ACCEPTED - 02/15/2022

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
	D0222	A. BUILDING: _____ B. WING _____	01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF FOLEY	615 E LAUREL AVENUE FOLEY, AL 36536

(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 January 13, 2022, an unannounced licensure survey was conducted for this 28 bed Assisted Living Facility with a census of 21. There were two complaints investigated during this survey. LC#20200708010 and LC#2022012047 were substantiated with deficiencies cited as a result of the complaint investigations. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities (ALF). The deficiencies cited resulted in harm for one resident, placed the remaining 20 residents at a significant risk of harm and requires a plan of correction.	A 000		
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		

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A 302	Continued From page 1 (i) Facility responsibility to protect all residents from abuse, neglect, and exploitation. (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,	A 302		

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A 302	Continued From page 2	A 302		

with the approval of the administrator, shall develop written policies and procedures for the guidance of all personnel handling food as 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.

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A 302	Continued From page 3 (IX) Storage of food. (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 observation, record review, and interview, the facility employees failed to follow the infection control policy and procedure for the use of face masks to prevent the spread of Covid-19. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. Findings: On January 04, 2022, at approximately 8:35 AM, the surveyor observed EI#2's surgical mask was worn with EI#2's nose exposed. EI#2 did not wear the surgical mask as required for proper protection and prevention for the spread of Covid-19. On January 04, 2022, at approximately 8:37 AM, the surveyor observed EI#6 walking about the facility without a face mask of any kind. After EI#6 saw that the surveyor was in the facility, EI#6 went to a table in the common living room, got a surgical face mask from the drawer and put it on. On January 04, 2022, at approximately 11:40 AM, the surveyor with EI#1, reviewed the Infection	A 302	**420-5-4-03 (1) (e) Administration** 1) The facility employees will follow the infection control policy and procedure for the use of face masks to prevent the spread of Covid-19. 2) On 1/24/22 EI #2, EI #6, EI#7 and EI #10 were In-Serviced by EI #1 on the use of face masks and procedures regarding active cases of Covid 19 in the building to prevent the spread of Covid-19. On 1/7/22 EI #1 In-Serviced all staff on the current CPSL Covid Policy and Procedures regarding the Infection Control Policy and Procedure designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Documentation of this training will be maintained in the Administrator's office. On 1/24/22 EI #1 In-Serviced all staff on proper use and disposal of PPE, how to properly don and doff required/ appropriate face masks, and proper donning and doffing of gloves to prevent transmission of disease and infection. Documentation of this training will be maintained in the Administrator's office.	

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A 302	Continued From page 4 Prevention and Control during the Covid Pandemic policy and Procedure effective November 2021. The policy documented that,"all staff will continue to use routine face masks." On January 04, 2022, at approximately 11:43 AM, the surveyor with EI#1, observed EI#2 sitting at the nurse's desk in the common living room area. RI#5 was observed sitting within four (4) feet of EI#2. EI#2 was talking on the phone and had put EI#2's surgical mask under EI#2's chin exposing EI#2's mouth and nose. EI#1 agreed that EI#2 should have had the surgical mask over EI#2's nose and mouth. On January 04, 2022 at approximately 11:43 AM, the surveyor with EI#1, observed EI#7 lean over RI#6 to adjust RI#6's oxygen tank. EI#7 was talking on the phone and had put EI#7's face mask under his/her chin, exposing EI#7's mouth and nose. EI#1 agreed that EI#7 should have had the surgical mask over EI#7's nose and mouth. On January 04, and 05, 2022, the surveyor observed throughout the survey that none of the facility residents wore a face mask when the residents were in the facility's common areas. On January 13, 2022, at approximately 8:55 AM, EI#10 told the surveyor that EI#10 had worked today and yesterday, but was unaware of any residents in the facility who had tested positive for Covid 19. On January 13, 2022, at approximately 8:56 AM, the surveyor with EI#2 observed that RI#3 tested positive for Covid 19, but there had not been any quarantine or caution sign placed on RI#3's apartment door. There was no personal	A 302	Continued from page 4 As of February 4, 2022 EI#2 has given notice of resignation of employment. Resignation has been accepted. EI#2's replacement will be trained by the administrator on Infection Control Policy and Procedures as part of his/her orientation. Documentation of his training will be maintained in the Administrator's office. 3) On 1/24/22 EI #1 In-Serviced all staff on Infection Control Policy and procedures, that would affect all residents, including but not limited to; proper use, proper placement, proper disposal, as well as proper donning and doffing of ALL personal protective equipment. Documentation of this training will be maintained in the Administrator's office. 4) All staff, upon new hire training, will be trained by the Administrator or Designee on the current Covid Policy and Procedure and the Infection Control Policy including but not limited to the safe donning and doffing of all PPE. All staff will be In-Serviced yearly on Infection Control Procedures with specific emphasis given to donning and doffing appropriate PPE. To continue and will be ongoing. Documentation of this training will be maintained in the Administrator's office. 5) Administrator or designee will randomly assess staff use of PPE daily x4 weeks, weekly x4 weeks, then monthly until all staff perform appropriately. 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 including possible discharge. Approval from the Corporate Director of Operations will be received before ceasing the monthly audits/ evaluations. This will begin starting 2/14/22.	

