident Care Coordinator reviewed policies and procedures to identify any other visitation concerns not identified during the survey. No other deficiencies were found. 4) Administrator and Resident Care Coordinator will review resident rights with each admission going forward, with specific attention given to the cognitive capacities of each resident. Focus will be given on compliance with resident's rights along with the safety and protection of each resident as a priority. 5) The Regional Manager will conduct on-site visits quarterly for the next year to ensure compliance and effectiveness of the plan of correction. Any evidence of non-compliance or continued deficient practice will result in additional in-servicing of Administrator on policies and procedures, changes to the monitoring process or appropriate discipline, up to and including discharge.	

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A 303	Continued From page 4 containers were not found with trash bags piled up preventing lids from being able to close. Please refer to deficiency 1001 for additional information.	A 303		
A 504	420-5-20-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission, of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate. 1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility. 2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints. 3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy. 4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened	A 504		

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A 504	Continued From page 5	A 504		

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.

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

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A 504	Continued From page 6	A 504		

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.

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

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A 504	Continued From page 7	A 504		

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.

(iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time without recourse.

15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges.

16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities.

17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public

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A 504	Continued From page 8 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, and to keep and use his or her own personal possessions, including toilet articles, except for personal possessions too large to be stored in the resident's room. 22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings. 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable	A 504		

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A 504	Continued From page 9 hours. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident's right to visit with a person of their choice. Findings: On May 31, 2023, a complaint was received in the ALF unit regarding RI#4 not being allowed to have visitors. The complainant reported he/she was not allowed to visit their parent. On November 6 - 7, 2024, a surveyor with the ADPH conducted an onsite survey and complaint investigation and substantiated the complaint. Resident Identifier (RI)#4 was admitted to the facility May 3, 2023, with a diagnosis of dementia. The RN assessment completed after RI#4 was admitted indicated RI#4 was continent and independent regarding ADLs (Activities of Daily Living). RI#4 was independent with mobility and walking. RI#4 was assessed with no deficit in communication and understanding. Review of RI#4's signed RESIDENT RIGHTS revealed, "... 4. Unrestricted private communication, ... and visiting with any person of	A 504	420-05-20-.05 (3) (d) Records and Reports 1)Facility will ensure every resident's rights are followed to allow visitors of choice. 2)(11.12.24) Administrator in-serviced with governing authority to review resident rights with specific regard to visitation rights. 3)Administrator and Resident Care Coordinator reviewed policies and procedures and resident rights to identify any other visitation concerns not identified during the survey. No other deficiencies were found. 4)Administrator and Resident Care Coordinator will review resident rights with each admission going forward, with specific attention given to the cognitive capacities of each resident. Focus will be given on compliance with resident's rights along with the safety and protection of each resident as a priority. 5)The Regional Manager will conduct on-site visits quarterly for the next year to ensure compliance and effectiveness of the plan of correction. Any evidence of non-compliance or continued deficient practice will result in additional in- servicing of Administrator on policies and procedures, changes to the monitoring process or appropriate discipline, up to and including discharge.	

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A 504	Continued From page 10 his (his/her) choice, ..." A review of a Country Place Memory Care communication form dated May 3, 2023, revealed, "...PROBLEM/CONCERN: New Resident ... No visitors for 2 (two) weeks. (He/She) is not to leave the facility with anyone. ..." This communication was signed by all facility staff employed on that date. On the afternoon of November 6, 2024, EI#1 provided a document that indicated RI#4 was to have no visitors for two weeks. On the morning of November 7, 2024, EI#5, a Resident Care Associate (RCA), acknowledged RI#4 was not allowed to have visitors when he/she was admitted to the facility. EI#5 said, "There was a note by the time clock." instructing staff that RI#4 was not to have visitors. On the afternoon of November 7, 2024, EI#3, a Registered Nurse (RN) and EI#2, a Licensed Practical Nurse (LPN)/Resident Care Coordinator (RCA), both acknowledged RI#4 was not allowed to have visitors. On the afternoon of November 7, 2024, EI#1 admitted residents were not to be denied visitors. EI#1 acknowledged RI#4's right to meet in private was not honored because the sponsor had requested it.	A 504		
A 508	420-5-20-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in a specialty care assisted living facility, the facility administrator shall be immediately notified, the	A 508		

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A 508	Continued From page 11	A 508		

facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review.

1. Incidents which require investigation are:

(i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as extensive bruising, pain, or injury that is not consistent with actions necessary in providing day-to-day care to a resident or for which medical treatment was sought.

(ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid including but not limited to a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office.

(iii) The onset of wandering behavior by any resident who is not fully cognitively intact.

(iv) Elopement by a resident.

(v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules.

