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A 000	Initial Comments On June 18, 2024, an unannounced licensure and complaint survey was conducted for this 100 bed Specialty Care Assisted Living Facility (SCALF) with a census of 39 There were two (2) complaints investigated during this survey. LC#20240110002 and LC#20240529014 were substantiated. Deficiencies were written 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 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practices resulted in the potential for significant harm to all residents.	A 000		
A 204	420-5-20-.02 (4) The License. (4) Revocation of License. (a) The State Board of Health may revoke or downgrade the license of a specialty care assisted living facility for any of the following reasons: 1. Violation of any of the provisions of these rules. 2. Permitting, aiding, or abetting the commission of any unlawful act in the specialty care assisted living facility. 3. Conduct or practices deemed by the State Board of Health to be detrimental to the lives, health, safety, or welfare of the residents of	A 204		

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A 204	Continued From page 1 the specialty care assisted living facility. Conduct and practices deemed detrimental to the welfare of patients of a facility include: (i) The administrator of the facility, the governing authority of a facility, or an agent authorized by the governing authority of the facility has deliberately falsified any material information or record submitted as part of the application for licensure or on a Department survey. (ii) The facility or its governing authority has changed its corporate name, charter, entity, or its partnership name or composition to avoid the imposition of liens or court action. (iii) The governing authority, any principal associated with the governing authority, or the administrator has been found to have engaged in the physical, mental, sexual, or verbal abuse or in the financial exploitation of a resident or residents of this facility or any other licensed health care facility. (iv) The facility has been operated in a manner that resulted in one or more violations of applicable laws or other requirements and as a result caused death, injury, disability, or serious risk of death, injury, or disability to any resident or residents of the facility and such conduct causes the Department to reasonably believe that continued licensure of the facility to its current governing authority would likely be detrimental to the life, health, or safety of residents of the facility. (v) The facility is unable to meet its financial obligations and as a result its residents	A 204		

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are at risk, as evidenced by more than one utility cut-off notice for non-payment, inadequate amounts food or supplies, vendors placing the facility on cash on delivery only status due to non-payment of prior invoices, or the failure of banks to honor employee payroll checks due to insufficient funds on deposit.

(vi) The governing authority or any principal associated with the governing authority has been found to have committed fraud in this or any other jurisdiction.

(vii) The governing authority or any principal associated with the governing authority has falsified records or otherwise made a deliberate and material misrepresentation of facts to an employee of the Department in an attempt to influence the outcome of a survey or some other regulatory compliance determination by the Department.

(viii) The governing authority or any principal associated with the governing authority has induced, or attempted to induce, a subordinate employee to falsify records or to otherwise make a deliberate and material misrepresentation of facts to an employee of the Department in an attempt to influence the outcome of a survey or some other regulatory compliance determination by the Department.

(ix) The governing authority or any principal associated with the governing authority is operating, or has in the past operated, an unlicensed health care facility.

(x) Other serious misconduct or failure which, in the judgment of the Board, poses a

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A 204	Continued From page 3 serious risk to resident health or safety. 4. Refusal by the owner or administrator to permit full inspection or survey of the facility, to permit any resident assessment or interview, or to permit a review of any records deemed necessary by the Department to fulfill a survey. 5. Failure by the facility to submit an acceptable plan of correction for deficiencies cited by the Department. 6. The proposed revocation or downgrade of a license shall be governed by the provisions of the Alabama Administrative Procedure Act, §41-22-1, et seq., Code of Ala. 1975, and the Board's Rules for Hearing of Contested Cases, Chapter 420-1-3, Ala. Admin. Code. (i) Before any license to operate a specialty care assisted living facility is revoked or downgraded to probational status, written notice shall be given to the administrator of the specialty care assisted living facility, and may also be given to the governing authority, giving a brief explanation of the reason or reasons that the Board proposes to revoke or downgrade the license. The written notice shall also state a time and place at which a hearing or other lawful administrative proceeding shall occur to determine whether the license will be revoked or downgraded. The date of the hearing shall be not less than 30 days from the date of the notice. The notice shall be sent by registered or certified mail to the administrator of the facility as shown on the records of the Department, and shall be mailed to the address of the specialty care assisted living facility. The hearing or other administrative	A 204		

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A 204	Continued From page 4 proceeding shall comply in all respects with the Alabama Administrative Procedure Act and the State Board of Health rules for contested case proceedings. The licensee may be represented by legal counsel at the hearing at their own expense. (ii) If a license is revoked, a new license may be considered by the State Board of Health only after the conditions which resulted in the revocation, have been corrected to the satisfaction of the Board. (iii) Violations of these rules may result in a penalty under Code of Ala. 1975, Section 22-21 -33. (iv) Return of License Certificate. Each license certificate shall be returned to the Board immediately upon its revocation or after the facility voluntarily ceases operation. This Rule is not met as evidenced by: Based on observation, interview and record review, the governing authority operated the facility in conduct and practice deemed detrimental to the welfare of the residents as evidenced by multiple, significantly, past due accounts for goods and services, more than one utility cut-off notice for non-payment and one utility (water) disconnected due to non-payment. Findings: On May 29, 2024, a complaint was received by the ADPH ALF unit by telephone from the Mobile area ombudsman that the facility was not paying	A 204		

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its bills, facility grounds were unkept and buildings were in disrepair. The complainant stated he was extremely concerned for the residents' well being.

The complaint was substantiated during an onsite survey conducted on June 10, 2024.

During an interview on the morning of June 11, 2024, Employee Identifier (EI)#10, Human Resources (HR)/Accounts Payable clerk, said there were twelve vendors or providers of goods and services that had not been paid timely. EI#10 said they included Alabama Power company, Bagby Elevator company, Fire and Safety Commodities, Gulf Breeze Landscaping, Information on Demand (background check provider), Mobile Water company, Prewett Pest Control, Spire (gas company), Waste Solutions, and the facility dietician. When asked what had been done regarding the issue of non payment for goods or services, EI#10 answered nothing. EI#10 said EI#2 was responsible for the financial management of the facility and had been there since October 27, 2022. EI#10 said lawn care and pest control was not being performed because of non-payment. She (EI#10) named prior providers, Bay Landscaping and Cook's pest control, as having unpaid balances but could not provide invoices. EI#10 said as of February 28, 2024, EI#17, the former dietitian, was owed $1,800.00 and had not been to the facility since January or February 2024. When asked about the status of payment for EI#7, the former medical director, EI#10 answered the facility was trying to get EI#7 back under contract as the medical director. EI#10 said EI#7 stopped providing services in March of 2024. The past due balance for medical director services was $8,800.00.

On June 12, 2024, a red, door hanger from the

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utility company Spire (gas company) was observed by the surveyor. The door hanger was dated June 11, 2024. Written on the hanger was "Past due gas bill need payment today." On this same day, EI#5, the Administrator, told the surveyor EI#11 had to speak with the TV cable provider because many of the cable channels were no longer available. EI#5 said the cable was turned off but the provider turned it right back on after speaking with EI#11. At 2:45PM EI#11 stated the cable provider started "ticking away" channels due to non-payment. EI#11 said once the invoice was paid the cable was fully restored. EI#11 was asked if other services were stopped due to non-payment. EI#11 said the lawn service. EI#11 was asked if there were complaints of staff not receiving paychecks. EI#11 said she was not receiving commission as promised per her contract with the facility. EI#11 said she was owed commission for April and May 2024. EI#11 stated when she asked EI#2 about her missing commission payment, EI#2 told her it would be in EI#11's next paycheck. Thus far, EI#11 had not received her commission payment. EI#11 said two months prior to the survey, staff was supposed to be paid on a Thursday but they did not receive their paychecks until Monday creating a hardship for staff.

During an interview with EI#3, Nurse Consultant, on June 18, 2024, EI#3 was asked about potential employee background checks being delayed. EI#3 responded she heard there was a billing issue. EI#3 was asked about her knowledge of the number of delinquencies to vendors and service providers. EI#3 said she was aware of problems with pest control, plumbers and electricians.