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A 302	Continued From page 5 protective equipment (PPE) placed outside RI#3's room for employee use. On January 13, 2022, at approximately 9:00 AM, the surveyor asked EI#2 when RI#3 tested positive for Covid 19. EI#2 told the surveyor she (EI#2) had it written down at EI#2's desk. EI#2 left the library and returned with RI#3's actual Covid 19 specimens attached to the Covid rapid test cards in EI#2's bare hands and placed RI#3's positive Covid specimens on the table in front of the surveyor. RI#3's specimens had not been placed in any type of bag to prevent contamination of any surface that it came into contact with. Then EI#2 tried to dispose of RI#3's Covid specimens by trying to put them in a sharps container in a cabinet in the medication room.	A 302		
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.	A 504		

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A 504	Continued From page 6 2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints. 3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy. 4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time. 5. Every resident shall have freedom to participate in and benefit from social, religious, and community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. 6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the 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.	A 504		

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

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A 504	Continued From page 8 governing authority, and to any other person without restraint, interference, coercion, discrimination, or reprisal. 13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file. 14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the facility, provided that: (i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care. (ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation; 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	A 504		

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A 504	Continued From page 9 available in the facility, and of related charges. 16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities. 17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll-free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll-free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area. 18. All state inspection reports and any resulting corrective action plan from the past 24 months shall be posted in a prominent location. If there has been no inspection in the past 24 months, then the results of the most recent inspection and any resulting corrective action plan shall be posted. 19. Every resident shall have the right to 30 days prior written notice to both resident and 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.	A 504		

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A 504	Continued From page 10 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 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, the facility failed to ensure all resident protected health information was kept confidential at all times. This deficient practice had the potential to affect all 21 residents living in the facility. Findings: On January 04, 2022, at approximately 11:43 AM, the surveyor and EI#1 observed EI#2 sitting at the nurse's desk in the common living room area talking on the phone. A resident was sitting in a chair at the end of the nurses desk. EI#1 and	A 504		
		A 504	**Deficiency Number: 420-5-4-05(3)(d) Records and Reports** 1) The facility will ensure all resident protected health information will be kept confidential at all times.	

