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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDTON AT ATHENS, THE	22171 TRADITIONS WAY ATHENS, AL 35613

(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, 2023, an unannounced complaint investigation was conducted for this 80 bed Assisted Living Facility (ALF) with a census of 59. There were two complaints investigated during this survey. LC#20230720013 and LC#20230919008 were investigated and 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. The deficiencies cited placed all 59 residents of the facility at risk of harm.	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, with the approval of the administrator, shall	A 302		

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A 302	Continued From page 2 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.	A 302		

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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 observations, interviews and record reviews, the facility failed to follow its own policies. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received complaints which alleged medications were not administered to residents as ordered and residents were verbally and physically abused at the facility. Multiple deficiencies were cited during the investigation of these complaints which resulted from failure of the facility to follow its own policies. According to the facility's Abuse, Neglect & Exploitation policy, "... Policy Overview Our Company is committed to maintaining a safe environment for each resident, ... Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow-up. ... 5. Investigation: ... d. Investigation Record. The Executive Director or designee should maintain a written record of the investigation. ...". The facility	A 302		

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A 302	Continued From page 4	A 302		

failed to complete the required documentation of an allegation of verbal abuse. Refer to deficiency 501 for additional information.

According to the facility's Assistance with Medications and Treatments policy, "...Medication assistance and treatment...shall be provided safely and promptly and as prescribed by the resident's health care provider...". The facility failed to ensure medication assistance was provided safely and as prescribed by the resident's physician as well as according to community standards of care. Refer to deficiencies 504, 601 and 614 for additional information.

According to the facility's Abuse, Neglect & Exploitation policy, "... Policy Overview Our Company is committed to maintaining a safe environment for each resident, ... Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow-up. ... 5. Investigation: a. Internal Investigation. Upon receipt of an allegation of abuse, neglect or exploitation, the Executive Director, or their designee, should conduct a confidential internal investigation of the incident. b. Manner of Conducting Investigation. The investigation should be conducted confidentially and in a manner that is least disruptive to the on-going delivery of services and daily routine of the community. (1) The investigation should include interviews with potential witnesses, which may include the alleged perpetrator, the alleged victim, associates, other residents, and visitors to the community. (2) Witnesses should be interviewed separately so that their statements are not influenced by others' recollections. The interviews

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A 302	Continued From page 5	A 302		

should occur in a private area. ... c. Timing of Investigation. The investigation should be initiated as soon as practicable upon becoming aware of an incident. ... 6. External Reporting/Notification ... a. Notifying Responsible Party. The Executive Director or supervisor on duty should notify the resident's legally responsible party, if there is an allegation of abuse, neglect or exploitation. ... b. Notifying Physician. The Executive Director or supervisor on duty should notify the resident's physician if there is an allegation of resident abuse, neglect or exploitation. ...". The facility failed to properly investigate abuse allegations. Refer to deficiencies 508 and 609 for additional information.

According to the facility's Incident Reporting policy, "...Incidents must be documented by the Wellness Director/designee and the Executive Director/designee...Investigation of incidents...should occur with...state specific regulations. After the investigation, interventions should be placed on the care plan...Timely reports to state agencies should occur as required by state regulations." The facility failed to report incidents timely to the ADPH Online Incident Reporting System and failed to update a resident's care plan following an alleged abuse incident. Refer to deficiencies 508 and 611 for additional information.

According to the facility's Assessment policy, "... (b) Monthly Assessments. The facility shall assess each resident monthly or more often when necessary to identify changes in the resident's status. ...". The facility failed to complete monthly assessments of residents as required. Refer to deficiency #604 for additional information.

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A 302	Continued From page 6 According to the facility's Admission, retention and Discharge Criteria policy, "...Individuals should not be retained who...have unmanageable behaviors or behaviors that may be dangerous to themselves or others. The facility retained a resident who did not meet the criteria for retention in an ALF. Refer to deficiency 621 for additional information. According to the facility's Video Surveillance policy, "... Rooms with camera surveillance shall have signs posted stating that monitoring is in progress. ...". On the morning of October 17, 2023, Employee Identifier (EI)#1 informed the surveyors that Resident Identifier (RI)#6 had video cameras installed in his/her room. There was no sign outside or on RI#6's door to alert visitors and staff that monitoring was in progress. EI#1 posted a sign on the door that same morning.	A 302		
A 303	420-5-4-.03 (2) (a) Administration. The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an administrator shall meet all applicable statutory requirements.	A 303		

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A 303	Continued From page 7 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. 5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age. 6. The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character. 7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week. 8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment and adequate care being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement. 9. The facility administrator is responsible for ensuring that required training is provided to all staff. 10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting.	A 303		

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A 303	Continued From page 8 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 interviews and record reviews, the former Executive Director (ED), EI#26, failed to perform her administrative duties to ensure the care and safety needs of all residents were met. This deficient practice resulted in potential harm for all 59 residents currently residing at the assisted living facility. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged management was not investigating allegations of abuse. The complaint was substantiated with two allegations of abuse that were not investigated. An allegation of abuse investigation was	A 303		

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A 303	Continued From page 9 incomplete and inaccurate. Also, an allegation of abuse that was reported to EI#26, former ED, was not investigated or reported to the Alabama Department of Public Health's Online Incident Reporting System. Refer to deficiency #508. The Abuse Policy was not implemented by EI#26 regarding allegations of abuse. Refer to deficiencies #302 and #609. EI#26 failed to document an allegation of abuse or her (EI#26) response to the allegation. Refer to deficiency #501. Residents did not have current care plans with appropriate individualized interventions that addressed their care and safety needs. Refer to deficiencies #508 and #611. The Executive Director job description did not document the need for the Administrator to have knowledge of the State Board of Health (SBOH) rules and regulations for an assisted living facility (ALF) and to ensure compliance with the rules.	A 303		
A 501	420-5-4-.05 (1) Records and Reports. (1) General. (a) Responsibility for Records. The administrator shall prepare and file all records, or shall oversee the preparation and filing of records. This duty shall be assigned to other employees in the administrator's absence. (b) All records and reports required by these rules shall be completed in a timely manner, and shall be maintained and filed in an orderly manner within the assisted living facility	A 501		

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A 501	Continued From page 10	A 501		

premises.

(c) Storage and Safety. Provision shall be made for the safe storage of records within the facility. Records shall be stored in a manner to reasonably protect them from water or fire damage. Records shall be safeguarded from unauthorized access.

(d) All facility records, including resident medical records, shall be made readily available for review and copying on demand by representatives of the State Board of Health upon request.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the former Executive Director, EI#26, failed to complete the required documentation for an allegation of verbal abuse she was admittedly aware of.

THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

Findings:

The Alabama Department of Public Health received a complaint which alleged management was not investigating allegations of abuse. The complaint was substantiated with two allegations of abuse not being investigated.