On June 13, 2024, in the morning, EI#20,

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Resident Assistant (RA) and EI#25, RA, told the surveyor every staff member had a bounced check this year, 2024, toward the beginning of the year. Both staff told the surveyor there were several check cashing entities around town who would no longer cash employee checks because they were not getting reimbursed by the facility.

On June 13, 2024, at 1:00PM, EI#6, Director of Nursing, was asked if she ever had a payroll check bounce. EI#6 said no, but she had been paid late, up to five days late, on a couple of occasions. EI#6 said around Christmas time in 2023, staff did not receive paychecks on time. EI#6 stated, "It wasn't good." EI#6 said staff had bills to pay and Christmas to buy and no paycheck.

A review of invoices from venders and service providers and a spreadsheet, provided by the accounts payable department, revealed seven vendors' or service providers' invoices mailed to the facility or directly to the accounts payable department on campus. The spreadsheet showed the following account status of those vendors and service providers.

Alabama Power - 31-60 days past due amount of $29,638.52 and 91+ days past due amount of $35,352.29 totaling $64,990.81 past due.

Bagby Elevator Company, Inc. - 91+ days past due amount total of $3,133.60.

Fire and Safety Commodities - 91+ days past due amount total of $971.54.

Gulf Breeze Landscaping, LLC - 1-30 day past due amount of $2,363.32, 61-90 days past due amount of $2,363.32 (no amount was shown in

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the 91+ column) however, a total of $14,606.51 was noted as past due.

Information on Demand, Inc. - 1-30 day past due amount of $403.00, 61-90 days past due amount of $132.00, 91+ days past due amount of $736.00 totaling $1,271.00 past due.

Mobile Area Water & Sewer - 91+ days past due amount of $3,478.02 as the total amount past due.

Prewett Pest Control Gulf Coast - 91+ days past due amount of $723.00 as the total amount past due.

Spire (gas utility company) 31-60 days past due amount of $1,315.81, 61-90 days past due amount of $710.53, 91+ days past due amount of $2,002.60 totaling $4,028.94.

Waste Solution Services - 1-30 day past due amount of $2,230.72, 31-60 days past due amount of $2,230.72, 91+ days past due amount of $4,361.44 totaling $8,822.88.

The spreadsheet was signed by EI#10 as being accurate.

During an interview on the evening of June 17, 2024, EI#2, CEO, was asked who provided oversight of EI#5, Administrator. EI#2 said he only provided oversight of financial matters. When asked what oversight he provided of the day to day operation of the facility, EI#2 said originally he was to oversee the construction. EI#2 said he was not involved in the day to day operations, but was involved in managing payment for goods and services. EI#2 was asked about delinquent accounts including registered

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dietitian services, background check services, utilities including gas and water, lawn care, pest control, pool cleaning services, and cable. EI#2 only responded that he refused to pay half of the money up front for the pool cleaning. EI#2 initially denied the cable channels had been canceled but then said they were changing cable companies anyway. EI#2 went on to say the delinquencies were an oversight related to the bills not coming to the facility address. The surveyor requested to see the invoices to confirm the address they were mailed to. When EI#2 was asked if the person paying the bills should be the last person to receive them, he said of course not. After EI#2 returned from requesting the invoices, he reported he agreed with what the invoices confirmed, the only bill that did not come to the facility was for waste management. EI#2 said the other bills were sent to accounts payable to be paid and he was only made aware of the bills if they were not paid. EI#2 was asked specifically about the delinquent balance of $8,800.00 for medical director services. EI#2 said he did not know why the bill wasn't paid. EI#2 was asked why Information on Demand was not paid for the background checks they conducted so additional staff could be hired. EI#2 said he was not aware. EI#2 said, "I have to change the system and I want to be on top of it to begin with. I am ultimately responsible for paying the bills." EI#2 admitted the cable channels were suspended for lack of payment. EI#2 was asked again why the bills were not paid. EI#2 answered, "It was an oversight. It ultimately falls on my shoulders as an investor."

After the onsite survey was completed, an anonymous complaint was received by the ADPH ALF unit via telephone call on July 10, 2024. The complainant stated he/she was aware the

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facility's water had been turned off, the facility was three months past due on its power bill and the elevator repair service suspended the facility's account due to non-payment.

An onsite visit was made by the surveyor on the afternoon of July 11, 2024, to investigate an anonymous complaint. During the visit, the surveyor substantiated the complaint that water service had been disconnected. On July 10, 2024, the facility's water service was turned off from approximately 9:00AM until 3:30PM, due to non-payment of past due bills. Residents could not shower, brush their teeth, flush toilets or wash their hands during that time. That same afternoon, the surveyor again discussed with EI#10, accounts payable clerk, what goods or services had been interrupted due to non payment. EI#10 confirmed the water was disconnected for non-payment. EI#10 said Bagby Elevator company would not come and service the facility elevator until the past-due amount was paid. This was confirmed with Bagby Elevator company staff during an interview and record review of notations made on the facility's account documentation for Bagby Elevator company.

On the afternoon of July 11, 2024, EI#6, registered nurse (RN), said the water was turned off for non-payment.

On the afternoon of July 11, 2024, EI#2 was asked what goods or services had been discontinued and why. EI#2 said the water service was disconnected from 9:40AM until 3:13PM on July 10, 2024. EI#2 said the water was disconnected because the Mobile Area Water and Sewer System claimed they had not been paid in a couple of months. EI#2 acknowledged residents were unable to shower

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while the water was off. EI#2 was asked since the delinquencies of needed services had been discussed with him prior to June 18, 2024, why were the bills not paid. EI#2 said he did not think they (Mobile Water and Sewer System) would turn the water off for these elderly people. EI#2 added he had previously been given two warnings that the water would be turned off, however, EI#2 said he just didn't think they would do it.

A review of the power bill statement for service from June 4, 2024, through July 4, 2024, revealed, "... Pay By Jul (July) 19, 2024 Total Due $63,233.43 Service Address 3145 KNOLLWOOD DR Service Period June 4, 2024 - July 4, 2024 Disconnect Notice Our records indicate that your electric service is past due. The balance of $63,233.43 which consists of all past due service amounts plus current service charges is due now and delinquent after July 19, 2024. If $63,233.43 is not paid by July 19, 2024, your electric service may be disconnected without further notice. ... Billing Summary Previous Bill Amount $54,974.87 Payment received on 06/13/24 ... -2,892.14 Past Due Electric Service $44,223.95 ... Total Due $63,233.43 ..."

On the morning of July 11, 2024, during a telephone call, EI#2 said the funds were available to pay the bills. When asked what was being done about the $63,233.43 power bill with the disconnect notice, EI#2 responded he had already paid $30,000.00 but would not give the surveyor the date of when the payment was made.

On the morning of July 11, 2024, EI#1, Owner, said via telephone call, he was unaware of the water being turned off and the other delinquent bills. EI#1 was asked, as the owner, why didn't he

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ensure bills were paid. EI#1 said EI#2 was supposed to be handling the bills. Later that morning, EI#1 called the surveyor back with EI#2 on the telephone as well. EI#2 claimed he paid money to the Alabama Power company but they had not credited the account for the facility. The surveyor reminded both EI#1 and EI#2 that 24 hours earlier the surveyor had requested copies of receipts of payment but none had been provided. Both EI#1 and EI#2 were silent. EI#1 and EI#2 were also reminded the only reason EI#2 gave for not paying the bills was because he thought the providers would not disconnect service because of the elderly residents.

Please note that on numerous occasions, EI#2 was asked why he did not pay the bills when they were due. The only reason given by EI#2 was he thought the providers would not disconnect services because of the elderly residents. When the surveyor discussed EI#2's response with the facility owner (EI#1), EI#1 said EI#2 did not answer the question because he (EI#2) did not have a good answer.