(vi) Suspected, alleged, confessed,

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A 508	Continued From page 12 witnessed, or actual neglect of a resident or residents as defined in these rules. (vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules. (viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or Staphylococcus aureus). (ix) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (xi) An unplanned occurrence that results in media attention. (xii) A medication error, overdose, or over sedation. (xiii) Ingestion by a resident of a toxic substance that requires medical attention. (xiv) Any indication of malfunction of the sprinkler system, or fire alarm system. 2. In addition to other items required by	A 508		

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A 508	Continued From page 13 the facility's policies and procedures, the incident investigation shall contain the following: (i) Names of all residents involved. (ii) Names of all staff involved including person in charge at the time of the incident. (iii) When the administrator was notified (date and time). (iv) Circumstances under which the incident occurred. (v) When the incident occurred (date and time). (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken. (viii) The extent and description of injury, if any, to the affected resident or residents. (ix) Immediate treatment rendered. (x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified. (xi) Names, telephone numbers, and addresses of witnesses. (xii) Date and time relatives or sponsor were notified. (xiii) Out-of-facility treatment.	A 508		

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COUNTRY PLACE MEMORY CARE OF GREENVILLE	3108 LUVERNE HIGHWAY GREENVILLE, AL 36037

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A 508	Continued From page 14 (xiv) Follow-up care. (xv) Outcome resolution. (xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future. (xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation. (xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request. (xix) The entire investigative file and documentation of all corrective action taken shall be retained for a period of not less than 3 years after the resident is discharged or dies. (xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff. 3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident: (i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention. (ii) Elopement by a resident. (iii) Suspected, alleged, confessed,	A 508		

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A 508	Continued From page 15	A 508		

witnessed, or actual abuse, neglect, or exploitation of a resident or residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file.

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

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

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

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

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

(ix) Notifiable diseases and health conditions listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04. shall also be reported by the facility to the State Health Officer or the County Health Officer within the

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A 508	Continued From page 16	A 508		

time frames specified in 420-4-1-.04. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than three years.

(x) Any indication of a malfunction of the sprinkler system, fire alarm system, or a door locking device.

4. The report to the Department's Online Incident Reporting System shall include the following:

(i) Facility name and direct phone number.

(ii) Time and date of the report.

(iii) Reporter's name.

(iv) Name of resident(s), staff, or visitor(s) involved in the incident.

(v) Names of staff on duty at the time of the incident.

(vi) Date and time of the incident.

(vii) A brief description of the incident.

(viii) Any injury or injuries to resident(s).

(ix) Action taken by the facility in response to the incident.

(i) Vital Statistics Reports. A record shall be kept of all births, deaths, and stillbirths that

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A 508	Continued From page 17 occur within the specialty care assisted living facility. By the fifth day of each month, the administrator shall make a report of such births, deaths, and stillbirths for the preceding month on such forms as the State Board of Health shall provide to the county health officer, or in counties without a county health officer, to the State Registrar. This report shall be in addition to the official birth, death, and stillbirth certificates. If there are no births, deaths, or stillbirths in any month, a report shall be made stating that fact to the county health officer.	A 508		
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an elopement was investigated. Findings: RI#5 was admitted to the facility on August 29, 2019, with dementia and bipolar disorder. RI#5's care plan revealed for safety reasons, staff were to assist and monitor RI#5 when going outside. On May 17, 2022 the ADPH received an online incident report that RI#5 had eloped. On the afternoon of November 7, 2024, EI#1 said the secure perimeter for the facility was the exit doors of the building because the alarms sound anytime an exit door is opened. EI#1 was asked why RI#5 was not supervised while outside of the building. EI#1 said a staff member left to go and check on a resident. EI#1 acknowledged the safety of RI#5 was not maintained when three staff were present and not one staff member was	A508	420-5-20-.05 (3) (h) Records and Reports 1) The facility will ensure all investigations are completed and filed in a timely manner. 2) 11.12.24 Administrator and Resident Care Coordinator reviewed policies and procedures related to elopement and documentation of such with Regional Manager. Emphasis was given on the requirements of documenting and retaining the written documentation of every incident. 3) 11.12.24 Resident charts were reviewed to ensure no other deficiencies were found related to missing investigations. None were found.	