A review of the Abuse, Neglect & Exploitation policy with a revision dated of January 1, 2021 revealed, "...Policy Overview Our Company is committed to maintaining a safe environment for each resident,...Instances or allegations of abuse,

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A 501	Continued From page 11 neglect or exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow-up. ...5. Investigation:...d. Investigation Record. The Executive Director or designee should maintain a written record of the investigation. ..." RI#1 was admitted to the facility October 30, 2021 with diagnoses to include hypertensive heart disease and osteoarthritis. An interview was conducted in the morning of October 26, 2023, with EI#26. EI#26 was asked who reported verbal abuse by EI#29, former Medication Technician (Med Tech). EI#26 responded by naming RI#1. EI#26 stated she did not document the allegation of verbal abuse reported by RI#1, and there was no investigation documented. EI#26 agreed that she did not document RI#1's verbal abuse allegation and did not investigate it.	A 501		
A 504	420-5-4-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate. 1. No resident shall be deprived of any	A 504		

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civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility.

2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints.

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

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

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

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

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A 504	Continued From page 13 7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so. 8. Every resident shall have the right to a reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals. 9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident. 10. Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to receive or reject medical care, dental care, or other health care services except those required to control communicable diseases. 11. Every resident shall have the right to at least 30 days prior written notice of involuntary relocation or termination of residence from the facility unless the resident is a patient in a facility providing a higher level of care and no longer meets the eligibility and continued stay requirements in these rules, or for medical reasons the resident is considered by a physician to require an emergency relocation to a facility providing a more skilled level of care, or unless 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.	A 504		

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

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A 504	Continued From page 15 15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges. 16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities. 17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll-free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll-free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area. 18. All state inspection reports and any resulting corrective action plan from the past 24 months shall be posted in a prominent location. If there has been no inspection in the past 24 months, then the results of the most recent inspection and any resulting corrective action plan shall be posted. 19. Every resident shall have the right to 30 days prior written notice to both resident and 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	A 504		

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A 504	Continued From page 16 unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. 21. Every resident shall have the right to wear his or her own clothes, to keep and use his or her own personal possessions including toilet 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 observations and interviews, community standards of care were not followed for medication assistance when facility staff failed to observe that the resident actually took the medications. Findings: RI#5 was admitted to the facility on September 8,	A 504		

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A 504	Continued From page 17 2020, with diagnoses which included hyperlipidemia, depression, gastroesophageal reflux disorder, glaucoma, hypothyroidism, prediabetes, occipital neuralgia, and low back pain. On the morning of October 24, 2023, the surveyor entered RI#5's room. RI#5 was resting in bed. The surveyor observed a small plastic cup containing several pills sitting on the table beside RI#5's bed. When asked about the cup of pills, RI#5 stated staff brought the cup of pills in earlier and left them for RI#5 to take after getting out of bed. RI#5 stated this was the method normally used for RI#5's medication assistance and that the medications were usually left in his/her room to be taken by RI#5 at a later time without observation by facility staff. On the morning of October 24, 2023, EI#14, Medication Technician, was questioned about RI#5's medications. EI#14 admitted she (EI#14) had not observed RI#5 taking his/her medications that morning. EI#14 added that she (EI#14) would go to RI#5's room to make sure the medications had been taken by RI#5. EI#14 agreed this was not the correct method for providing medication assistance to residents and stated that residents should be observed swallowing medications with each dose.	A 504		
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	A 508		

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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.

(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.

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A 508	Continued From page 19 (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 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:	A 508		

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A 508	Continued From page 20 (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. (xiv) Follow-up care.	A 508		

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A 508	Continued From page 21 (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 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	A 508		

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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 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

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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.

(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.

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A 508	Continued From page 24 This Rule is not met as evidenced by: Based on interviews and record reviews, the former Executive Director, EI#26, failed to: investigate an allegation of abuse; report an allegation of abuse to the Alabama Department of Public Health's Online Incident Reporting System; submit incident reports to the Department's Online Incident Reporting System within 24 hours as required; thoroughly investigate an allegation of abuse given to EI#26 by corporate leaders, as evidence by the lack of documneted interviews with the alleged perpetrator and potential witnesses. There was also no documented investigation of an incident of alleged physical abuse between two residents (RI#8 and RI#9). THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: EI#26 received a complaint from RI#1 of verbal abuse on an unknown date that she did not investigate or document. EI#26 received a complaint on May 17, 2023, involving abuse of RI#3 and RI#7 which EI#26 documented inaccurately and failed to investigate. The Alabama Department of Public Health received a complaint which alleged that management was not investigating allegations of abuse. The complaint was substantiated with two allegations of abuse not being investigated. RI#1 was admitted to the facility on October 30, 2021, with diagnoses to include hypertensive heart disease and osteoarthritis.	A 508		

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In late August 2023, according to a witness (EI#22, Resident Care Associate), EI#29 yelled at and cursed at RI#1.

An interview was conducted in the morning of October 26, 2023, with EI#26. EI #26 said RI#1 had reported an allegation of verbal abuse by EI#29. EI#26 reported she (EI#26) did not document the allegation, therefore there was no documentation of an investigation. EI#26 said she (EI#26) did not report the allegation to the Alabama Department of Public Health Online Incident Reporting System and did not know why. EI#26 said she (EI#26) did not document RI#1's verbal abuse allegation and did not investigate it.

Please Note: The surveyor did not find an online report for the allegation of verbal abuse against RI#1 in the ADPH Online Incident Reporting System.

RI#3 was admitted to the facility on June 23, 2022 with diagnoses to include hypertension, atrial fibrillation, congestive heart failure, osteoarthritis, major depressive disorder, and anxiety.

EI#30 reported that EI#29 had pushed RI#3 down in the abuse allegation that EI#30 had sent to the Corporate Management on May 17, 2023. EI#30 did not indicate who witnessed this incident or when it occurred.

RI#7 was admitted to the facility on October 28, 2022 with diagnoses to include iron deficiency anemia, type 2 diabetes mellitus, major depressive disorder and adjustment disorders.

On three separate occasions including March 23, 2023, April 6, 2023, and an unknown date witnesses (EI#28, EI#30 and EI#36) observed

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EI#29 abused RI#7 physically and verbally. According to these witnesses, EI#29 cursed and punched RI#7.
On March 23, 2023 EI#30, former Dietary Manager witnessed EI#29 curse RI#7.
On April 6th, EI#28, former Medication Technician (Med Tech), witnessed EI#29 cursing and punching RI#7.
On an unknown date EI#36, former Maintenance Director, witnessed verbal abuse of RI#7 by EI#29.

An interview was conducted in the morning of October 25, 2023 with EI#6, Regional Director of Clinical Compliance. EI#6 stated EI#26 was responsible to investigate the abuse allegations from the incidents reported on May 17, 2023. EI#6 reported EI#29, former Medication Technician should have been interviewed by EI#26 during the abuse investigation. EI#6 told the surveyor that a statement of denial is not an interview.