On July 18, 2024, the ALF unit supervisor contacted EI#2 by telephone to ask if the delinquent power bill had been paid and the threat of disconnect was no longer an issue. EI#2 said, "They (Alabama Power) took a lot of money out of our accounts but applied it to the wrong account." EI#2 said the facility and Alabama Power were currently in negotiations. EI#2 was asked if the power was going to be disconnected tomorrow (July 19, 2024) as stated in the delinquent notice. EI#2 said, "No, No."

That same day at 3:37PM, the ALF unit supervisor contacted Alabama Power by telephone. The supervisor was told the facility's

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A 204	Continued From page 13 new balance was $50,012.76. The power company representative stated there was no order to disconnect the power on July 19, 2024 and Alabama Power does not disconnect power over the weekend. Note: There was no evidence of a payment of $30,000.00 as stated by EI#2. The balance only decreased by $13,220.67 On Monday, July 22, 2024, a surveyor was dispatched to the facility to confirm the facility still had power. The surveyor observed power had not been disconnected.	A 204		
A 301	420-5-20-.03 (1) (a) (b) (c) (d) Administration. (1) The Specialty Care Assisted Living Facility Governing Authority. (a) A specialty care assisted living facility shall have an identified sole proprietorship, corporation, partnership, limited partnership, or other business entity that is its governing authority, or it shall have a designated individual or group of designated individuals who serve as its governing authority. A facility must give complete information to the Department identifying: 1. Each person who has an ownership interest of 10 percent or more of the governing authority. 2. Each person or entity who has an ownership interest of 10 percent or more in the real property or building used by the specialty care assisted living facility to offer its services. 3. Each officer and each director of the corporation if the governing authority is a	A 301		

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A 301	Continued From page 14 corporation. 4. Each partner, including any limited partners, if the governing authority is a partnership. (b) The governing authority shall submit any changes to the information listed above to the Department within 15 days of the change. (c) Responsibility of Staff to Governing Authority. The administrator, medical staff, facility personnel, and all auxiliary organizations shall be directly or indirectly responsible to the governing authority. For the purposes of these rules, auxiliary organizations include but are not limited to licensed or certified outside providers, consultants, management companies that are not the facility license holder. (d) The governing authority is responsible for appointing and supervising the administrator who is responsible for overall management and the day-to-day operation of the facility. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days. This Rule is not met as evidenced by: Based on observation, interview and record review, the governing authority failed to properly orient and provide oversight of the current administrator, failed to ensure the facility was not without a licensed administrator for greater than forty-five days, failed to financially manage the facility in a manner to prevent interruption of goods or services, failed to provide adequate staffing to meet the care and safety needs of all	A 301		

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residents and failed to provide a safe, clean and decent environment for residents. The governing authority's lack of adequate oversight and failure to apply the SBOH rules to the day to day operation of the facility resulted in deficient practices which placed all 39 residents of the facility at significant risk for harm.

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

THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEYS COMPLETED JUNE 13, 2016 AND NOVEMBER 3, 2016.

Findings:

On May 29, 2024, the Alabama Department of Public Health (ADPH) received a complaint from the area Ombudsman regarding management of the facility. The complainant alleged there were numerous grounds and building issues including roach infestation, raccoons in the attic/ceiling space and a courtyard area that was a "train wreck". Additional concerns included frequent administrator turnover, doors not opening properly, water leaks, and air conditioners that weren't working. The complainant stated the facility was not paying its bills and he was concerned for the resident's safety due to the owner's and maintenance man's poor management of the facility.

Upon arrival at the facility on June 10, 2024, the surveyors observed the facility grounds and flower beds to be unkept and overgrown. The grass was greater than 24 inches tall. As the survey tour progressed to inside the facility, the surveyors observed roaches in resident rooms and roaches and flies in the main dining area

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where facility residents food is prepared. Residents were observed fanning flies away from their food and covering their glasses with napkins. The atrium/courtyard area was overgrown and unkept. There was a fenced in swimming pool that was filled with green, slimy water with bugs on the water's surface and around the pool area. A staff member showed the surveyor a video of a raccoon wandering around the enclosed courtyard during daytime hours just a couple of months prior to the survey. In the back hallway, a mop bucket was observed under a leak in the ceiling. Ceiling tiles were stained from leaks, there were missing ceiling tiles with exposed insulation hanging down in multiple areas of the facility. Toilets were not working and were filled with waste.

Governing Authority Oversight

The surveyors learned EI#5 had been the facility administrator for only three weeks, beginning May 20, 2024. The ADPH had not been notified EI#5 was the new administrator. In fact, several administrators had come and gone without the department being notified of the changes as required.

Interviews conducted on June 13, 2024 with two former administrators revealed, from March 29, 2024 until May 21, 2024, (52 days) there was no licensed administrator overseeing the day to day operation of the facility. In fact, the governing authority allowed a nursing home administrator, who was not a licensed assisted living administrator, to manage the facility in addition to the nursing home on the same campus.

During an interview with EI#5 on the morning of June 11, 2024, EI#5 said she (EI#5) was trying to

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find out who the governing authority was. EI#5 said there was a "money man" and named EI#2. When asked the name of the company that owned the facility, EI#5 said she (EI#5) did not know. EI#5 said she (EI#5) knew nothing related to the governing authority. When asked if she (EI#5) had articles of ownership or incorporation on file in the facility for the surveyor to review, EI#5 said they were trying to get them. EI#5 was asked how she (EI#5) knew who she (EI#5) was supposed to answer to. EI#5 said, "I don't." The surveyor asked EI#5 who she (EI#5) would refer residents, sponsors or family members to if they wanted to talk to her (EI#5's) supervisor. EI#5 said EI#2.

During an interview on the evening of June 17, 2024, EI#2 identified his (EI#2's) role at the facility as Investor/Operator. EI#2 said EI#3, Regional Consultant Nurse, was responsible for reporting changes in administration and orienting EI#5. EI#2 said he (EI#2) only provided oversight of financial matters.

During an interview on the morning of June 18, 2024, EI#3 said she (EI#3) was a consultant RN and part of the governing authority. EI#3 said she (EI#3) had no background in assisted living facilities and could not provide guidance to EI#5 regarding state regulations. EI#3 denied it was her (EI#3's) responsibility to report administrator changes and said it was EI#2's responsibility to orient new administrators. EI#3 added they never had an administrator because they used an executive director who ran the skilled nursing facility (SNF), the assisted living facility (ALF) and the specialty care assisted living facility (SCALF). EI#3 said the SNF assessment revealed it was a special focus which meant the SNF administrator should not be overseeing the entire campus. EI#3

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said she (EI#3) advised EI#2 that it was too much and if something was going on in the SNF and the SCALF, one person could not go back and forth. EI#3 said it was causing turnover because there was too much work to be over more than one facility.

During an interview on the morning of June 18, 2024, EI#1, Owner, was asked who oversees the day to day operation of the facility. EI#1 named EI#2, adding the administrator should be answering to EI#2. EI#1 said EI#2 is living on-site and should be overseeing the facility.

The following deficient practices were cited due to the lack of management and oversight of the facility by the governing authority.

302 - The facility failed to establish and implement its own policies and procedures.

303 - The administrator failed to properly manage the day to day operations of the facility and failed to ensure previously cited deficiencies were corrected and compliance with SBOH rules for SCALF's was maintained. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

305 - The facility failed to notify the SBOH of administrator changes within a timely manner.

401 - The facility failed to provide adequate staffing to meet the care and safety needs of all residents 24 hours a day, seven (7) days a week.

405 - The facility failed to have a medical director and the facility RN failed to identify training needs and ensure staff were CPR certified.