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A 508	Continued From page 18 designated to monitor RI#5. RI#5 was picked up and taken to a nearby gas station and the police were called. EI#1 admitted she had no investigation. EI#1 acknowledged the elopement policy was not followed.	A 508	4) Administrator and Resident Care Coordinator will comply and complete all investigations to remain in compliance with this rule. Documentation of all in-services are filed in the in-service binder located and kept in the Administrator's office.	
A 604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility RN or care coordinator shall screen prospective residents for eligibility for admission into the specialty care assisted living facility. The screening shall include a clinical history, a mental status examination to include aphasia screening, a geriatric depression screen, a physical self-maintenance screen, and a behavior screen. Appendix A herein, contains the Physical Self Maintenance Scale (PSMS) form and the Behavior Screening form. These forms shall be completed to screen physical functioning and behaviors. The PSMS and Behavior Screen assessments shall be completed by the RN or care coordinator upon admission, annually, and when there is a change in the resident's status. The facility RN shall perform a comprehensive assessment of each prospective resident for facility eligibility. This assessment shall document identified care needs and serve as a baseline for the RN plan of care and future assessments. (b) Monthly Assessments. The RN shall assess each resident monthly and more often	A 604	5) The Regional Manager will conduct on- site visits quarterly for the next year to ensure compliance and effectiveness of the plan of correction. Any evidence of non-compliance or continued deficient practice will result in additional in-servicing of Administrator on policies and procedures, changes to the monitoring process or appropriate discipline, up to and including discharge.	

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A 604	Continued From page 19	A 604		

when necessary to identify changes in the resident's health status. The monthly assessment shall include a review of monthly weights, falls, incidents, elopements, behavioral symptoms, medications, changes in resident status, and appropriateness of the resident's plan of care.

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

1. Weight loss:

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

(ii) A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half percent or greater weight loss in a period of 3 months or less, or a 10 percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician.

2. Falls (two or more falls within a 30 day period).

3. Elopement.

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A 604	Continued From page 20 4. Any sign and symptom of adverse drug reaction, interaction or over sedation, or circumstances which contraindicate medications that have been prescribed for the resident. 5. Unmanageable, combative, or potentially harmful behavior(s). 6. Any accident with injury. (d) Focused Assessments. The RN or LPN shall conduct focused assessments when necessary to identify changes in resident status. (e) Any change in resident status requires immediate documentation and implementation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Registered Nurse (RN) or Resident Care Coordinator (RCC), screened a prospective resident prior to admission. Findings: RI#4 was admitted to the facility May 3, 2023, with a diagnosis of dementia. The "RN ADMISSION COMPREHENSIVE ASSESSMENT" was completed after RI#4 was admitted. On the afternoon of November 7, 2024, EI#4, the RN, said she had not completed a pre-admission screening of RI#4. She completed a comprehensive assessment after RI#4 was	A 604 A604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents 1) Facility will ensure Registered Nurse (RN) or Resident Care Coordinator (RCC) performs all screening for prospective residents prior to admission. 2) (11.12.24) Administrator and Resident Care Coordinator were in-serviced by Regional Manager to review ADPH regulations with regard to admission screening of prospective residents prior to admission.	

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A 604	Continued From page 21 admitted to the facility. On the afternoon of November 7, 2024, EI#3, the RCC, said she did not know who performed the pre-admission screening of RI#4. EI#3 added the RN does those screenings. On the afternoon of November 7, 2024, EI#1 was asked who performed the pre-admission screening of RI#4. EI#1 said she did. EI#1 was asked if she was an nurse and she said no. EI#1 said the RN was supposed to do the screening. When asked why the pre-admission screening was not done, EI#1 said RI#4's sponsor was in a rush. EI#1 acknowledged the deficient practice of not prescreening RI#4 before admission to the facility.	A 604	3) 11.12.24 Resident charts were reviewed to identify any other deficiencies related to pre-screening that were not cited during the survey. No other deficiencies were found. 4) Administrator and Resident Care Coordinator will ensure proper screening is performed by the RN or RCC for prospective residents prior to admission to remain in compliance this rule. Documentation of all in-services are filed in the in-service binder and kept in the Administrator's office. 5) The Regional Manager will conduct on- site visits quarterly for the next year to ensure compliance and effectiveness of the plan of correction. Any evidence of non-compliance or continued deficient practice will result in additional in-servicing of Administrator on policies and procedures, changes to the monitoring process or appropriatediscipline, up to and including discharge.	
A 606	420-5-20-.06 (3) (g) Care of Residents. (g) Services Beyond Capability of Specialty Care Assisted Living Facility. Whenever a resident requires hospitalization, medical, nursing, or other care beyond the capabilities of the specialty care assisted living facility, arrangements shall be made to discharge the resident to an appropriate setting, or to transfer the resident promptly to a hospital or other health care facility able to provide the appropriate level of care. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to make arrangements for discharge of a resident to an appropriate	A 606 A606	420-5-20-.06 (3) (g) Care of Residents 1) All staff will follow the CPMC Policy and Procedures related to admission, continued stay and discharge criteria to include residents requiring skilled care.	