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A 504	Continued From page 11 EI#2 both told the surveyor in separate interviews that they were concerned about confidentiality of resident's protected health information because of the location of the nurse's desk. EI#1 and EI#2 both told the surveyor that there were residents milling and sitting around the nurse's desk all day long while the nurse talked to medical providers about other residents' protected health information. EI#1 and EI#2 both told the surveyor in separate interviews that they had both talked with corporate representatives about moving the nurse's desk to a private room with a door and were told that was not acceptable.	A 504	Continued from page 11 2) 1/7/22 EI #1 In-Serviced EI #2 on HIPAA compliance to ensure Resident PHI is kept confidential at all times. Documentation of In-Service training is maintained in the Administrator's office. 3) 1/7/22 Facility rounds were conducted by the administrator to assess for other potential concerns. No other concerns were identified. 4) 2/10/22 EI #1 In-Serviced all staff on Resident Rights and HIPAA. In-service will be complete by all staff by 02/15/22 and will be provided on an ongoing basis as needed as determined by the Administrator, Designee, or Governing Authority. Documentation of this training will be maintained in the Administrator's office. 2/10/22 EI #1 In-Serviced all staff regarding Resident Rights with specific attention and discussion regarding Resident Right #13: "Every resident shall have the right to confidential treatment of personal and medical information". No health information shall be discussed in common areas. All conversations involving resident PHI will take place in a private location behind closed doors, or within the private suite of the resident. 02/04/22 EI#2 has given notice of resignation of employment. Resignation has been accepted. EI#2's replacement will be trained by the administrator on Resident Rights and HIPAA compliance as part of his/her orientation. Documentation of his training will be maintained in the Administrator's office. 5) The Administrator shall conduct rounds to ensure compliance is maintained with confidential information daily x4 weeks and monthly x4 months. Any evidence of non-compliance or continued deficient practice will result in additional in-servicing of staff on policies, possible change in monitoring process, or appropriate discipline including possible discharge. This began on 2/9/22.	
A 508	420.5.4-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in an assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review. 1. Incidents which require investigation are: (i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as 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.	A 508		

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A 508	Continued From page 12 (ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid, including but not limited to: a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office. (iii) The onset of wandering behavior by any resident who is not fully cognitively intact. (iv) Elopement by a resident. (v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. (vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules. (vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules. (viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I of 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	A 508		

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	D0222	A. BUILDING: _____ B. WING _____	01/13/2022

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A 508	Continued From page 13 God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (xi) An unplanned occurrence that results in media attention. (xii) A medication error, overdose, or over sedation. (xiii) Ingestion by a resident of a toxic substance that requires medical attention. (xiv) Any indication of malfunction of the sprinkler system, or fire alarm system. 2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following: (i) Names of all residents involved. (ii) Names of all staff involved including person in charge at the time of the incident. (iii) When the administrator was notified (date and time). (iv) Circumstances under which the incident occurred. (v) When the incident occurred (date and time).	A 508		

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A 508	Continued From page 14 (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken. (viii) The extent and description of injury, if any, to the affected resident or residents. (ix) Immediate treatment rendered. (x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified. (xi) Names, telephone numbers, and addresses of witnesses. (xii) Date and time relatives or sponsor were notified. (xiii) Out-of-facility treatment. (xiv) Follow-up care. (xv) Outcome resolution. (xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future. (xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation. (xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request.	A 508		

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A 508	Continued From page 15 (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 as defined in these rules. (ii) Elopement by a resident. (iii) Suspected, alleged, confessed, or witnessed abuse, neglect, or exploitation 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. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file. (iv) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical	A 508		

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A 508	Continued From page 16 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 of the Alabama Administrative Code Sec. 420-4-1-.04. shall be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1-.04. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than 3 years. (x) Any indication of malfunction of the sprinkler system, or fire alarm system. 4. The report to the Department's Online Incident Reporting System shall include the following: (i) Facility name and direct phone number.	A 508		

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A 508	Continued From page 17 (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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to complete an incident report for a resident fall and also failed to complete a thorough investigation for a fall with injuries that required medical treatment. This deficient practice affected at least one resident and had the potential to affect the remaining 20 residents living in the facility. Findings: On January 05, 2022, at approximately 11:00 AM, RI#3's record was reviewed with EI#1 and EI#2. RI#3 was admitted to the facility on September	A 508		
		A 508	**Deficiency Number: 420.5.4-.05 (3) (h) Records and Reports** 1) The facility will complete an incident report for a resident fall and also complete a thorough investigation for a fall with injuries that require medical treatment. 2) 1/6/22 An incident report and thorough investigation was completed and submitted by EI #1 to ADPH for RI#3 fall with injuries that required medical treatment.	