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A 301	Continued From page 19 406 - Staff members were not CPR certified and trained in special needs of the residents. 502 - The facility failed to maintain original articles of incorporation and a copy of the bylaws of the governing authority. 504 - The facility failed to post a copy of Residents Rights and the previous inspection report. In addition, the facility failed to provide a safe and decent environment for all residents at all times and failed to provide residents the right to be outdoors at regular and frequent intervals. 508 - The facility failed to report to the ADPH a malfunction of the fire alarm system and failed to investigate a reportable incident. 612 - The facility failed to have an activities program. 701 - The facility failed to provide the services of a professionally qualified dietician. 805 - The facility failed to provide a safe space for outside activities. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 901 - Clean lint traps were not maintained for all dryers. 1001 - The facility failed to ensure the premises was clean, neat, free of pests, free of over-grown grass and weeds, and other conditions that could create a health or safety hazard. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 1002 - The facility failed to provide a decent and	A 301		

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A 301	Continued From page 20 comfortable environment by storing mattresses, furniture and other items of prior residents in resident rooms. 1101 - The facility failed to conduct fire drills monthly and quarterly on each shift and to ensure the fire alarm and sprinkler systems were inspected semi-annually for compliance with respective codes. 1201 - The facility was not maintained in a safe operating condition. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 1203 - The facility failed to ensure the building was free from leaks, unsecured hand rails, windows without screens, broken windows and foliage infiltration. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 1204 - The facility failed to ensure smoke barrier doors closed automatically upon fire alarm activation and that fire doors sealed. 1205 - The facility failed to have panic hardware in working order on a fire exit door and failed to ensure smoke compartment doors were sealed. 1206 - The facility failed to ensure all locks automatically released upon activation of the fire alarm system.	A 301		
A 302	420-5-20-.03 (e) Administration. (e) Policies. The governing authority shall be responsible for establishing and implementing written policies for the	A 302		

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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 resident. 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:

(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.

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A 302	Continued From page 22 (xi) Fire safety and emergency plan, fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness. (xii) Staffing and conduct of staff while on duty. (xiii) Oxygen administration and storage if used in the facility. (xiv) Dietary Policies. The dietitian, with the approval of the administrator, shall develop written policies and procedures for the guidance of all personnel handling food as 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 302		

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A 302	Continued From page 23 a therapeutic diet or special dietary needs. (VI) Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food. (VII) Provision of necessary services to any resident requiring adaptive devices to eat. (VIII) Procedure for the handling of potentially hazardous foods such as meat, milk, ice, and eggs. (IX) Storage of food. (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 develop and implement written policies and procedures. THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEY COMPLETED JUNE 29, 2021. Findings: The facility's policy titled, "Administration - Department Notification" revealed, "... POLICY: To provide appropriate Notice of changes to the Alabama Department of Public Health. ... The Board of Health shall be provided written notification not later than fifteen (15) days after	A 302		

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any change in Administrator." The facility did not notify the SBOH of administrator changes as required. Refer to deficiency 305 for additional information.

The facility's policy titled, "Emergency Procedure - Cardiopulmonary Resuscitation" revealed, "... Policy Statement Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR). ..."

The facility's policy titled, "Personnel and Training - Required Training" revealed, "... PROCEDURE: Staff members shall have initial training prior to resident contact. ... An RN (Registered Nurse) shall identify staff refresher training needs and shall provide or arrange for needed training. ... In addition to the previous training, the facility shall ensure that, prior to resident contact, all staff receive training on the subject listed below: Current certification from the American heart (H) Association or the American Red Cross (ARC) in cardiopulmonary resuscitation within ninety (90) days of hire. ..." The facility did not ensure all staff were certified in CPR. Refer to deficiency 405 for additional information.

The facility's policy titled, "Care of Residents - Personal Care and Services - Activity Program" revealed, "... POLICY: To develop and implement a meaningful activity program ..." The facility did not provide an activities program for residents. Refer to deficiency 612 for additional information.

The facility policy titled, "Food Service - General - Dietitian Responsibilities/Duties" revealed, "... POLICY: To ensure that facility dietary services are appropriately directed and supervised. PROCEDURE: 1. General (a) Direction and Supervision. The Administrator and/or his/her

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designee shall employ the services of a Dietitian who shall be available to any resident ..." The facility did not provide services of a qualified, professional dietician. Refer to deficiency 701 for additional information.

The facility's policy titled, "Sanitation and Housekeeping - Sanitation ... POLICY: The facility will provide and maintain a safe, functional sanitary environment for residents, staff and visitors. PROCEDURE: ... Sanitation: (a) Water Supply ... 3. Tubs, showers, sinks, lavatories and other fixtures used by residents shall have hot water supplied not to exceed ... (110) degrees Fahrenheit. ... Housekeeping (a) Premises 1. The premises shall be kept neat and clean, and free of accumulation of rubbish, weeds, ponded water, or other conditions of a similar nature which would have tendency to create a health or sanitation hazard. (b) Control of Insects, Rodents 1. Each facility shall be kept free of ants, flies, roaches, ... Proper methods for their eradication or control shall be utilized. ..." The facility did not provide a clean, safe, sanitary environment for residents. Refer to deficiencies 504, 805, 1001 and 1201 for additional information.

The facility's policy titled, "Fire and Safety - General" revealed, "... PROCEDURE: ... Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days, quarterly on each shift. ... Fire Alarm System. ... to comply with NFPA 72, ... The fire alarm system shall be inspected by licensed, trained and qualified personnel at least semiannually for compliance with respective codes. ... Sprinkler System. The sprinkler system shall be inspected by licensed, trained and qualified personnel at least semiannually for compliance with respective codes. ..." The facility

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A 302	Continued From page 26 did not conduct fire drills as required and did not ensure the fire alarm and sprinkler systems were inspected semiannually. Refer to deficiency 1101 for additional information. The facility's policy titled, Physical Plant revealed "... The interior and exterior shall be kept clean and orderly." ... The facility did not maintain clean, orderly grounds. Refer to 805, 1001, 1201, 1203, and 1206. On the afternoon of June 18, 2024, EI#5 identified that policies and procedures had not been followed and it was deficient practice.	A 302		
A 303	420-5-20-.03 (2) (a) Administration. (2) The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the specialty care assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an administrator shall meet all applicable statutory requirements. 4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences. Under no	A 303		

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circumstances shall the facility operate without a licensed administrator for greater than 45 days.

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

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

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

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

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

10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting.

11. The administrator shall ensure that facility staff members observe each resident for

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changes in health and physical abilities and obtain appropriate medical attention when needed.

12. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan.

13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the administrator failed to perform her duties to ensure the care and safety needs of all residents were met.

Findings:

On May 29, 2024, a complaint was received in the ALF unit regarding poor environmental and building conditions, bills for goods and services not paid and frequent administrator turnover.

On June 10 - June 18, 2024, surveyors with the ADPH conducted an onsite survey and complaint investigation. The complaint was substantiated.

During an interview on the evening of June 13, 2024, EI#4, former administrator, reported she (EI#4) was the administrator from April 8, 2024, until May 20, 2024. EI#4 was a licensed skilled nursing facility (SNF) administrator; however, she (EI#4) did not hold a valid assisted living facility administrator license.