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A 606	Continued From page 22 setting when the resident required a higher level of care than the SCALF could provide. Findings: RI#1 was admitted to the facility on February 23, 2023, with diagnoses to include Alzheimer's disease and dementia. RI#1's medical record revealed a wound, requiring daily dressing changes, developed in February of 2024. On the morning of November 7, 2024, EI#6, a care associate, reported RI#1 could not direct their own care. On the morning of November 7, 2024, a hospice nurse said RI#1 could not direct his/her care. On the morning of November 7, 2024, an observation was made of EI#2 changing the dressing for RI#1. At no time during the observation did RI#1 direct a step of the care. On the afternoon of November 7, 2024, EI#2 said RI#1 had dressing changes daily by either the hospice nurse or the facility nurse. EI#2 said a resident could receive skilled nursing for 90 before being issued a 30 day notice. EI#2 said RI#1 was unable to direct his/her care. EI#2 said skilled nursing should be performed by home health or hospice for residents in a specialty care assisted living facility. On the afternoon of November 7, 2024, EI#1 said a resident can receive skilled nursing for 90 days while at a specialty care assisted living facility after that, he/she should have been discharged. EI#1 said RI#1 was able to speak well enough to be understood when he/she was admitted but now cannot be understood. EI#1 said RI#1 was	A 606	2) (12.06.24) Administrator will train and in-service all staff regarding the ADPH Rules and Regulations and the CPMC Policy and Procedures regarding admission, continued stay and discharge criteria to include residents requiring skilled care. On (11-.08.24) RI#1 was issued a 30-day discharge notice. 3) Training and In-service with all staff will be completed by 12.06.24. Residents and charts were reviewed upon exit of surveyor to identify any other concerns not identified during the survey, and no other deficiencies were found. 4) Administrator will randomly review and assess 4 Residents assessments and care plans to identify potential needs beyond the facility license. Documentation of training and In-services will be kept in the Administrator's office. 5) CPMC Regional Manager will conduct on-site visits quarterly for the next year to ensure compliance and effectiveness of the plan of corrections. Any evidence of non-compliance or continued deficient practice will result in additional in-servicing of staff on policies and procedures, changes to the monitoring process or appropriate discipline, up to and including discharge. **NOTE: Hospice Nurse will be doing wound care 3x weekly until resident is discharged.**	

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A 606	Continued From page 23 unable to direct their care.	A 606		
A 611	420-5-20-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. The RN shall develop written plans of care for each resident prior to or at the time of admission. The plans of care shall be based on resident's assessments, diagnoses, and recommendations of the resident's physician. The plan of care shall be developed in cooperation with the resident, if appropriate, and the sponsor. The RN shall identify resident care problem areas and formulate written interventions to address those problems. The RN shall evaluate the implementation of the interventions and the resident's response to the interventions and modify the plan of care as necessary. 1. The plan shall at all times reflect the current condition of the resident. All entries on the plan of care shall be accurately dated. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following: 2. A listing of the resident's individual needs or problems that require intervention by the facility.	A 611		

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A 611	Continued From page 24 3. A listing of interventions provided by the facility to address the resident's identified needs or problems. 4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider. 5. Activities of Daily Living. Residents of a specialty care assisted living facility shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident. (i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested. (ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips. (iii) Hair. Residents' hair shall be kept clean, neat, and well groomed. (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.	A 611		

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A 611	Continued From page 25 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 updated to address a wound that required daily dressing changes. Also, the facility staff did not implement a care plan to assist and monitor a resident who subsequently eloped. Findings: RI#1 was admitted to the facility on February 23, 2023, with diagnoses to include Alzheimer's disease and dementia. RI#1's medical record revealed a wound requiring daily dressing changes developed in February of 2024. Review of the care plan found the wound was not addressed. RI#5 was admitted to the facility on August 29, 2019, with dementia and bipolar disorder. RI#5's care plan revealed for safety reasons staff were to assist and monitor RI#5 when going outside. An incident report revealed RI#5 eloped on May 16, 2022. On the afternoon of November 7, 2024, EI#2 acknowledged RI#1's care plan did not address the wound requiring daily dressing changes. On the afternoon of November 7, 2024, EI#1 was asked why RI#5 was not supervised while outside	A 611	420-5-20-.06 (4) (a) (b) Care of Residents 1) All staff will follow the CPMC Policy and Procedures related to admission, continued stay and discharge criteria to include residents requiring skilled care. All staff will follow care plans to prevent risk of resident elopement. 2) (12.06.24) Administrator will train and in-service all staff regarding the ADPH Rules and Regulations and the CPMC Policy and Procedures regarding admission, continued stay and discharge criteria to include residents requiring skilled care. On (11-.08.24) RI#1 was issued a 30-day discharge notice. On (12.06.24) Administrator will train and in-service all staff regarding properly following care plans to prevent risk of resident elopement. 3) Training and In-service with all staff will be completed by 12.06.24. Residents and charts were reviewed upon exit of surveyor to identify any other concerns not identified during the survey, and no other deficiencies were found.	