An interview was conducted in the afternoon of October 25, 2023, with EI#35, Certified Registered Nurse Practitioner (CRNP), for RI#3 and RI#7. EI#35 said he (EI#35) was never notified of any allegation of abuse involving RI#3 and RI#7.

An interview was conducted in the morning of October 26, 2023, with EI#26. EI#26 said RI#1 had reported an allegation of verbal abuse by EI#29. EI#26 reported she (EI#26) had not documented the allegation of abuse, therefore, no investigation was documented. EI#26 said she (EI#26) did not report the allegation to the Alabama Department of Public Health Online Incident Reporting System and did not know why. EI#26 agreed that EI#26 did not document RI#1's

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A 508	Continued From page 27 abuse allegation and did not investigate it. EI#26 was interviewed regarding the allegations of abuse involving RI#3 and RI#7 that were reported to corporate. EI#26 did not interview EI#29, the alleged perpetrator, and potential witnesses EI#28, Med Tech and EI#33, Resident Care Assistant. EI#26 documented that EI#35 had been notified of the alleged abuse; when in fact, EI#35 told the surveyor in a previous interview that EI#35 had not been notified. EI#26 accepted a statement of denial from the alleged perpetrator and reviewed previous statements given by EI#28 and EI#33. EI#26 agreed that none of the three staff members (EI#28, EI#29, EI#33) were actually interviewed. EI#26 acknowledged that an interview was for gathering information by asking a variety of questions. When asked how EI#26 could ascertain what had occurred if EI#26 did not interview the persons involved in or accused of abuse; EI#26 said she could not. EI#26 said she (EI#26) had nothing to show that EI#29, the alleged perpetrator, had been investigated for the abuse incidents involving RI#3 and RI#7. Alleged Abuse Between Two Residents of the Facility RI#9 was admitted to the facility on February 21, 2023 and had diagnoses which included hypertension, depression, dementia, transient ischemic attacks, vitamin B12 deficiency and hyperlipidemia. Refer to deficiency 611 for additional information on RI#9. RI#9 had a documented history of disruptive behaviors, on March 6, 2023, which included inappropriate comments to visitors and staff, yelling at another resident, and taunting comments to visitors and other residents regarding their clothing.	A 508		

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A 508	Continued From page 28 On April 27, 2023, an incident was reported to EI#7 and EI#27 which involved RI#9 taunting RI#8, followed by RI#8 cursing and hitting RI#9. RI#8 was discharged from the facility that same day. When interviewed on the morning of October 24, 2023, EI#7 stated she (EI#7) was in the facility when the incident occurred between RI#8 and RI#9, but was not involved in the investigation. EI#7 further stated that EI#27 would likely have been the designated staff member to conduct the investigation of the incident. When interviewed on the afternoon of October 25, 2023, EI#27 stated she (EI#27) was aware of the incident between RI#8 and RI#9, and had reported the incident to EI#6, Regional Director of Clinical Compliance. When interviewed on October 31, 2023, EI#6 stated he (EI#6) did not remember the incident between RI#8 and RI#9, but is sure he (EI#6) would have directed staff to follow the usual procedure of investigating the incident. EI#26 was the Executive Director of the facility at the time the incident occurred between RI#8 and RI#9. When interviewed on the morning of October 26, 2023, EI#26 stated she (EI#26) was not working at the time the incident occurred and was on a leave of absence. EI#26 added that EI#27 would have been responsible for the incident investigation in EI#26's absence. On October 26, 2023, EI#1 was unable to locate the investigation documentation for the incident involving RI#8 and RI#9 on April 27, 2023.	A 508		

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A 508	Continued From page 29 Incidents Not Reported to the Department Timely On October 17, 2023, surveyors reviewed incidents, received by the Alabama Department of Public Health Online Incident Reporting System, since the last survey. The following three incidents had not been reported within 24 hours as required by the SBOH (State Board of Health) rules. A report of a resident fall which occurred on September 30, 2023, at 11:20 AM, was not received until October 1, 2023 at 11:58 AM. A report of a resident fall which occurred on September 15, 2023, at 3:35 PM, was not received until September 18, 2023, at 11:31 AM. A report of a resident fall which occurred on July 28, 2023, at 5:00 PM, was not received until July 31, 2023, at 11:55 AM. On October 26, 2023, EI#4 stated that EI#26 and EI#27 had been responsible for reporting these incidents within 24 hours as required. A review of the Abuse, Neglect & Exploitation policy with a revision date of January 01, 2021 documented, "...Policy Overview Our Company is committed to maintaining a safe environment for each resident, ...Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow-up. ...5. Investigation: a. Internal Investigation. Upon receipt of an allegation of abuse, neglect or exploitation, the Executive Director, or their designee, should conduct a confidential internal investigation of the incident. b. Manner of Conducting Investigation. The investigation should be conducted confidentially and in a manner that is least disruptive to the on-going delivery of services and daily routine of the community. (1) The	A 508		

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A 508	Continued From page 30 investigation should include interviews with potential witnesses, which may include the alleged perpetrator, the alleged victim, associates, other residents, and visitors to the community. (2) Witnesses should be interviewed separately so that their statements are not influenced by others' recollections. The interviews should occur in a private area. ...c. Timing of Investigation. The investigation should be initiated as soon as practicable upon becoming aware of an incident. ...6. External Reporting/Notification...a. Notifying Responsible Party. The Executive Director or supervisor on duty should notify the resident's legally responsible party, if there is an allegation of abuse, neglect or exploitation. ...b. Notifying Physician. The Executive Director or supervisor on duty should notify the resident's physician if there is an allegation of resident abuse, neglect or exploitation. ..." Review of an "INVESTIGATION REPORT" dated May 17, 2023, revealed EI#6, Regional Director of Clinical Compliance, had notified EI#26 and EI#27, former Wellness Director/Registered Nurse, of alleged abuse of two residents. The "INVESTIGATION REPORT" indicated the following: "Residents involved: (named RI#s 3 and 7)...Staff involved: Pending investigation questioning. ...Notify Physician: (named EI#35, the CRNP (Certified Registered Nurse Practitioner) for RI#3 and RI#7) Follow up actions taken by facility: ...Interview all employees to assess if they have ever witnessed a staff member abusing a resident and if they know how to report abuse. ...".	A 508		
A 601	420-5-4-.06 (1) Care of Residents.	A 601		

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A 601	Continued From page 31 (1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician. (a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her choice. If the resident is unable to designate an attending physician, or does not wish to designate an attending physician, the facility shall assist the resident in identifying an attending physician who will serve the resident. A resident shall be permitted to change the designation of his or her attending physician at any time. Whenever a resident requires medical attention, an attempt shall first be made to contact the resident's attending physician, except in medical emergencies requiring activation of the local EMS system (911 or another emergency call). (b) Back-up Physician Support. Each assisted living facility shall have an agreement with one or more duly licensed physicians to serve in those instances when a resident's own attending physician cannot be reached, and to provide temporary medical attention to any resident whose attending physician is temporarily not available. A nurse practitioner or physician's assistant shall not serve as the back-up physician in an assisted living facility. (c) All physician orders shall be written in accordance with community standards. If verbal orders are used, they are to be used infrequently. A physician verbal order shall only be accepted by an RN or LPN employed by the facility and authorized to do so by facility policy and procedures and state law. All verbal orders shall be reduced to writing on the physicians' order	A 601		

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A 601	Continued From page 32	A 601		

sheet by a licensed facility nurse and shall be dated and signed by the nurse receiving the order. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, or another practitioner who is responsible for the care of the resident and authorized to write orders by facility policy. All verbal orders must be authenticated within such time period as provided by facility policy, but in no case shall exceed 30 days following entry of the order.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to follow the physician's orders for assistance with a resident's medications.

THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

Findings:

The Alabama Department of Public Health received a complaint which alleged a resident did not receive eye medications as ordered by the resident's physician, causing complications of an eye condition. The surveyor was able to substantiate that the resident's eye drops had not been administered as ordered by the resident's physician while the resident was at the facility.

Review of facility records on October 17-19, 2023, revealed the following information.

RI#10 was admitted to the facility on August 5, 2022, and had diagnoses which included glaucoma, hypertension, low back pain, diabetes

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mellitus II, hypothyroidism and prior cerebrovascular accident. RI#10 was discharged from the facility on July 16, 2023. Refer to deficiencies #604, #611, and #621 for additional information about RI#10.

RI#10 had a physician's order for Latanoprost eye drops, one drop to be placed in each eye every night. According to information posted on National Institutes of Health website, Latanoprost is "...indicated for the reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension...If one dose is missed, treatment should continue with the next dose as normal...".

During an interview on the morning of October 19, 2023, RI#10's sponsor stated RI#10's optometrist was upset because the pressures were high in RI#10's eyes during an office visit around February 2023. The sponsor also stated RI#10's optometrist stated RI#10 had not been using the prescribed eye drops which was what caused the increased pressure in RI#10's eyes. RI#10's sponsor added that RI#10's Latanaprost drops had been located by a Medication Technician, in the drawer of the medication cart, when the sponsor questioned if RI#10 was receiving the drops during a visit to the facility one evening.

RI#10's Medication Assistance Records (MARs) were reviewed for the months of August 2022 through July 2023. Numerous doses of the Latanoprost were omitted as follows: August 2022 - two doses; September 2022 - nine doses; October 2022 - eleven doses; November 2022 - twenty-one doses; December 2022 - eighteen doses; January 2023 - three doses; February 2023 - two doses. The MARs contained codes to

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be used for documenting the reason why a dose was not given. These codes were to be documented with the staff members initials. On RI#10's MARs, the omitted doses were either left blank with no code number and no initials or documented as code "9" beside the initials of the staff member. Code "9" was used to document "Other/See Progress Notes". EI#3 explained a code 9 on the MAR indicated the dose of medication had not been given and added that an explanation for the omission of the dose should be documented in Progress Notes on the MAR.

On November 01, 2023, EI#3 provided RI#10's MAR Progress Notes to the surveyor. Review of the Progress Notes on November 2, 2023 revealed the following documented reasons for the omitted doses of Latanoprost for RI#10: "not available" - three doses; "waiting on pharmacy" - two doses; "meds not given" - one dose; "self med" - forty doses. The omitted dose on November 8, 2022, was documented as "meds not given". EI#3 verified that "self med" indicated the resident self-medicated that specific medication. There was no physician's order for RI#10 to self-administer medications, including Latanoprost. Former and current Medication Technicians (EI#14, EI#15, EI#29) as well as EI#27 (former Wellness Director) were interviewed regarding RI#10's eye drops but none were able to explain why the eye drops had not been administered as ordered.

On November 6, 2023, EI#3 stated she (EI#3) had reviewed RI#10's facility record and confirmed there was no physician's order for RI#10 to self-medicate. RI#10's Medical Examination Record, signed July 25, 2022, by RI#10's physician, read "...Does Resident require assistance by staff with administration of

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medications/treatments? Yes...". A Clinical Assessment form was documented for RI#10. The form contained no date but read "...pre admission...Medications-Requires staff assistance and supervision with storage and taking medications...". An Assisted Living Monthly Assessment form was documented for RI#10 on August 5, 2022, and read "...Medications...meds are kept on the med cart..." An Atlas Level of Care-V3 form was documented for RI#10 on May 3, 2023 and read "...Medications-Requires staff assistance and supervision with storage and taking medications...meds will be kept on med cart...".

RI#10's prescribed eye drops had not been administered as ordered by RI#10's physician which placed RI#10 at significant risk for complications from glaucoma. The improper administration of RI#10's eye drops could potentially have caused increased pressure in RI#10's eyes as described during RI#10's sponsor's interview and documented in the eye physician (optometrist) progress notes. A statement from RI#10's optometrist was received by the ADPH on November 13, 2023 which read "...My most recent exams on 12/9/22 and 7/3/23 showed some instability in the pressure readings which led to questioning of compliance (with prescription eye drops)...". According to the National Eye Institute, complications of glaucoma can include loss of side (peripheral) vision, blind spots and blindness... prescription eye drops are the most common treatment to prevent glaucoma from getting worse. The facility failed to follow physician's orders for RI#10's eye medications for the treatment of glaucoma.

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A 604	Continued From page 36	A 604		
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 resident status. 4. Assess the appropriateness of each	A 604		

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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 interviews and record reviews, monthly assessments of residents were not completed as required.

Findings:

According to the facility's Assessment policy, "... (b) Monthly Assessments. The facility shall assess each resident monthly or more often when necessary to identify changes in the resident's status. ...".

1. RI#2 had resided at the facility since December 30, 2017. RI#2 had diagnoses to include hypertensive heart disease, chronic obstructive pulmonary disease, type 2 diabetes mellitus, major depressive disorder, and Parkinson's disease.

A review of RI#2's medical record revealed no monthly assessment for the month of September 2023.

An interview was conducted with EI#3, Wellness Director Specialist/Licensed Practical Nurse on the evening of October 24, 2023. EI#3 stated she (EI#3) could not find a monthly assessment for RI#2 for the month of September 2023.