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A 303	Continued From page 29 During an interview later in the evening of June 13, 2024, EI#8, former administrator, reported he (EI#8) was the administrator from January 17, 2024 through March 28, 2024. During an interview on the morning of June 11, 2024, EI#5 reported she (EI#5) had been the administrator of the facility for only three weeks. EI#5's start date was May 21, 2024. During an interview with EI#5 on the morning of June 11, 2024, EI#5 admitted she (EI#5) did not know anything about the governing authority and did not know who she (EI#5) should report to. During an interview on the evening of June 17, 2024, EI#2 said EI#3 was responsible for the orientation of EI#5. EI#2 said he (EI#2) did not know what was included in EI#5's orientation. EI#2 thought EI#3 had oriented EI#5 to the magnetic door lock release system. When asked who had authority over EI#5, EI#2 named EI#4. EI#4 was the skilled nursing facility administrator, on the same campus, and the former unlicensed administrator of the SCALF. When EI#2 was reminded EI#4 was not a licensed assisted living administrator, EI#2 said, in New York, nursing home administrators can oversee assisted living facilities. When asked who oversees EI#5, EI#2 said he (EI#2) did for financial matters. When asked what oversight he (EI#2) provided for the day to day operation of the facility, EI#2 said originally it was to oversee construction. EI#2 said he (EI#2) was not involved in the day to day operation of the facility, but only in managing payments of goods and services. During an interview on the morning of June 18, 2024, EI#3 said she (EI#3) was a consultant RN	A 303		

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A 303	Continued From page 30 with no background in assisted living facilities and she (EI#3) could not provide guidance on state regulations. EI#3 was not familiar with the Alabama State Board of Health (SBOH) Rules for Assisted Living Facilities. When asked what oversight she provided and for whom, EI#3 said she (EI#3) could only answer questions related to nursing and she (EI#3) did not have an Alabama nursing license. EI#3 said EI#2 was responsible for orienting new administrators. EI#3 did not know who oriented EI#5. When asked if EI#5 had signed documentation to validate she (EI#5) had been oriented, EI#3 said she (EI#3) did not know except for the offer letter with a job description. EI#3 said her (EI#3's) orientation with EI#5 was over the phone when she (EI#3) went over the layout of the building and EI#5's offer letter. The facility had operated 52 days, from March 29, 2024 through May 20, 2024, without a properly licensed administrator. EI#2 and EI#3, who identified themselves as the governing authority, had not oriented EI#5 to her (EI#5's) duties regarding the day to day operation of the facility. EI#2 and EI#3 were not providing supervision or training of EI#5. The failure to provide a properly licensed administrator, frequent administrator turnover and lack of training by the governing authority resulted in the following deficient practices which directly reflect the responsibilities of a licensed administrator. The administrator did not ensure facility policies and procedures were implemented. Refer to deficiency 302 for additional information. The administrator failed to ensure adequate staff were on duty to meet the care needs of residents. Refer to deficiency 401 for additional information.	A 303		

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A 303	Continued From page 31 The administrator failed to ensure the services of a medical director were provided and failed to ensure the facility RN identified staff training needs. Refer to deficiency 405 for additional information The administrator failed to ensure employees were CPR certified and had completed required training. Refer to deficiency 406 for additional information. The administrator failed to ensure the original articles of incorporation and a copy of the bylaws of the governing authority were maintained and available. Refer to deficiency 604 for additional information. The administrator failed to ensure a copy of resident's rights and the previous inspection report were posted. In addition, the administrator failed to direct maintenance staff to provide a safe and decent environment for all residents at all times. Refer to deficiency 504 for additional information. The administrator failed to report to ADPH a malfunction of the fire alarm system and investigate a reported incident. Refer to deficiency 508 for additional information. The administrator failed to ensure an appropriate activity program was offered to residents. Refer to deficiency 612 for additional information. The administrator failed to ensure services of a professionally qualified dietitian were provided to residents. Refer to deficiency 701 for additional information. The administrator failed to direct maintenance	A 303		

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A 303	Continued From page 32 staff to provide safe space for outside activities. Refer to deficiency 805 for additional information The administrator failed to ensure lint traps were cleaned for all dryers. Refer to deficiency 901 for additional information. The administrator failed to direct maintenance staff to ensure the premises was clean, neat, free of pests, free of over-grown grass and weeds and other conditions that could create a health or safety hazard. Refer to deficiency 1001 for additional information. The administrator did not ensure fire drills and semi-annual inspections of the fire alarm and sprinkler systems were conducted. Refer to deficiency 1101 for additional information. The administrator failed to ensure the facility was maintained in a safe operating condition. Refer to deficiency 1201 for additional information. The administrator failed to ensure the facility was free of leaks, that hand rails were secured and operable windows had screens. Refer to deficiency 1203 for additional information The administrator failed to ensure smoke compartment doors released during fire alarm activation. Refer to deficiency 1204 for additional information. The administrator failed to ensure a fire exit door had panic hardware in working order and smoke compartment doors sealed when closed. Refer to deficiency 1205 for additional information. The administrator failed to ensure locked fire exit doors released automatically during fire alarm	A 303		

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A 303	Continued From page 33 activation and that she (the administrator) had knowledge of how to perform a fire drill and activate the "Kill Switch" to release locked doors for evacuation in the event of a fire. Refer to deficiency 1206 for additional information.	A 303		
A 305	420-5-20-.03 (2) (c) Administration. (c) Department Notification. 1. The licensee of a specialty care assisted living facility shall provide written notification of voluntary closure of the facility to the State Board of Health at least 30 days prior to the expected closure date. 2. The State Board of Health shall be provided written notification not later than 15 days after any change in administrator. 3. The State Board of Health shall be provided written notification not later than 15 days after any change in management company. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to notify the State Board of Health of administrator changes. THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEY COMPLETED MAY 19, 2013 Findings: During an interview on the morning of June 11,	A 305		

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A 305	Continued From page 34 2024, EI#5 reported she had been the Administrator since May 21, 2024. During an interview on the evening of June 13, 2024, EI#4, former administrator, reported she was administrator from April 8, 2024, until May 20, 2024. During an interview, on the evening of June 13, 2024, EI#8, a former administrator reported he was the administrator from January 17, 2024 through March 28, 2024. Review of the "New Employee Setup Form" for EI#5, EI#4 and EI#8, confirmed their dates of hire. There was no record of these three (3) administrator changes for the facility on file with the ADPH.	A 305		
A 401	420-5-20-.04 (1) (2) Personnel. (1) A specialty care assisted living facility shall ensure adequate personnel are employed and on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. No specialty care assisted living facility shall have fewer staff on duty than specified in Table A below. Even if this minimum staffing ratio is met, the governing authority of a specialty care assisted living facility shall have additional staff on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. Facilities with resident bedroom wings separated from the remainder of the facility by a lockable door shall maintain dedicated staff to these areas adequate to meet all care and safety needs of the residents in these areas at all times.	A 401		

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A 401	Continued From page 35 Table A Staff Number 7 AM - 3 PM 3 PM - 11 PM 11 PM - 7 AM 2 1 -16 Residents 1 - 16 Residents 1 - 16 Residents 3 17 - 24 Residents 17 - 36 Residents 17 - 48 Residents 4 25 - 32 Resident 37 - 48 Residents 49 - 64 Residents 5 33 - 40 Residents 49 - 60 Residents 65 - 80 Residents 6 41 - 48 Residents 61 - 72 Residents 81 - 96 Residents 7 49 - 56 Residents 73 - 84 Residents 97 - 112 Residents 8 57 - 64 Residents 85 - 96 Residents 113 - 128 Residents 9 65 - 72 Residents 97 - 108 Residents 129 - 144 Residents 10 73 - 80 Residents 109 - 120 Residents 145 - 160 Residents 11 81 - 88 Residents 120 - 132 Residents 161 - 176 Residents 1 Additional Staff For each 8 residents, or any fraction thereof, by which the census exceeds 88 For each 12 residents, or any fraction thereof, by which the census exceeds 132 For each 16 residents, or any fraction thereof, by which the census exceeds 176 (a) A specialty care assisted living facility shall be staffed at all times by at least one individual who has a current certification in	A 401		