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(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 26 of the building. EI#1 said a staff member left to go and check on another resident. EI#1 acknowledged the care plan was not followed.	A 611	4) Administrator will randomly review and assess 4 Residents assessments and care plans monthly to identify potential needs beyond the facility license and to ensure care plans are being properly followed.	
A 621	420-5-20-.06 (9) (b) Care of Residents. (b) Retention. 1. A specialty care assisted living facility shall not allow any resident to return to the specialty care assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the specialty care assisted living facility is licensed to provide or the facility is capable of providing. 2. A specialty care assisted living facility shall not retain a resident that has a PSMS score greater than 23 or a score of five in feeding, dressing, grooming, bathing or a score of four or five in physical ambulation. 3. A specialty care assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility. 4. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in a specialty care assisted living facility. 5. A specialty care assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless: (i) The individual is capable of performing and does perform all tasks related to	A 621	Documentation of training and In-services will be kept in the Administrator's office. 5) CPMC Regional Manager will conduct on-site visits quarterly for the next year to ensure compliance and effectiveness of the plan of corrections. Any evidence of non-compliance or continued deficient practice will result in additional in-servicing of staff on policies and procedures, changes to the monitoring process or appropriate discipline, up to and including discharge.	

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A 621	Continued From page 27 his or her own care; OR (ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity but the individual has sufficient cognitive ability to direct his or her own care and the individual is able to direct facility staff and does direct facility staff to provide the physical assistance needed to complete such tasks, and the facility staff is capable of providing such assistance and does provide such assistance. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. 6. If a resident of a specialty care assisted living facility is diagnosed with a terminal illness and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90 days. If the facility is unable or becomes unable to meet the needs of a resident receiving hospice care, or if a resident receiving hospice care requires care beyond what the facility may lawfully provide pursuant to this section, then the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for specialty care assisted living facilities. The facility would in all cases remain responsible for ensuring the appropriate delivery of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident.	A 621		

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A 621	Continued From page 28 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility retained a resident who required skilled nursing care which had exceeded 90 days. Findings: RI#1 was admitted to the facility on February 23, 2023, with diagnoses to include Alzheimer's disease and dementia. RI#1's medical record revealed a wound requiring daily dressing changes developed in February of 2024. On the afternoon of November 7, 2024, EI#2 said RI#1 had dressing changes daily by either the hospice nurse of the facility nurse. EI#2 said a resident could receive skilled nursing for 90 before being issued a 30 day notice. EI#2 said RI#1 was unable to direct his/her care. EI#2 said skilled nursing should be performed by home health or hospice for residents in a specialty care assisted living facility. On the afternoon of November 7, 2024, EI#1 said a resident can receive skilled nursing for 90 days while at a specialty care assisted living facility after that, he/she should have been discharged. EI#1 acknowledged RI#1 could not direct the wound care. EI#1 admitted home health or hospice should be providing skilled nursing.	A 621 A521	420-5-20-.06 (9) (b) Care of Residents 1) The facility will identify and discharge Residents with care needs that exceed the capability of the facility's license. 2) An immediate plan of action was created for the care of RI#1 which included a discharge notice given on (11.08.24). 3) Completed upon survey exit a several day audit, observations, record review, and interviews conducted by the Administrator and Residence Nurse to identify any other concerns not identified during the survey. No other deficiencies were found 4) The Residence Nurse and the Administrator have reviewed the ADPH rules and regulations on proper care levels allowed within the SCALF. Documentation of this review will be maintained in the Administrator's office. 5) CPMC Regional Manager will conduct on-site visits quarterly for the next year to ensure compliance and effectiveness of the plan of corrections. Any evidence of non-compliance or continued deficient practice will result in additional in- servicing of staff on policies and procedures, changes to the monitoring process or appropriate discipline, up to and including discharge.	
A 703	420-5-20-.07 (3) Food Service.	A 703	**NOTE: Hospice Nurse will be doing wound care 3x weekly until resident is discharged.**	

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A 703	Continued From page 29 (3) Dietary Service. (a) Number of Meals. No fewer than three meals shall be provided each 24 hours. Food service shall be provided in a resident's room during temporary illness if necessary. The diet shall be well-balanced, palatable, properly prepared, and sufficient in quantity and quality to meet the nutritional needs of the residents in accordance with Dietary Reference Intakes of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The food must be adapted in type and preparation to the habits, preferences, and physical abilities of the residents. (b) Timing of Meals. A time schedule for serving meals to residents and personnel shall be established. Meals shall be served approximately five hours apart with no more than 14 hours between the evening meal and breakfast. The time schedule of meals shall be posted with the menu. The facility shall make evening snacks available after service of the evening meal. The facility shall provide fluids throughout the day and shall make between-meal nourishment (snacks) available. (c) Menu. The menu shall be planned and written at least 1 week in advance. The current week's menu shall be posted in the food service area and shall be kept on file for the following 2 weeks. For any resident with a physician's order for a therapeutic diet, the facility shall have a copy of the diet and the facility shall document the adjustment of its menu to accommodate the resident's needs. (d) Alternate food selections or	A 703		