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A 508	Continued From page 18 14, 2014, with diagnoses which included dementia, anxiety, and bipolar disorder. On May 10, 2021, at 6:40 AM, RI#3's record documented that RI#3 slid from bed trying to go to the bathroom and no injuries were noted. RI#3's incident report documented that RI#3 had slippers with slippery soles and that staff should ensure RI#3's walker was in reach. RI#3's incident report did not indicate if the resident's call light was utilized or working at the time of the fall. On July 07, 2021, at 2:30 AM, RI#3's record documented RI#3 was found on the floor with no apparent injuries and RI#3 was trying to get into RI#3's chair/recliner to watch television. RI#3's incident report did not document if the resident's call light was utilized or functioning. RI#3's incident report documented the resident called staff on the phone to get help. RI#3's incident report and care plan documented RI#3 was shown how to properly use RI#3's walker and staff were to ensure RI#3's walker was in reach. On September 26, 2021, at 2:10 AM, RI#3's record documented RI#3 was found on the floor with no apparent injuries and that RI#3 slid off of the bed trying to go to the bathroom. RI#3's incident report did not document if RI#3's call light was functioning or utilized. RI#3's incident report documented the "resident called and co-worker answered." RI#3's incident report also documented the "resident's (should) call for assistance to the bathroom in the night and staff to offer assistance to the bathroom on routine rounds." On October 24, 2021, RI#3's record documented RI#3's physician was notified that RI#3 was found on the floor in front of RI#3's chair/recliner at	A 508	Continued from page 18 3) 1/6/22 Director of Operations has reviewed 420-5-4-05(3)(h) Records and Reports and In-Serviced this regulation with EI #1 and EI #2. Documentation of In-Service training has been signed as acknowledgment and is maintained in the Administrator's office. After review by the administrator on 1/6/22, no other incidents have occurred that were not reported and investigated. 4) 2/10/22 EI #1 In-Serviced all staff regarding Resident Falls, Incident Reporting, and Investigations. Staff will report ALL falls, with or without suspected injury, to the Residence nurse and/or Administrator immediately. An incident report will be completed immediately following knowledge of a resident fall or injury and submitted to the Administrator or Designee for appropriate investigation. All falls require an incident report with an investigation. An investigation report will be submitted to ADPH within the 24-hour reporting guidelines when the criterion of the incident meets the reporting requirements as outlined in the regulations. Refresher training will be provided as needed or deemed necessary by the Residence Nurse, Administrator, or Director of Operations. Documentation of this training will be maintained in the Administrator's office. 5) 2/10/22 EI #1 implemented and In-Serviced all staff on shift reporting to the Residence Nurse. Shift Reports will be complete and documented every shift and submitted to the Residence Nurse. Shift reports will include, but not limited to, any incidents or falls. Nurse will review shift reports daily x4 weeks, then weekly x4 months. Residence nurse will initial and submit reports to the Administrator daily. Administrator will forward shift reports, incident reports with investigations, & ADPH reports to the Director of Operations for review daily x4 weeks, weekly x4 weeks, and monthly x4 months to ensure compliance. Documentation of all reports are maintained in the Administrator's office. This monitoring process shall begin on 2/14/22. Refresher training will be provided as necessary to all staff when deemed necessary by the Residence Nurse, Administrator, or Director of Operations. Any evidence of non-compliance or continued deficient practice will result in additional in-servicing of staff on policies, possible change in monitoring process, or appropriate discipline including possible discharge.	