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A 401	Continued From page 36 cardiopulmonary resuscitation (CPR). (b) A specialty care assisted living facility must be sufficiently staffed to ensure the safe evacuation of all residents in the event of a fire or emergency. (2) Employee Schedule. A specialty care assisted living facility shall post a schedule of employees indicating names and days and hours scheduled to work. This schedule shall be retained in the facility for 6 months after use. In the event of an unplanned staff shortage which would make it otherwise impossible to meet the staffing requirements imposed by these rules, a facility may employ a certified nurse aide who has not received the training specified in these rules. For the purposes of this subsection, a certified nurse aide is defined as an individual who has been deemed or determined to be competent by the Alabama Nurse Aide Registry maintained by the Alabama Department of Public Health. This individual may not work unless accompanied at all times by an individual who is appropriately trained in accordance with these rules. Such employment shall last only until the facility has employed staff trained in accordance with the above. In no event may the period during which such staff is employed in a facility exceed 120 consecutive hours. This Rule is not met as evidenced by: Based on observation and interviews, the facility did not provide adequate staffing to meet the care and safety needs of all residents twenty-four	A 401		

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A 401	Continued From page 37 hours a day, seven (7) days a week. This deficient practice affected all 39 residents currently residing in the facility. THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEY COMPLETED JULY 29, 2021 Findings: In the early morning on June 12, 2024, an observation was made to determine staffing for the 11:00 PM to 7:00 AM shift. One person was on the floor with 39 residents. This was EI#13, a Resident Assistant. At that time EI#13 was interviewed and reported she had been there with EI#14, a Licensed Practical Nurse (LPN), who splits her time between the SCALF and assisted living facility (ALF) since 11:00 PM the night before. EI#13 said it was not the first time she had been the only person in the SCALF unit with a nurse shared with ALF. Note: the ALF is located on the first floor of the building. On the afternoon of June 17, 2024, EI#6 was asked how many days since May 1, 2024, the unit had been understaffed. EI#6 said 26 days. EI#6 was asked why they were understaffed. EI#6 said EI#2 told her to cut staff to cut costs. On June 13, 2024 at 1:00PM, the surveyor discussed staffing with EI#6, RN. EI#6 said when EI#8, was the administrator, EI#8 cut one resident assistant from the schedule leaving only two resident assistance on duty for over thirty residents. EI#6 said she explained staffing requirements to EI#2 and showed him (EI#2) the SBOH rule book but EI#2 and EI#8 still wanted to cut staff.	A 401		

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A 401	Continued From page 38 During the same interview, EI#6 said she hired ten new employees in March 2024 but the background checks took too long to come back, so potential employees took other jobs. When EI#6 was asked why it took so long to get the reports back, EI#6 said because the facility did not pay the back ground check company's bill. EI#6 was asked what administration was going to do about staffing. EI#6 said EI#2 wanted to move the only ALF caregiver to the SCALF, on the second floor, leaving the ALF residents with no staff on duty. The surveyor asked EI#6 if she (EI#6) thought it was safe to operate the facility short staffed. EI#6 said no. EI#6 said she told EI#2 it was not safe. EI#6 also said she told EI#3 she needed to hire nurses. EI#6 said EI#3 also told EI#2 the facility needed more staff. On the afternoon of June 18, 2024, EI#5 acknowledged the facility had been understaffed and that was a deficient practice.	A 401		
A 405	420-5-20-.04 (6) (7) (8) Personnel. (6) Medical Director. Each specialty care assisted living facility shall have a medical director who is a physician currently licensed to practice medicine in Alabama. The medical director is responsible for implementation of resident care policies, and the coordination of medical care in the facility. The medical director shall participate in quality assurance activities in the facility. A nurse practitioner or physician's assistant shall not serve as the medical director of a specialty care assisted living facility. (7) Registered Professional Nurse. Each facility shall have at least one RN. An RN may also serve as the administrator or as the	A 405		

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A 405	Continued From page 39	A 405		

care coordinator, but not as both. In all instances where the facility's RN is assigned other duties as an administrator or care coordinator the facility must assure that the RN devotes sufficient time and effort to all clinical duties.

(a) Responsibility. The RN shall be responsible for oversite and coordination of resident care.

1. The RN shall assess the residents in the specialty care assisted living facility.

2. The RN shall develop, document, and evaluate resident plans of care.

3. The RN shall consult with the administrator on all issues of resident safety, health, and wellbeing.

4. The RN shall communicate significant resident changes to the resident's physician and sponsor or responsible family member.

5. The RN shall identify staff training needs and ensure needed training is appropriately provided.

6. The RN shall direct the practice of any licensed practical nurse.

(8) Care Coordinator. There shall be a care coordinator who will manage the daily routine delivery of resident care. This person shall be an LPN or RN. An LPN care coordinator shall work under the supervision of the RN in the management and delivery of resident care.

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A 405	Continued From page 40 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a medical director. In addition, the facility RN failed to identify staff training needs and ensure all staff were currently certified in Cardiopulmonary Resuscitation (CPR). THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION Findings: A review of provider contracts revealed there was no current contract for a facility medical director. During an interview on the afternoon of June 17, 2024, EI#10 was asked about the status of the former medical director (EI#7). EI#10 answered EI#7 stopped providing services to the facility in March of 2024. EI#10 stated EI#7's billing company was owed a past due balance of $8,800.00 for services. EI#10 sated they were trying to get EI#7 back. On June 13, 2024 at 11:15AM, the surveyor met EI#7 in the hallway, on the first floor. EI#7 said his contract with the facility had ended and he was no longer the medical director. EI#7 said he still sees some of the residents, but not as the medical director. EI#7 said the facility has not paid Team Health, the billing company, in approximately one year. On the afternoon of June 18, 2024, EI#5 acknowledged they did not have a Medical Director.	A 405		

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A 405	Continued From page 41 Training and CPR A review of CPR certifications for staff members revealed 20 current staff member were not CPR certified. On the afternoon of June 17, 2024, EI#6, the Director of Nursing, said she was responsible for ensuring staff were CPR certified. EI#6 said the concern of staff not being CPR certified was in the event a resident needed CPR, staff may not know how to perform it correctly. A review of the personnel file for EI#5 revealed required training had not been completed for the following topics: Advanced Directives, Safety and Nutritional Needs of the Elderly, Resident Fire and Environmental Safety, Safety Needs of Residents with Dementia, Special Needs of the Mentally Ill and Retarded, Identifying the Signs and Symptoms of Dementia, Diabetes, Oxygen Therapy and Basic First Aide. EI#11 did not receive required training in the following topics: Identifying and Reporting Abuse, Advance Directive, Safety Nutritional Needs of the Elderly, Nutritional Hydration Needs of Residents with Dementia, Special Needs of the Mentally Ill, Retarded and Elderly and Basic First Aid. On the afternoon of June 18, 2024, EI#5 acknowledged the deficient practices that training had not been completed and staff were working without being CPR certified.	A 405		
A 406	420-5-20-.04 (9) Personnel. (9) Training.	A 406		

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A 406	Continued From page 42 (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. An RN shall identify staff training needs and shall provide or arrange for needed training. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that, prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on specialty care assisted living facilities. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire. 5. Identifying and reporting abuse, neglect, and exploitation. 6. Basic first aid. 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environmental safety. (b) Prior to providing any resident care,	A 406		

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all staff shall complete The Dementia Education and Training Act (DETA) Care Series Training developed by the Alabama Department of Mental Health or equivalent training approved by the State Health Officer. All licensed staff shall complete DETA Brain Series Training, The Pharmacological Management of Dementia, and the Dementia Assessment Series provided by the DETA Program or equivalent training approved by the State Health Officer prior to resident contact. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained.

(c) All staff who have resident contact shall be able to demonstrate diversional methods and redirection. All staff shall be able to demonstrate an understanding of the implications of caring for residents with agnosia, amnesia, aphasia, and apraxia. All staff shall be able to demonstrate an understanding of the facility's fire and evacuation plan and all other policies regarding safety, including policies for preventing elopements, responding to elopements, and fall prevention.