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A 703	Continued From page 30 substitutes shall be made available to all residents. (e) A facility shall not obtain food from charitable organizations. A facility shall not avoid serving a meal by sending or transporting residents to missions, soup kitchens, or other charitable facilities for meals. (f) The amount of food on hand shall be sufficient to serve three meals per day to all residents for 3 days. Non-perishable food and potable water shall be maintained in the facility in sufficient quantity to serve three meals per day to all residents for 3 days. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a three day emergency supply of non-perishable food was on hand. Findings: On the morning of November 7, 2024, a copy of the disaster menu was compared to the available non-perishable food items. EI#7, the cook, agreed the 3-day required supply was not available. On the evening of November 7, 2024, EI#1 agreed with the surveyor's findings.	A 703	A703 420-05-20-.07 (3) Food Service 1) The facility will ensure a 3-day supply of emergency non-perishable food is always available. 2) In-service will be completed EI#7 and all kitchen staff by 12.06.24 to review ADPH Regulations and CPMC policy & procedures regarding emergency food supply requirements. Emergency food supply was replaced and a log is attached to the disaster menu to be kept on the containers with expiration dates.	
A 804	420-5-20-.08 (4) Physical Facilities. (4) Food Service Facilities.			

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A 804	Continued From page 31 (a) Floors. Floors in food service areas shall be of such construction as to be easily cleaned, sound, smooth, non-absorbent, without cracks or crevices, and shall be provided with approved and conveniently located facilities for the disposal of floor wash water. (b) Walls and Ceilings. Walls and ceilings of food service areas shall be of tight and substantial construction, and smoothly finished. The walls and ceilings shall be without horizontal ledges and shall be washable up to the highest level reached by splash and spray. Roofs and walls shall be maintained free of leaks. All openings to the exterior shall be provided with doors or windows, which prevent the entrance of rain or dust during inclement weather. (c) Screens or Outside Openings. Openings to the outside shall be effectively screened, or suitable provisions made equal to screening (such as fly fans). Screen doors shall be equipped with self-closing devices. (d) Lighting. The kitchen, dishwashing area, and the dining room shall have adequate light. (e) Ventilation. Vent/exhaust hoods, vented to the outdoors, shall be provided over cooking surfaces to aid in removing cooking odors. Group homes with residential stoves may use a residential hood sized for the stove. Commercial exhaust hoods shall be installed when commercial cooking equipment is used. Congregate facilities shall use a commercial exhaust hood system. (f) Employee Toilet Facilities. Toilet	A 703 (cont)	3) (11.22.24) Administrator reviewed the emergency supplies and no other deficiencies were found. 4) The lead cook will check the log monthly for expiration and replacement needs. beginning 12/01/24. Administrator will oversee the lead cook to ensure the plan of correction is followed. Documentation of the updated emergency food supply log with current expiration dates will be submitted monthly to the Administrator and kept in the Administrator's office with a copy attached to the emergency supply container. 5) The Regional Manger will conduct quarterly on-site visits to ensure compliance and effectiveness with the plan of correction. Any evidence on non-compliance or continued deficient practice will result in additional in-serviing of staff on policies and procedures, changes to the monitoring process, or appropriate discipline, up to and including possible discharge.	

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A 804	Continued From page 32	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 with a soap dispenser and disposable towels, and shall be well lighted and ventilated.

(g) Hand washing Facilities. Each Group and Congregate specialty care assisted living facility shall provide a hand washing lavatory in the kitchens which shall be equipped with a soap dispenser and a supply of soap, disposable towels, and hot and cold running water through a mixing valve or combination faucet. The use of a common towel and common bar soap is prohibited. Hands shall not be washed in sinks where food is prepared.

(h) Refrigeration Facilities. Adequate refrigeration facilities, automatic in operation for the storage of perishable foods, shall be provided Refrigeration shall be maintained at 41 degrees Fahrenheit or less. All refrigerators shall be provided with thermometers. All refrigerators shall be kept clean.

(i) Equipment and Utensil Construction. Equipment and utensils, except single service utensils, shall be so constructed as to be easily cleaned and shall be kept in good repair. No cadmium plated, lead, or readily corrodible utensils or equipment shall be used.