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A 508	Continued From page 19 12:36 AM. RI#3 had no apparent injuries. There was no incident report or investigation for this fall. On January 03, 2022, at 11:17 PM, an incident report documented that RI#3 found face down on the floor in front of RI#3's recliner. The incident report completed by EI#8 documented " (RI#3) refused assistance from the R.A.'s (resident assistants), called 911 (emergency services) sent (RI#3) to SBRMC (South Baldwin Regional Medical Center) - pain in (right) hip". There were no other injuries for RI#3 documented on the incident report. On January 05, 2022, at approximately 10:30 AM, the surveyor and EI#1 observed RI#3 had severe pitting edema (swelling) of both lower legs and feet. RI#3 was also unsteady when transferring from the recliner to a wheelchair and to the chair scales. RI#3 had dark purple bruising observed on RI#3's right upper forehead, light purple bruising around both eyes, on RI#3's nose, and under both eyes. RI#3 had dark purple bruising on RI#3's left shoulder and right thumb area. RI#3 also had abrasions of various shapes and sizes located on the bridge of RI#3's nose, right cheek, and left forehead. RI#3 had a skin tear on RI#3's right thumb. RI#3 told the surveyor and EI#1 that the night shift staff "dragged me across the rug, even though I told them not too." RI#3 made sure that the surveyor and EI#1 understood that the wounds on RI#3's face were "not caused by the EMT's, it was from the people who work here." On January 05, 2022, at approximately 11:00 AM, EI#1 told the surveyor there was no incident report or investigation available for review for RI#3's fall on October 24, 2021. EI#1 also told the surveyor she (EI#1) had not completed an	A 508		

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A 508	Continued From page 20 investigation for RI#3's fall on January 03, 2022, at 11:17 PM.	A 508		
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. 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	A 604		

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A 604	Continued From page 21 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 record review and interview, the facility failed to complete appropriate monthly assessments, and perform adequate health supervision for all residents. This deficient practice resulted in actual harm for one resident (RI#3) and potentially affected 17 of 21 residents who had been admitted to the facility prior to December 2021. Findings: On January 05, 2022, at approximately 11:00 AM, the records for RI#1, RI#2, and RI#3 were reviewed with EI#1 and EI#2. RI#1 was admitted to the facility on April 30, 2021, with diagnoses which included chronic obstructive pulmonary disease, chronic respiratory failure, and vascular dementia. RI#1's last documented monthly assessment was dated October 01, 2021. RI#2 was admitted to the facility on August 09, 2021, with diagnoses which included atrial fibrillation, diabetes, anxiety, and hypertension.	A 604	**A 604** **Deficiency Number: 420-5-4-06(3)(a)(b) Care of Residents** 1) The facility will complete appropriate monthly assessments, and perform adequate health supervision for all residents. 2) 1/14/22 In-Service and training was provided to EI#2 by a tenured CPSL Nurse/Administrator from a sister community with a focus given to the requirement of timely monthly assessments. This In-Service and training also provided for appropriate care plans, care plan interventions, and adequate health supervision for all residents. Documentation of this training will be maintained in the Administrator's office. 1/24/22 January monthly assessments were completed for RI#1, RI#2, and RI#3 to address recent falls, incidents, and changes in condition by a RN 3rd party consultant. 2/4/22 EI#2 has given notice of resignation of employment. Resignation has been accepted. The replacement will be trained on how to complete appropriate monthly assessments, and perform adequate health supervision for all residents upon new hire orientation by the administrator.	