(d) Cardiopulmonary Resuscitation. A specialty care assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of a specialty care assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within 90 days of hire. A specialty care assisted living facility equipped with an automated external defibrillator (AED) shall be staffed at all times by

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A 406	Continued From page 44 at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or the American Red Cross in CPR or AED utilization. (e) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training. (f) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above. This Rule is not met as evidenced by: Based on record review and interview, staff were not cardiopulmonary resuscitation (CPR) certified and were not trained in special needs of residents. Findings: CPR A review of the CPR certifications for facility staff revealed, 20 staff members were not CPR certified. In the early morning of June 12, 2024, an observation was made to determine staffing for the 11:00 PM to 7:00 AM shift. EI#13 and EI#14 were the only staff on the unit and neither were	A 406		

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A 406	Continued From page 45 CPR certified. An immediate plan of action was requested by the surveyor and implemented by EI#5 and EI#6 on June 17, 2024, at approximately 8:45 AM. The plan of action included identifying each staff member that was not CPR certified. EI#6 scheduled CPR training for June 17, 2024 at 5:00 PM and June 21, 2024 at 11:30 AM. Beginning June 17, 2024 all staff scheduled to work will be CPR certified. Required training A review of the personnel file for EI#5 revealed the following training was not completed: Advanced Directives, Safety and Nutritional Needs of the Elderly, Resident Fire and Environmental Safety, Safety Needs of Residents with Dementia, Special Needs of the Mentally Ill and Retarded, Identifying the Signs and Symptoms of Dementia, Diabetes, Oxygen Therapy and Basic First Aide. EI#11 did not receive training in the following areas: Identifying and Reporting Abuse, Advance Directive, Safety Nutritional Needs of the Elderly, Nutritional Hydration Needs of Residents with Dementia, Special Needs of the Mentally Ill, Retarded and Elderly and Basic First Aid. On the morning of June 12, 2024, EI#5 said she had not completed the required training and her CPR certification had expired. EI#5 said all staff should have completed the required training. On the afternoon of June 17, 2024, EI#6, RN, said she was responsible for ensuring staff were CPR certified. EI#6 said the concern of staff not being CPR certified was in the event a resident needed CPR, staff may not know how to perform	A 406		

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A 406	Continued From page 46 it correctly. On the afternoon of June 18, 2024. EI#5 acknowledged training had not been completed and staff were working without CPR certification which left shifts where no one on duty was CPR certified.	A 406		
A 502	420-5-20-.05 (2) Records and Reports. (2) Administrative Records and Documents. (a) Each specialty care assisted living facility shall maintain the following records and documents. Unless otherwise specified below, a photocopy of the record or document shall be sufficient to meet this requirement. 1. Original Articles of Incorporation or certified copies thereof, if the governing authority is incorporated, or partnership documents if the governing authority is a partnership or limited partnership. 2. A current copy of the constitution or bylaws of the governing authority, with a current roster of the membership of the governing authority. 3. Up-to-date personnel records for all employees and former employees of the facility. Personnel records for former employees shall be retained for at least three years after the employee leaves employment. 4. Current policy and procedure manual.	A 502		

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A 502	Continued From page 47 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain original articles of incorporation and a copy of the bylaws of the governing authority. Findings: A record review was made of the document provided by the facility when articles of incorporation and governing authority bylaws were requested. The document provided was an organizational chart that showed EI#5 as the administrator of the nursing home on the campus. The articles of incorporation and bylaws of the governing authority were not provided although they had been requested since June 10, 2024. On the morning of June 11, 2024, EI#5 said she was trying to find out who made up the governing authority. When asked the name of the company that owned the facility, EI#5 said all she knew was Gordon Oaks. EI#5 said she did not know the name of the company that owned Gordon Oaks and knew nothing about the governing authority. On the evening of June 13, 2024, EI#5 said she did not have the articles of incorporation or the bylaws of the governing authority.	A 502		
A 504	420-5-20-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission, of these rights. A copy of these rights shall be conspicuously posted in a resident	A 504		

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common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate.

1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility.

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

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

4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened 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.

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A 504	Continued From page 49 6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the premises, an individual account record for each resident shall be maintained by the administrator and an up-to-date record shall be maintained for all transactions. 7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so. 8. Every resident shall have the right to a reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals. 9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident. 10. Every resident shall have access to adequate and appropriate health care consistent 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	A 504		

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A 504	Continued From page 50 meets the eligibility and continued stay requirements in these rules, or for medical reasons the resident is considered by a physician to require an emergency relocation to a facility providing a more skilled level of care, or unless the resident engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record. 12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person without restraint, interference, coercion, discrimination, or reprisal. 13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file. 14. Every resident shall have the right to refuse to perform work or services for the facility 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.	A 504		

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A 504	Continued From page 51 (ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation. (iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time without recourse. 15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges. 16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities. 17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public 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	A 504		

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A 504	Continued From page 52 inspection and any resulting corrective action plan shall be posted. 19. Every resident shall have the right to 30 days prior written notice to both resident and sponsor of any increase of fees or charges. 20. Every resident shall have the right to 30 days prior written notice of any involuntary change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. 21. Every resident shall have the right to wear his or her own clothes, and to keep and use his or her own personal possessions, including toilet articles, except for personal possessions too large to be stored in the resident's room. 22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings. 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file.	A 504		

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A 504	Continued From page 53 This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to post a copy of the Residents Rights and the most recent inspection report. The facility also failed to ensure residents were provided a safe and decent environment and the right to be outdoors at regular and frequent intervals. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEY COMPLETED JULY 29, 2021. Findings: Postings An observation was made in the morning of June 10, 2024, for the required postings and previous inspection report. There was no copy of Resident's Rights or the previous inspection report posted. On the morning of June 10, 2024, EI#6 was asked where the Resident's Rights and the previous survey were posted. EI#6 said the Resident's Rights were not posted and she did not know where the survey book was. Outdoor Activity A review of the activity calendar, provided by the facility, revealed on June 10, 2024, a 1:00PM sing along activity was scheduled. At 1:30PM the calendar documented the activity "Courtyard." An observation was made at approximately 1:15PM on June 10, 2024, of 16 residents seated	A 504		

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in the common area/TV room. The residents were watching a movie. Residents were not being led in a sing along and no residents went out to the courtyard.

On the morning of June 13, 2024, EI#16, a Resident Assistant, reported she had worked in the SCALF unit for approximately three (3) months. When asked how often the residents go outside, EI#16 answered she had never seen the residents escorted outside. EI#16 said a resident had asked to go outside that morning. EI#16 added she thought the residents had the right to go outside.

On June 12, 2024, at 12:40PM, the surveyor observed the courtyard off the dining room was overgrown and unkept. There was a large in the ground swimming pool in the center of the courtyard full of stagnant, green, slimy water and bugs were observed on the water's surface. Flies and other bugs were observed flying around the courtyard and into the dining room through the door. The door leading from the dining room into the courtyard did not fully close allowing pests to enter. EI#11 was asked who uses the courtyard. EI#11 said independent living residents and ALF residents could use the courtyard without assistance but SCALF residents had to be escorted.

Safe and decent environment

An observation of the facility's two dining rooms revealed the facility dining room at the front of the building was a comfortable temperature, however, the dining room could not accommodate all 39 residents. An inspection underneath the dining room sink revealed, a leak

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had eroded the structural integrity of the cabinetry and liquid drained through the rotted floor to the ceiling below. The ceiling tiles were stained and growth of a substance in the ceiling and tiles was observed. Gnats were observed flying around the sink area. The second dining room, across the hall at the back of the building, was extremely hot. EI#22 was asked if residents took their meals in the hot dining room. EI#22 said yes. EI#22 said administration had been told many times that the air conditioning was not working in the second dining room. The air conditioners were turned on but the dining room temperature remained hot.