(j) Separation of Kitchen from Resident Rooms and Sleeping Quarters. Any room used for sleeping quarters shall be separated from the food service area by a solid wall with no direct openings. Sleeping accommodations shall not be

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A 804	Continued From page 33 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 Group specialty care assisted living facility, a residential use range is permitted. A Congregate specialty care assisted living facility shall have a heavy duty range suitable for institutional use with double oven, or equivalent. 2. Refrigerator. A Group specialty care assisted living facility may use a residential refrigerator. A Congregate specialty care assisted living facility shall have a heavy-duty refrigerator suitable for institutional use.	A 804		

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A 804	Continued From page 34 3. Fire extinguisher. Five-pound type BC for residential hoods and K type for commercial hoods. 4. Dishwashing. The dishwashing equipment for Group assisted living facilities shall be either residential type using cold water sanitizers or commercial type with a booster water heater. Dishwashing equipment for all Congregate assisted living facilities shall be commercial type using a booster water heater or an automatic dispensing sanitizing chemical system. 5. A three-compartment sink with a booster heater or chemical sanitizing system for the third compartment shall be provided in Congregate assisted living facilities. 6. Garbage cans with cover. (p) Food Storage. A well-ventilated, cool food storage room, pantry, or cabinets shall be provided. Adequate shelving, bins, suitable cans, and raised platforms shall be provided and kept clean. Perishable food shall be stored at least six inches above the floor. The storeroom shall be of such construction as to prevent the invasion of rodents and insects, the seepage of dust and water, leakage, or any other source of contamination. (q) Dining Room. 1. A resident dining room, or rooms, shall be provided which is large enough to seat not less than 100 percent of the bed capacity. (r) Water Heating Equipment.	A 804		

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A 804	Continued From page 35 Equipment for heating an ample supply of water, under pressure, for all washing purposes shall be provided. Hot water shall be piped to all hand-washing facilities, and to each compartment of all dishwashing and laundry sinks. Water heaters shall be of the automatic type. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure the ice machine was clean. Findings: On the morning of November 7, 2024, an observation was made of the ice machine. A black glossy looking substance was seen on the back of the inside the ice compartment. EI#7 said, "That looks like mold." On the evening of November 7, 2024, EI#1 agreed with the surveyor's findings.	A 804	A804 420-5-20-.08 (4) Physical Facilities 1) The facility will ensure that kitchen equipment is clean and properly maintained. 2) On 11.15.24 the ice machine was thoroughly disassembled and cleaned by the maintenance staff. A replacement part was ordered and installed to replace a soiled tube. In-Service and training will be provided by 12.06.24 to all kitchen, Maintenance and cleaning staff by Administrator with a focus given to proper processes for cleaning the kitchen equipment. Additionally EI#7 will be In-service and trained about the proper process for reporting any physical plant findings that must be repaired or replaced. 3) On 11.22.24 a kitchen inspection was conducted by the Administrator to assess other potential concerns and no other concerns were identified.	
A1001	420-5-20-.10 (1) Sanitation and Housekeeping. (1) Sanitation. (a) Water Supply. 1. If at all possible, all water shall be obtained from a public water supply. If it is impossible to connect to a public water system, the private water supply shall meet the approval of the local County Health Department.			

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A1001	Continued From page 36 2. Water under pressure of not less than 15 pounds per square inch shall be piped within the building to all sinks, toilets, lavatories, tubs, showers, and other fixtures requiring water. Tubs, showers, sinks, lavatories, and other fixtures used by residents shall have hot water supplied. Hot water accessible to residents shall in no case exceed 110 degrees Fahrenheit. (b) Disposal of Liquid and Human Wastes. 1. There shall be installed within the building a properly designed waste disposal system, connecting to all fixtures to which water under pressure is piped. 2. All liquid and human waste, including floor wash water and liquid waste from refrigerators, shall be disposed through trapped drains into a public sewer in localities where such system is available. 3. In localities where a public sanitary sewer is not available, liquid and human waste shall be disposed through trapped drains into a sewage disposal system approved by the local County Health Department. The sewage disposal system shall be of a size and capacity based on the number of residents and personnel housed and employed in the institution. Where the sewage disposal system is installed at an existing facility prior to granting of a license, it shall be inspected and approved by the local County Health Department. (c) Premises. The premises shall be kept neat and clean. The property shall be free	A1001	4) Ice machine will be wiped down, cleaned and rinsed monthly beginning 12.01.24. Maintenance will disassemble and thoroughly clean all parts annually. Documentation of cleaning will be kept in the Maintenance binder located in the Administrators office. 5) The Regional Manger will conduct quarterly on-site visits to ensure compliance and effectiveness with the plan of correction. Any evidence on non-compliance or continued deficient practice will result in additional in-servicing of staff on policies and procedures, changes to the monitoring process, or appropriate discipline, up to and including possible discharge.	