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A 604	Continued From page 22 RI#2's last documented monthly assessment was dated October 01, 2021. RI#3 was admitted to the facility on September 14, 2014, with diagnoses which included dementia, anxiety, and bipolar disorder. On October 24, 2021, RI#3's record documented RI#3's physician was notified that RI#3 was found on the floor in front of RI#3's chair/recliner at 12:36 AM. RI#3 had no apparent injuries. There was no investigation or incident report completed for this fall. On January 03, 2022, at 11:17 PM, an incident report documented that RI#3 was found face down on the floor in front of RI#3's recliners. The incident report completed by EI#8 documented that RI#3 "refused assistance from the R.A.'s (resident assistants), called 911 (emergency services) sent (RI#3) to SBRMC (South Baldwin Regional Medical Center) - pain in (right) hip". There were no other injuries for RI#3 documented on the incident report. On January 05, 2022, at approximately 10:30 AM, the surveyor and EI#1 observed RI#3 had severe pitting edema (swelling) of both lower legs and feet. RI#3 was also unsteady when transferring from the recliner to a wheelchair and to the chair scales. RI#3 had dark purple bruising observed on RI#3's right upper forehead; light purple bruising around both eyes, and on RI#3's nose and cheeks (under the eyes), dark purple bruising on RI#3's left shoulder and right thumb. RI#3 also had abrasions of various shapes and sizes located on the bridge of RI#3's nose, right cheek, and left forehead. RI#3 also had a skin tear with bruising on RI#3's right thumb. RI#3 told the	A 604	Continued from page 22 3) On 1/26/22 A several day in depth audit was completed by a 3rd party RN Consultant to identify all deficiencies related to monthly assessments. All resident charts were updated with a January assessment. 4) Between 1/24/22 - 1/26/22 Additional support, In-Service, and training was provided by a 3rd party RN Consultant to EI #1 and EI#2 covering the assisted living rules and regulations, review of monthly assessment requirements, incident reporting, appropriate care plan interventions, proper medication administration documentation, and adequate health supervision for all residents. 5) A licensed nurse will complete the monthly assessments. Administrator will randomly audit 8 charts, care plans, and assessments per month x6 months beginning on 2/14/22. All audits will be forwarded to the Director of Operations to ensure compliance. Audits will be maintained in Administrator's office. In-services will be provided on an ongoing basis as needed and/or as determined by the Administrator, Designee, or Governing Authority. Documentation of in-service training is maintained in the Administrator's office. Any evidence of non-compliance or continued deficient practice will result in additional in-servicing of staff on policies, possible change in monitoring process, or appropriate discipline including possible discharge.	

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A 604	Continued From page 23 surveyor and EI#1 that the night shift staff had "dragged me across the rug, even though I told them not too." RI#3 made sure that the surveyor and EI#1 understood that the wounds on RI#3's face were "not caused by the EMT's, it was the people who work here." RI#3's last documented monthly assessment was dated October 01, 2021. On January 05, 2022, at approximately 11:00 AM, EI#2 told the surveyor and EI#1 she (EI#2) did not know there was more to the monthly assessment than the medication awareness forms. EI#2 had been employed by the facility for approximately two months. EI#2 verified the monthly assessments for November and December 2021, for RI#1, RI#2, or RI#3, did not address falls, incidents or changes in resident status.	A 604		
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 be based on the initial medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care	A 611		

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A 611	Continued From page 24 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 all needed assistance with activities of daily living to each resident.	A 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D0222	A. BUILDING: _____ B. WING _____	01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 611	Continued From page 25 (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 observation, record review and interview, the facility failed to ensure all resident care plans contained interventions which met the needs of the residents. This deficient practice resulted in harm for one resident's and placed the remaining 20 residents at risk for harm.	A 611		