2. RI#10 had resided at the facility since August

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A 604	Continued From page 38 5, 2022. Refer to deficiencies #601, #611, and #621 for additional information regarding RI#10. Review of RI#10's medical record revealed no monthly assessment for the month of January 2023. On November 6, 2023, EI#3 stated she (EI#3) could not find a monthly assessment for RI#10 for the month of January 2023.	A 604		
A 609	420-5-4-.06 (3) (h) Care of Residents. (h) Resident Abuse, Neglect, and Exploitation. Each facility shall develop and implement a policy and procedure to protect each resident of the facility from abuse, neglect, and exploitation. The facility shall ensure that all staff can demonstrate an understanding of what constitutes abuse, neglect, and exploitation, and shall ensure that all staff understands his or her responsibility to immediately report suspected, alleged, confessed, witnessed, or actual incidents of abuse, neglect, or exploitation of a resident to the administrator. When abuse, neglect, or exploitation is suspected, alleged, confessed, witnessed, or actual the facility shall conduct and document a thorough investigation and take appropriate action to prevent further abuse. All allegations, suspicions, confessions, witnessed, or actual incidents shall be reported to the Assisted Living Unit of the Alabama Department of Public Health and to the victim's sponsor or responsible family member within 24 hours. Suspected, alleged, confessed, witnessed, or actual abuse, neglect, or exploitation of a resident shall be reported to the Department of Human Resources or law enforcement in accordance with Code of Ala. 1975, Section 38-9-8. At any	A 609		

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time that a resident has been the victim of sexual assault or sexual abuse perpetrated by a staff member or visitor, local law enforcement authorities shall be immediately notified.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure its' abuse policy was followed regarding: Five staff members who did not report allegations of abuse; EI#26, former Executive Director, did not conduct an investigation of an allegation of abuse made to her by RI#1; EI#26 did not report an allegation of abuse to the Assisted Living Unit of the Alabama Department of Public Health; and EI #26 did not accurately or thoroughly investigate an allegation of abuse made on May 17, 2023, of a previously witnessed abuse incident involving RI#7.

THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

Findings:

The Alabama Department of Public Health received a complaint which alleged facility management was not investigating allegations of resident abuse. The complaint was substantiated due to the following allegations of abuse were not investigated.

1. RI#7 was admitted to the facility on October 28, 2022, with diagnoses to include iron deficiency anemia, type 2 diabetes mellitus, major depressive disorder and adjustment disorders.

EI#29 was observed abusing RI#7 physically and/or verbally by three different employees

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during three different incidents. The witness interviews are as follows:

EI#28 was interviewed on the morning of October 18, 2023. EI#28, said on April 6th, 2023, EI#28 witnessed EI#29, former Med Tech cursing and punching RI#7. EI#28 stated she reported the abuse to the oncoming nurse, EI#12, Licensed Practical Nurse (LPN). EI#28 said she was afraid of being fired if she (EI#28) reported the abuse to management/EI#26. EI#28 was asked what was done to prevent EI#29 from abusing other residents. EI#28 answered nothing was done. EI#28 said what she (EI#28) witnessed was verbal and physical abuse. It was noted that EI#28's training transcript indicated she (EI#28) completed Abuse Training for Preventing, Recognizing, and Reporting Abuse on September 13, 2022, indicating she knew to report any potential abuse to the Executive Director or Supervisor.

During an interview in the afternoon of October 18, 2023, with EI#36, EI#36 stated he witnessed verbal abuse of RI#7 by EI#29. EI#36 said EI#29 told RI#7 to "let go of her damn arm", when (RI#7) grabbed EI#29's arm for balance during a transfer. EI#36 admitted that EI#29 cursing RI#7 was verbal abuse and EI#36 should have reported it. It was noted that EI#36 signed the Acknowledgement of Receipt for the Associate Handbook on April 25, 2022, that included page 53 about reporting abuse, indicating he knew to report any potential abuse to the Executive Director or Supervisor.

During an interview on the morning of October 19, 2023, with EI#12, Licensed Practical Nurse, EI#12 said if someone made her aware that they had witnessed abuse, she (EI#12) should notify

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the Director of Wellness (DOW) or Executive Director (ED). EI#12 recalled that EI#28 reported RI#7 being abused by EI#29. EI#12 said she (EI#12) thought one of the department heads was aware of the abuse and handling it. EI#12 did not report the abuse incident involving RI#7. EI#12 acknowledged she (EI#12) should have verified that EI#28's allegation of abuse had been reported to the DOW, ED, and the Ombudsman. It is noted that EI#12's training transcript indicated she completed Abuse Training for Preventing, Recognizing, and Reporting Abuse on June 27, 2023, indicating she knew to report any suspected or actual abuse to the Executive Director or Supervisor.

During an interview in the evening of October 24, 2023, with EI#30, former Dietary Manager, EI#30 said on March 23, 2023, she (EI#30) witnessed EI#29 tell RI#7 "don't touch me, don't grab my damn arm." EI#30 acknowledged she (EI#30) was supposed to file a report with the supervisor on duty but she did not speak to anyone about the abuse that day involving RI#7. EI#30 claimed she (EI#30) reported the abuse involving RI#7 during a department head meeting the next day. It is noted that EI#30 signed the Acknowledgement of Receipt for Associate Handbook on July 15, 2022 that included page 53 about reporting abuse, indicating she knew to report any potential abuse to the Executive Director or Supervisor.

An interview was conducted on the morning of October 25, 2023, with EI#6, Regional Director of Clinical Compliance. EI#6 was asked who was responsible for ensuring the allegation of abuse on May 17, 2023, involving RI#7 being cursed by EI#29 was investigated. EI#6 named EI#26. EI#6 said he (EI#6) gave EI#26 instructions to

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interview all staff. EI#6 acknowledged EI#29 should have been interviewed and that a statement of denial was not an interview. EI#6 said EI#26 was responsible for ensuring the abuse allegation investigations were completed.

2. RI#1 was admitted to the facility on October 30, 2021 with diagnoses to include hypertensive heart disease and osteoarthritis.

In late August 2023, according to a witness (EI#22, Resident Care Associate), EI#29 yelled and cursed at RI#1.

During an interview in the afternoon of October 18, 2023, with EI#22, Resident Care Associate (RCA), EI#22 said in late August she (EI#22) witnessed EI#29 yell at RI#1 to "shut (his/her) (EXPLETIVE beginning with an F) mouth." EI#22 said she notified EI#26 of the verbal abuse. EI#22 said EI#26 told her she (EI#26) was going to get in touch with EI#27, former Director of Wellness, and it would be taken care of. When EI#22 was asked what was done about the incident involving verbal abuse of RI#1. EI#22 answered nothing was done for at least another month when EI#29 was fired. EI#22 said the concern with a staff member abusing a resident and continuing to work with residents, was the risk of abuse happening again. It is noted that EI#22 signed the Acknowledgement of Receipt for Associate Handbook on June 17, 2022, that included page 53 about reporting abuse which EI#22 did.

3. RI#3 was admitted to the facility on June 23, 2022 with diagnoses to include hypertension, atrial fibrillation, congestive heart failure, major depressive disorder, and anxiety.

EI#30 reported that RI#29 had pushed RI#3 down

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in the allegation she sent to the Corporate Management on May 17, 2023. She did not indicate who witnessed this occurrence or when it occurred.

An interview was conducted on the morning of October 25, 2023, with EI#6, Regional Director of Clinical Compliance. EI#6 was asked who was responsible for ensuring the allegation of abuse on May 17, 2023, involving RI#3 being pushed down by EI#29 was investigated. EI#6 named EI#26.