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A1001	Continued From page 37 of rubbish, weeds, ponded water, or other conditions, which may create a health, safety, or sanitation hazard. (d) Control of Insects, Rodents, and other Pests. Each facility shall be kept free of ants, flies, roaches, rodents, and other pests. Proper and lawful methods for their eradication or control shall be used. Droppings shall be evidence of infestation by pests. (e) Toilet Room Cleanliness. Floors, walls, ceilings, and fixtures of all toilet rooms shall be kept clean and free of objectionable odors. These rooms shall be kept free of an accumulation of rubbish, cleaning supplies, toiletry articles. The use of a common towel and common bar soap is prohibited. (f) Garbage Disposal. 1. Garbage must be kept in water-tight suitable containers with tight-fitting covers. Garbage containers must be emptied at frequent intervals and shall be thoroughly cleaned and aired before using again. 2. Garbage and waste shall be disposed of in accordance with local and state regulations. (g) Control of Odors. The facility shall be free of objectionable odors. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure garbage containers were emptied at frequent intervals to prevent bags of refuse	A1001		

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A1001	Continued From page 38 from being piled up high enough to prevent the trash cans from closing. Findings: On the morning of November 6, 2024, an observation was made of the facility grounds with EI#1. Four trash cans were observed partially opened with bagged trash piled up preventing the lids from closing. On the afternoon of November 6, 2024, EI#1 said she guessed they would have to make changes in trash pick up or get a trash bin. On the morning of November 7, 2024, an observation was made of the four trash cans still partially opened with bagged trash piled up preventing the lids from closing. The over-filled trash cans had been moved to the front of the building near the fence. On the evening of November 7, 2024, EI#1 agreed with the surveyor's findings.	A1001	420-5-20-.10 (1) Sanitation and Housekeeping 1) The facility will ensure garbage containers are emptied at frequent intervals to prevent build up and allow lids to close properly. 2) Upon survey exit, Administrator conducted an assessment of the garbage containers 3) Upon survey exit (11.07.24) Administrator assessed garbage containers and found the facility to require an additional receptacle to allow for the amount of weekly accumulation of trash to be properly contained. 4) Facility received an additional trash receptacle on 11.12.24 to accommodate the identified needs. An in-service was completed will all staff (11.22.24) to include proper placement of trash with emphasis on the lids properly closing to meet ADPH regulations. Documentation of in-service will be kept in the in-service binder located in the Administrator's office. 5) The Regional Manger will conduct quarterly on- site visits to ensure compliance and effectiveness with the plan of correction. Any evidence on non-compliance or continued deficient practice will result in additional in-servicing of staff on policies and procedures, changes to the monitoring process, or appropriate discipline, up to and including possible discharge.	
A1101	420-5-20-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All specialty care assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P0702	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1101	Continued From page 39	A1101		

at varying times and days and quarterly on each shift. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years.

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

(d) Roller latches are prohibited on doors separating corridors from adjacent spaces.

(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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1101	Continued From page 40 1. Fire Alarm System. Where fire alarm systems are required, a corridor smoke detection system shall be installed on each floor, including areas open to the exit access corridor, to comply with NFPA 72, connected to the facility's fire alarm system. In lieu of corridor smoke detection, smoke detectors connected to the building fire alarm system may be installed in each resident's room, open areas, and at smoke doors (except that corridor smoke detection shall not be deleted when its use is dictated by other requirements). 2. Fire alarm and sprinkler system outages of more than 4 hours require evacuation of the facility or the establishment of a continuous fire watch. The fire watch procedure must be coordinated with the Department and the local Fire Marshal. Outages and fire watch documentation shall be reported to the Department within 12 hours or no later than the next duty day, and shall be corrected expeditiously. 3. The fire alarm system and the sprinkler system shall be inspected by licensed, 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.	A1101		
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted every month as required. Findings:	A1001	420-5-20-.11 (1) Fire and Safety 1) The Facility will ensure fire drills are conducted monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1101	Continued From page 41 During record review conducted on November 7, 2024, the following was identified: The facility performed monthly fire drills on: January 31, 2024, 1st shift May 31, 2024, 2nd shift July 31, 2024, 1st shift Also, written effectiveness of the fire drill plan was not completed monthly. During an interview on November 7, 2024, EI#1 said things had slipped but it would be done going forward. THERESA HARRISON, REGISTERED NURSE	A1101	2) (11.12.24) Regional Manager counseled Administrator on importance of proper organization and immediate filing of all documentation, with a focus on monthly fire drill documentation. 3) (11.12.24) Administrator has assessed remaining fire drill documentation and no other deficiencies were found. 4) Administrator will ensure fire drills are conducted monthly to be compliant with ADPH regulation. The written effectiveness was found to be incomplete on several of the documents and will be corrected on each documentation of drills going forward, beginning 12.01.24. 5) The Regional Manger will conduct quarterly on- site visits to ensure compliance and effectiveness with the plan of correction. Any evidence on non-compliance or continued deficient practice will result in additional in-servicing of staff on policies and procedures, changes to the monitoring process, or appropriate discipline, up to and including possible discharge. **NOTE: Documentation of monitoring will be kept in the Administrator's office**	