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A 611	Continued From page 26 Findings: On January 05, 2022, at approximately 11:00 AM, the records for RI#1, RI#2, and RI#3 were reviewed with EI#1 and EI#2. RI#3 was admitted to the facility on September 14, 2014, with diagnoses which included dementia, anxiety, and bipolar disorder. On September 26, 2021, at 2:10 AM, RI#3's record documented RI#3 was found on the floor with no apparent injuries and that RI#3 slid off of the bed trying to go to the bathroom. RI#3's incident report did not document if RI#3's call light was functioning or utilized. RI#3's incident report documented the "resident called and co-worker answered." RI#3's incident report also documented that the "resident's (should) call for assistance to the bathroom in the night and staff to offer assistance to the bathroom on routine rounds." On October 24, 2021, RI#3's record documented RI#3's physician was notified RI#3 was found on the floor in front of RI#3's chair/recliner at 12:36 AM. RI#3 had no apparent injuries. There was no incident report or investigation for this fall. On January 03, 2022, at 11:17 PM, an incident report documented that RI#3 was found face down on the floor in front of RI#3's recliners. The incident report completed by EI#8 documented that RI#3 "refused assistance from the R.A.'s (resident assistants), called 911 (emergency services) sent (RI#3) to SBRMC (South Baldwin Regional Medical Center) - pain in (right) hip". There were no other injuries for RI#3 documented on the incident report.	A 611	**Deficiency Number: 420.5.4-.06 (4) (a) (b) Care of Residents** 1) The facility will ensure all resident care plans contain interventions which meet the needs of the residents. 2) 1/14/22 In-Service and training was provided to EI#2 by a tenured CPSL Nurse/Administrator from a sister community with a focus given to the requirement of appropriate care plans and care plan interventions. This In-Service and training also provided for timely monthly assessments and adequate health supervision for all residents. Documentation of this training will be maintained in the Administrator's office. 1/26/22 Care plans were completed by a licensed nurse and brought current for RI#1, RI#2, and RI#3 to address recent falls, incidents, and changes in condition. 2/4/22 EI#2 has given notice of resignation of employment. Resignation has been accepted. The replacement will be trained, upon new hire orientation, by the administrator on how to ensure all resident care plans contain interventions which meet the needs of the residents. 3) 1/26/22 A thorough audit was completed by a 3rd party RN Consultant to identify all deficiencies related to care plans and care plan interventions. All resident charts were updated with a current plan of care containing the appropriate interventions which meet the needs of all residents. 4) Between 1/17/22 - 1/18/22 and 1/24/22 - 1/26/22 Additional support, In-Service, and training was provided by a 3rd party RN Consultant to EI #1 and EI#2 covering the assisted living rules and regulations, review of monthly assessment requirements, incident reporting, appropriate care plan interventions, proper medication administration documentation, and adequate health supervision for all residents. These training records are maintained in the Administrator's office. 5) A licensed nurse will complete the care plans promptly with appropriate interventions any time there is a change in the status of the Resident. Administrator will randomly audit 8 charts, care plans, and assessments per month x6 months beginning on 2/14/22. All audits will be forwarded to the Director of Operations to ensure compliance. Audits will be maintained in Administrator's office. In-services will be provided on an ongoing basis as needed and/or as	

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A 611	Continued From page 27 On January 05, 2022, at approximately 10:30 AM, the surveyor and EI#1 observed RI#3 had severe pitting edema (swelling) of both lower legs and feet. RI#3 was also unsteady when transferring from the recliner to a wheelchair and to the chair scales. RI#3 had dark purple bruising observed on RI#3's right upper forehead; light purple bruising around both eyes and on RI#3's nose and cheeks (under the eyes), dark purple bruising on RI#3's left shoulder and right thumb. RI#3 also had abrasions of various shapes and sizes located on the bridge of RI#3's nose, right cheek, and left forehead. RI#3 had a skin tear with bruising on RI#3's right thumb. RI#3 told the surveyor and EI#1 that the night shift staff had "dragged me across the rug, even though I told them not too." RI#3 made sure the surveyor and EI#1 understood that the wounds on RI#3's face were "not caused by the EMT's, it was the people who work here." On January 05, 2022, at approximately 11:00 AM, EI#2 told the surveyor RI#3 had been to the local emergency room on January 04, 2022, and EI#2 "knew nothing was broken", however, EI#2 was not aware that RI#3 had wounds on RI#3's face. On January 05, 2022, at approximately 11:00 AM, EI#1 and EI#2 verified RI#3's care plan did not address RI#3's fall on October 26, 2021, the fall on January 03, 2022, or the facial wounds which were observed by the surveyor and EI#1 on January 05, 2022, at approximately 10:30 AM.	A 611	Continued from page 27 determined by the Administrator, Designee, or Governing Authority. Documentation of in-service training is maintained in the Administrator's office. Any evidence of non-compliance or continued deficient practice will result in additional in-servicing of staff on policies, possible change in monitoring process, or appropriate discipline including possible discharge.	
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	A 615		

Jennifer Williams 2-11-22