During an interview on the morning of October 26, 2023, EI#26, said the purpose of an interview was to gather information by asking a variety of questions. Regarding EI#26's answers to the investigation of the allegations made on May 17, 2023, EI#26 admitted her response of NA (not applicable) to "staff involved" was not an accurate response. EI#29 had been named, so N/A was incorrect. EI#26 admitted she (EI#26) could not ascertain what occurred if she (EI#26) did not question the people involved in or accused of abuse. EI#26 accepted a signed statement of denial from EI#29, the alleged perpetrator. She did not think about doing an interview with EI#29 even though EI#29 had been accused of abuse. EI#26 said the abuse policy indicated for her to start an investigation with an interview of the alleged perpetrator, in this case, EI#29.

EI#26 added she (EI#26) should have started an investigation immediately, after she (EI#26) was made aware of an allegation of abuse by RI#1. EI#26 said the verbal outbursts by EI#29 that led to her termination, was the allegation by RI#1 and it was not documented. EI#26 also said she (EI#26) did not report it to the state and did not know why. When EI#26 was asked about her

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investigation of RI#1s' allegation, EI#26 stated she (EI#26) did not document or investigate them really to determine if verbal abuse had occurred.

Regarding EI#26 response to the May 17, 2023 allegations of abuse, EI#26 said she did not interview other potential witnesses of RI#7's alleged abuse, namely, EI#28 and EI#33. EI#26 said she (EI#26) did not know why she (EI#26) did not interview the only two witnesses to the incident. EI#26 added she (EI#26) did not even think about interviewing EI#28 and EI#33. EI#26 named EI#29, when asked who was accused of pushing RI#3 down. EI#26 said she (EI#26) had no documentation to show that EI#29 had been investigated. When asked about EI#29's statement she witnessed on May 17, 2023, EI#26 responded, she (EI#29) just gave a statement and we witnessed it. EI#26 agreed the investigation was inaccurate and incomplete. Regarding her interviews with staff asking if any had witnessed abuse, EI#26 claimed nobody said that they had. When asked what she (EI#26) had done to address staff member (EI#10), indicating they had witnessed verbal abuse of a resident, EI#26 claimed she (EI#26) was not aware so she had not followed up. EI#26 said the concern of not following up on a staff member reporting they had witnessed abuse was whoever was doing it may do it again. EI#26 added it was mandatory to follow up. EI#26 did not remember EI#22 reporting EI#29 had yelled and cursed at RI#1. EI#26 documented the nurse practitioner had been notified but, he was not notified. EI#26 denied personal friendships between EI#29, EI#27 and herself, EI#26, affected her decision to not investigate an allegation of abuse against EI#29. EI#26 was supposed to investigate when staff reported abuse or potential abuse. EI#26 claimed there was no reason for staff to be fearful

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of getting fired if they reported abuse.
EI#26 did not investigate RI#3 being pushed down by EI#29.

A review of employee interviews conducted May 18, 2023 revealed EI#10, the Driver for the facility, answered the question have you ever witnessed a staff member abusing a resident with the response, "Yes, verbal abuse."

Policy

A review of the Abuse, Neglect & Exploitation policy revealed, "...Policy Overview Our Company is committed to maintaining a safe environment for each resident, ...Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow-up. ...3. Internal Reporting: a. Associate Obligations. Any employee who witnesses or becomes aware of alleged abuse, neglect or exploitation, should report such incident to the Executive Director or supervisor on duty immediately. If the supervisor on duty is the subject of the allegation, the incident should be reported to the Executive Director. If the Executive Director is the subject of the report, the incident should be reported to the owners. Suppose an associate does not believe that appropriate action is being taken. In that case the associate must report the alleged abuse, neglect or exploitation to the next level of supervisor. b. Internal Reporting Requirements. The Executive Director or designee should report the incident to the owner representatives immediately. ...5. Investigation: a. Internal Investigation. Upon receipt of an allegation of abuse, neglect or exploitation, the Executive Director, or their designee, should conduct a confidential internal

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investigation of the incident. b. Manner of Conducting Investigation. ...(1) The investigation should include interviews with potential witnesses, which may include the alleged perpetrator, the alleged victim, associates, other residents, and visitors to the community. ...c. Timing of Investigation. The investigation should be initiated as soon as practicable upon becoming aware of an incident. d. Investigation Record. The Executive Director or designee should maintain a written record of the investigation. A summary of interviews should be prepared by the Executive Director or designee, including the date, time and name of person being questioned and an impartial report of the facts. ...6. External Reporting/Notification ...b. Notifying Physician. The Executive Director or supervisor on duty should notify the resident's physician if there is an allegation of resident abuse, neglect or exploitation. ..."

A review of the Associate Handbook revealed on page 53, "...Internal Reporting Any associate who witnesses or becomes aware of alleged abuse, neglect or exploitation should report such incident to their immediate supervisor, supervisor on duty or Executive Director immediately. In the event the supervisor on duty is the subject of the allegation, the incident should be reported directly to the Executive Director. If the Executive Director is the subject of the report, or if the associate feels their complaint isn't being handled appropriated (appropriately), the incident should be reported to Corporate Compliance Director. ..."

Review of an "INVESTIGATION REPORT" dated May 17, 2023, revealed EI#6, Regional Director of Clinical Compliance, had notified EI#26 and EI#27, former Wellness Director/Registered Nurse, of alleged abuse involving two residents,

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A 609	Continued From page 47 RI#7 and RI#3). The "INVESTIGATION REPORT" documented the following: "...Staff involved: Pending investigation questioning. ...Notify Physician: (named EI#35, the CRNP (Certified Registered Nurse Practitioner) for RI#3 and RI#7) Follow up actions taken by facility: ...Interview all employees to assess if they have ever witnessed a staff member abusing a resident and if they know how to report abuse.	A 609		
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 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	A 611		

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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.

(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

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A 611	Continued From page 49 clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be provided assistance with personal safety. 6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on record reviews and interviews, residents' care plans were not updated with appropriate interventions when a change in the resident's status occurred. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: RI#9 RI#9 had resided at the facility since February 21, 2023. Refer to deficiency 508 for additional information on RI#9 and an incident involving alleged abuse which occurred on April 27, 2023. During the incident on April 27, 2023, RI#9 was reportedly taunting RI#8 which provoked RI#8 to	A 611		

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curse and hit RI#9. RI#9's facility Service Plan was not updated at the time the incident occurred with appropriate interventions to manage RI#9's behaviors and prevent a recurrence. RI#9's facility Service Plan was not updated until May 23, 2023 with a Goal of "will not act out in a way that is harmful to self or others" and an Intervention of "Exhibits inappropriate behavior: loud outburst, showing anger, provocation, getting in others personal space. Seroquel 25 mg po bid and one additional as needed for agitation". The Service Plan still did not include appropriate measures and staff interventions to monitor for and address RI#9's inappropriate behaviors to protect RI#9 and other residents. RI#9 was discharged from the facility in August 2023 due to continued inappropriate behaviors.

RI#10

RI#10 had resided at the facility since August 5, 2022. Refer to deficiencies 601, 604 and 621 for additional information on RI#10. RI#10 was discharged from the facility on July 16, 2023 to the care of a family member.

In July 2023, RI#10 sustained a significant weight loss of 12 percent of his/her total body weight for one month (100 pounds in June 2023 and 88 pounds in July 2023). This significant weight loss was not addressed on RI#10's facility care plan with appropriate interventions to prevent further weight loss. RI#10's facility Service Plan was provided to the surveyor by EI#3 and was dated June 26, 2023. Under the Focus "Eating/Meals", documentation read "Revision on 06/26/2023". However, no interventions had been added under this Focus item since August 9, 2022.

Review of RI#10's facility records as well as

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A 611	Continued From page 51 hospital records revealed RI#10 had episodes of confusion, hallucinations, refusal of medications and baths, wandering and difficulty taking medications from January 2023 until RI#10's discharge from the facility in July 2023. RI#10 required two emergency department visits to the hospital in three months (January and March 2023) due to altered mental status and hallucinations. Refer to deficiency 621 for additional information on RI#10's behaviors. The only interventions which addressed RI#10's behaviors and wandering on RI#10's facility Service Plan were as follows: January 3, 2023 - "Report changes from baseline behaviors to nurse...Responds to reorientation and redirection when wandering"; April 11, 2023 - "Report to nurse any unusual behavior...Staff to encourage resident to participate in activities"; May 30, 2023 - "Has mild to moderate disorientation or difficulty recalling/retaining information. Needs cueing". RI#10's behaviors were not adequately addressed on RI#10's facility Service Plan with appropriate interventions to ensure RI#10's safety and well-being. The above Service Plans were discussed with EI#3 on October 26, 2023. EI#3,Wellness Director Specialist, Licensed Practical Nurse, agreed the residents' Service Plans had not been appropriately updated when changes occurred in the residents' condition.	A 611		
A 614	420-5-4-.06 (5)(f)(g)(6)(7)(a)-(i) Care of Residents. (f) A resident may self-manage his or her medications. For the purposes of these rules, self-manage shall mean the resident is capable	A 614		

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of maintaining possession and control of his or her medications, who does maintain possession and control of his or her medications, and self-administers his or her medications without creating an unreasonable risk to health and safety.

(g) A resident that cannot self-manage his or her own medication without creating an unreasonable risk to health and safety may be assisted with self-administration of medication by any assisted living facility staff, including staff members who hold no professional licensure provided:

1. The resident can and does identify his or her name on the medication package and has a reasonable understanding of the unit dose packaging system in use by the facility such that the resident could protect himself or herself from medication errors when unit dose packages are brought to the resident by facility staff. The resident shall have the opportunity to demonstrate his or her ability to correctly utilize the unit dose package system at every opportunity for medication use.

(6) Assistance with self-administration of medication includes the following practices:

(a) Reminding a resident that it is time to take a medication or medications, where such medications have been prescribed for a specific time of day, a specific number of times per day, specific intervals of time, or for a specific time in relation to mealtimes or other activities such as arising from bed or retiring to bed.

(b) Physically assisting a resident by opening or helping to open a container holding

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A 614	Continued From page 53 medications. (c) Offering liquids to a resident to assist that resident in ingesting oral medications. (d) Physically bringing a container of medication to a resident. (7) Assistance with self-administration of medications shall under no circumstances include any of the following practices: (a) Medication administration as defined in these rules. (b) Determining the amount of medication to be given. If a medication is not available in unit dose packaging, unlicensed facility staff may measure the prescribed amount of medication only under the direction and control of the resident, provided that the resident is capable of determining the amount of medication to be given. (c) Giving a resident injections of any kind. (d) Telling or reminding a resident that it is time to take a PRN, or as needed medication. (e) Placing medications in a feeding tube. (f) Giving enemas or suppositories. (g) Crushing or splitting medications, provided that a physician has ordered a specific	A 614		

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medication to be crushed or split and the resident is capable of self-managing his or her own medication or the resident is capable of medication self-administration with assistance and would be capable of crushing or splitting his or her own medications but for limitations of mobility or dexterity, may be assisted with crushing or splitting medications by unlicensed staff so long as the assistance provided is under the total control and direction of the resident. 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.

(h) Mixing medications with food or liquids, provided that a physician has ordered a medication to be mixed with food or liquid and the resident is capable of self-managing his or her own medications or the resident is capable of medication self-administration with assistance and would be capable of mixing his or her own medications with food or liquid but for limitations of mobility or dexterity, may be assisted with mixing medications with food or liquid by unlicensed staff so long as the assistance provided is under the total control and direction of the resident. 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.

(i) Assisting with self-administration of eye drops, eardrops, nose drops, inhalers, nebulizers, or topical medications, provided that a resident who is capable of self-managing his or her own medication or a resident who is capable of medication self-administration with assistance and who would be capable of self-administration

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A 614	Continued From page 55 of his or her own medications but for limitations of mobility or dexterity, may be assisted with eye drops, ear drops, nose drops, inhalers, nebulizers, or topical medications by unlicensed facility staff so long as the assistance provided is under the total control and direction of the resident. 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. This Rule is not met as evidenced by: Based on observations and interviews, a resident was not given the opportunity to correctly utilize the unit dose package system at every opportunity for medication use. Findings: RI#5 had resided at the facility since September 8, 2020. Refer to deficiency 504 for additional information on RI#5. On the morning of October 24, 2023, the surveyor entered RI#5's room. RI#5 was resting in bed. On the table beside RI#5's bed was a small plastic cup containing several pills. When asked about the cup of pills, RI#5 stated staff brought it in earlier and left it for RI#5 to take after getting out of bed. The surveyor asked RI#5 if he/she had been asked to identify the medications before they were placed in the cup. RI#5 stated "no", adding that the pills were already in the cup when brought to his/her room. RI#5 also stated this was the method normally used for his/her medication assistance and that the medications were usually left in his/her room to be taken.	A 614		

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A 614	Continued From page 56 On the morning of October 24, 2023, EI#14, Medication Technician, was questioned about RI#5's medications. EI#14 stated she (EI#14) usually had RI#5 identify his/her medications but had not done so that morning. EI#14 agreed this was not the correct method for providing medication assistance to residents and that residents should be given the opportunity to identify medications with each dose.	A 614		
A 621	420-5-4-.06 (11) (b) Care of Residents. (b) Retention 1. An assisted living facility shall not allow any resident to return to the assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the facility is licensed to provide or the facility is capable of providing. 2. An assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility. 3. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in an assisted living facility. 4. An assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless: (i) The individual is capable of performing and does perform all tasks related to	A 621		

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A 621	Continued From page 57 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 others and does direct others to provide the physical assistance needed to complete such tasks, AND the facility staff is capable of providing such assistance and does provide such assistance. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. 5. If a resident of an assisted living facility is diagnosed with a terminal illness other than dementia and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90 days. If the facility is unable or becomes unable to meet the needs of a resident receiving hospice care, or if a resident receiving hospice care requires care beyond what the facility may lawfully provide pursuant to this section, then the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for assisted living facilities. The facility would in all cases remain responsible for ensuring the appropriate delivery of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident.	A 621		

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A 621	Continued From page 58 6. All skilled services provided in the facility, such as but not limited to wound care or insertion of a urinary catheter, shall be provided by the staff of properly licensed or certified agencies. Skilled services shall not be delegated to facility staff. 7. Residents that develop acute infectious pulmonary disease, such as active tuberculosis, or other diseases capable of transmission to other individuals through normal person-to-person contact shall be immediately transferred to an appropriate level of care until certified by a physician to be free of a contagious condition. 8. No assisted living facility shall be operated in whole or in part in a manner that prevents free and unhindered egress from the facility by any of its residents. 9. An assisted living facility shall not retain any resident who cannot safely reside in the facility unless his or her egress from the facility is restricted. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility retained a resident who did not meet the criteria for an ALF resident. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged RI#10	A 621		

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sustained significant weight loss while residing at the facility. Surveyors were able to confirm that RI#10 sustained significant weight loss at the facility which was reported to RI#10's physician but was not addressed on RI#10's facility care plan (refer to deficiency 611). In addition, numerous issues regarding RI#10's declining condition and ability to safely reside in the assisted living facility were identified which were not addressed by the facility with appropriate measures to prevent a further decline in RI#10's condition. These changes in RI#10's condition likely contributed to RI#10's weight loss.

RI#10 resided at the facility from August 5, 2022 until July 16, 2023. Refer to deficiencies 601, 604 and 611 for additional information on RI#10.

Review of RI#10's facility records and hospital records revealed the following documentation.

*On January 2, 2023, RI#10 was sent to the emergency department following three days of hallucinations, back pain and difficulty urinating. No determination of the etiology of RI#10's symptoms was documented in the hospital records.
*On January 3, 2023, following the hospital visit, RI#10's facility care plan was updated to read "Report changes from baseline behaviors to nurse...Responds to reorientation and redirection when wandering."
*On February 17, 2023, RI#10's facility Progress Notes read "...resident wandered into room 220 looking for (his/her) daughter".
*On March 4, 2023, RI#10's facility Progress Notes read "...resident appeared to be confused accused caregivers of stealing from (him/her)."
*On March 21, 2023, RI#10's facility Progress Notes read "resident...had (his/her) medication in

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A 621	Continued From page 60 (his/her) hand and tried to pour the water in (his/her) hand on the pills...resident is wandering the halls and saying that someone is after (him/her)...". *On March 21, 2023, RI#10 was sent to the hospital emergency department with reports that RI#10 recently started on antibiotics for a urinary tract infection and RI#10's altered mental status had not improved with the treatment of the infection. The hospital physician documented in RI#10's emergency department notes on March 21, 2023, "(He/She) does not have a urinary tract infection...increased confusion is thought to be secondary to dementia...". *On March 29, 2023, RI#10's facility Progress Notes read "Resident was very confused this morning". *RI#10's monthly assessment for March 2023 documented that a Certified Registered Nurse Practitioner from behavioral health had begun seeing RI#10 monthly for assessment and interventions as necessary. *On April 2, 2023, RI#10's facility Progress Notes documented that RI#10 refused lunch thinking it "was poison". *On April 3, 2023, RI#10's facility Progress Notes documented that RI#10 refused breakfast, because RI#10 thought he/she was having surgery that day and was not supposed to eat. RI#10 did not have surgery scheduled. *On April 5, 2023, RI#10's facility Progress Notes read "resident found in hallway bothering a family member of another resident...(he/she) is very confused today". *A Monthly Assessment, dated April 10, 2023, read "...Change in Status...Has there been a change in resident's status? Yes...Resident staying in bed more. Remedy (behavioral health) is now following resident and was put on Mirtazapine at bedtime on 3/1/23." *On April 11, 2023, an update to RI#10's facility	A 621		

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A 621	Continued From page 61	A 621		

care plan read "Report to nurse any unusual behavior...Staff to encourage resident to participate in activities".
*On April 17, 2023, RI#10's facility Progress Notes read "...found resident wandering the halls. Resident seemed very confused...said (his/her) son was in the hallway calling (him/her) to come down the hall".
*A facility Level of Care form, completed for RI#10 on May 7, 2023 read "Behaviors...wanders or trespasses within the residence, but presents no issues or concerns...".
*An update to RI#10's facility care plan, dated May 30, 2023, read "Has mild to moderate disorientation or difficulty recalling/retaining information. Needs cueing".
*RI#10's facility RCA Assignment Sheet Check Offs documented the following: on June 17, 2023, RI#10 refused a bath and, on Jun 20, 2023, RI#10 "was too disoriented to get a shower".
*On June 20, 2023, RI#10's facility Progress Notes read "had (his/her) pullup on over (his/her) pajama pants".
*On June 28, 2023, RI#10's facility Progress Notes read "on the toilet with (his/her) pull-up in (his/her) hand not knowing what to do with it...asked (staff) and told (him/her) to put it in the trash can...(he/she) was still confused about what to do about another pull-up not knowing how to put it on".
*In July 2023, RI#10 sustained a significant weight loss of 12 percent of his/her total body weight in one month (100 pounds in June 2023 and 88 pounds in July 2023).

RI#10 had documentation of confusion, wandering, difficulty taking medications and hallucinations since January 2023. RI#10 required two emergency department visits to the hospital in three months (January and March

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2023) due to altered mental status and hallucinations.

Current and former staff members were interviewed during the onsite survey from October 18-26, 2023. EI#14, EI#15, EI#16, EI#27, EI#29, EI#30, EI#31, EI#33 and EI#34 reported that RI#10 was confused at times. EI#14, EI#15, EI#16, EI#26, EI#27 and EI#30 reported that RI#10 did not eat well. Although RI#10's monthly assessments for February, March, April, May and June 2023 documented under Medications "...Is the resident able to safely manage their medications or safely self-administer medications with assistance?...Yes...", RI#10 was likely unable to protect himself/herself from a medication error at all times due to intermittent confusion. In addition, RI#10 was at increased risk for wandering, falls, weight loss and elopement due to periods of confusion and hallucinations.

A 30-day discharge notice was issued to RI#10 on June 21, 2023 due to "...Resident is unable to safely identify (his/her) medications per regulatory guidelines for Assisted Living...". RI#10 had been retained at the facility for greater than six months with behaviors that placed RI#10 at risk of harm. When interviewed on the afternoon of October 25, 2023, EI#27, former Wellness Director, stated RI#10's cognitive status would "come and go". When interviewed on the morning of October 26, 2023, EI#26, former Executive Director, stated that RI#10 "had to be redirected too many times". Neither EI#26 or EI#27 gave a reason why RI#10 had been retained at the facility when RI#10 did not meet the criteria for retention in an assisted living facility.

THERESA HARRISON, REGISTERED NURSE
CONNIE CHERRY, REGISTERED NURSE

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