In addition, surveyors observed the following practices which jeopardized the safety and wellbeing of residents. Utility bills and multiple bills for other goods and services were significantly past due. Water and cable TV services were disconnected due to non-payment and there were disconnect notices from Alabama Power and Spire gas companies. Lawn care and pest control were suspended due to non-payment. (Deficiency 204). There was no CPR certified staff on duty on multiple occasions during the night shift in May and June of 2024. Two staff including the administrator did not receive required initial training. (Deficiency 405). Residents did not have access to the services of a registered dietician. (Deficiency 701). The outdoor courtyard/atrium for residents was not safe and was overgrown and unkept with insect mounds observed. A swimming pool filled with stagnant, green water and insects was in the center of the residents' courtyard. (Deficiency 805). Lint was heavy in the dryer vents as well as around the dryers. (Deficiency 901). The facility grounds were overgrown with grass greater than 2 feet tall. Flower beds were unkept and overgrown, windows were missing screens,

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GORDON OAKS	3145 KNOLLWOOD DRIVE MOBILE, AL 36693

(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 504	Continued From page 56 roaches and flies were observed in resident rooms and in the dining room, refuse and bowls of animal food were seen behind the building, a video, provided by staff showed, a raccoon wandering around the courtyard in broad daylight. Ceiling tiles were stained and some were missing. Insulation was hanging from the open ceiling in the beauty shop and other areas. (Deficiencies 1001, 1201 and 1203). Fire drills had not been conducted in years and the fire alarm and sprinkler system inspections were not performed semiannually as required. (Deficiency 1101). On the afternoon of June 18, 2024, EI#5 identified the Residents Rights had not been posted, the previous survey results were not available, the facility grounds were unkept and the building was in disrepair. EI#5 acknowledged these were deficient practices.	A 504		
A 508	420-5-20-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in a specialty care assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review. 1. Incidents which require investigation are: (i) An accident or injury of known or	A 508		

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A 508	Continued From page 57 unknown origin that was unusual or suspicious in nature such as extensive bruising, pain, or injury that is not consistent with actions necessary in providing day-to-day care to a resident or for which medical treatment was sought. (ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid including but not limited to a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office. (iii) The onset of wandering behavior by any resident who is not fully cognitively intact. (iv) Elopement by a resident. (v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. (vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules. (vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules. (viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I to Alabama	A 508		

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A 508	Continued From page 58 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: (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	A 508		

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A 508	Continued From page 59 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. (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	A 508		

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A 508	Continued From page 60 connection with the investigation. (xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request. (xix) The entire investigative file and documentation of all corrective action taken shall be retained for a period of not less than 3 years after the resident is discharged or dies. (xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff. 3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident: (i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention. (ii) Elopement by a resident. (iii) Suspected, alleged, confessed, witnessed, or actual abuse, neglect, or exploitation of a resident or residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file.	A 508		

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A 508	Continued From page 61 (iv) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (vi) An unplanned occurrence that results in media attention. (vii) Any medication error, overdose, or over sedation. The incident shall be immediately reported to the attending physician, facility medical director, or back-up physician. (viii) Ingestion by a resident of a toxic substance that requires medical attention. (ix) Notifiable diseases and health conditions listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04. shall also be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1-.04. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than three years. (x) Any indication of a malfunction of the sprinkler system, fire alarm system, or a door locking device. 4. The report to the Department's Online Incident Reporting System shall include	A 508		

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A 508	Continued From page 62 the following: (i) Facility name and direct phone number. (ii) Time and date of the report. (iii) Reporter's name. (iv) Name of resident(s), staff, or visitor(s) involved in the incident. (v) Names of staff on duty at the time of the incident. (vi) Date and time of the incident. (vii) A brief description of the incident. (viii) Any injury or injuries to resident(s). (ix) Action taken by the facility in response to the incident. (i) Vital Statistics Reports. A record shall be kept of all births, deaths, and stillbirths that occur within the specialty care assisted living facility. By the fifth day of each month, the administrator shall make a report of such births, deaths, and stillbirths for the preceding month on such forms as the State Board of Health shall provide to the county health officer, or in counties without a county health officer, to the State Registrar. This report shall be in addition to the official birth, death, and stillbirth certificates. If there are no births, deaths, or stillbirths in any month, a report shall be made stating that fact to the county health officer.	A 508		

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A 508	Continued From page 63 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report to the ADPH a malfunction of the fire alarm system and failed to investigate an incident reported to the ADPH Online Reporting System. THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEYS COMPLETED JULY 13, 2016 AND AUGUST 15, 2019 Findings: On the afternoon of June 12, 2024, EI#5 presented the surveyor with an internal incident report for the malfunction of the fire alarm system identified earlier that morning. The surveyor asked EI#5 if she filed an incident report with the ADPH ALF unit online reporting system. She (EI#5) said no, she didn't know she needed to. On June 13, 2024 at 8:30AM, EI#5 showed the surveyor a completed internal report for the malfunction of the fire alarm system. The surveyor asked to see the state reportable incident report. EI# 5 said she didn't know she was supposed to complete one. The surveyor reminded EI#5 that on June 12, 2024, the surveyor told her she needed to file a report with the ADPH. A review of the online reportable incidents revealed there was no incident report submitted to the department regarding the malfunction of the fire alarm system.	A 508		

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A 508	Continued From page 64 A review of the investigation file of reportable incidents revealed no investigation had been conducted by the facility for incident report LC#20240125014. The report alleged a resident on resident altercation. The department requested the facility's investigation on January 30, 2024, but never received it. On the morning of June 18, 2024, EI#5 said there was no investigation into the altercation between two residents.	A 508		
A 612	420-5-20-.06 (4) (c) (d) (e) (f) Care of Residents. (c) Activity Program. There shall be an activity program designed to meet the individual needs of each resident. The facility shall maintain supplies and equipment as necessary to implement the activity programs. Every day the facility shall provide activities appropriate to residents with dementia. Residents who have wandering behaviors shall have a documented activity program to manage this behavior. (d) Pets residing at the facility or used in activity programs shall be in good health and shall have current vaccinations as required by law. Vaccination certificates, or copies of vaccination certificates, shall be kept on file at the facility to demonstrate compliance with this requirement. (e) Mail, Telegrams, and Other Communications. 1. Incoming mail, telegrams, and other written communications addressed to the resident	A 612		

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A 612	Continued From page 65 shall be delivered to the resident unopened. Outgoing mail shall be promptly delivered to regular postal channels upon receipt from the resident. Residents shall be permitted to receive telephone calls at the facility in complete privacy. 2. Personnel of the facility shall assist residents with communications, such as writing letters or assisting with writing letters, or reading mail out loud if requested to do so. (f) Appointments. Residents shall be assisted in making and keeping appointments. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to offer an appropriate activity program to residents. Findings: A review of the activity calendar provided by the facility revealed on June 10, 2024, a 1:00(PM) sing-a-long activity and a 1:30(PM) activity of "Courtyard" were documented. On the morning of June 10, 2024, EI#6 was asked why there were no activities observed. EI#6 said they did not have an activities person at the time. EI#6 was asked who was performing the activities person's duties. She said no one had been designated. EI#6 said it had been about 4 weeks since the residents last had an activities person performing activities duties.	A 612		

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A 612	Continued From page 66 On the afternoon of June 10, 2024, 16 residents were seated in the common area/TV room. The residents were watching a movie. No one was leading residents in a sing-a-long and residents did not go out to the courtyard. On June 12, 2024, at 12:40PM, the surveyor observed the courtyard off the dining room was overgrown, unkept and unsafe for residents. There was a large in the ground swimming pool in the center of the courtyard full of stagnant, green, slimy water and bugs were observed on the water's surface. Flies and other bugs were observed flying around the courtyard and into the dining room through the door. The door leading from the dining room into the courtyard did not fully close allowing pests to enter. EI#11 was asked who uses the courtyard. EI#11 said independent living residents and ALF residents could use the courtyard without assistance but SCALF residents had to be escorted. On the morning of June 13, 2024, EI#19, a resident assistant, stated, "Since I have been here I never see any of the SCALF people go outside, except RI#5 as (he/she) smokes and has to be escorted." On the afternoon of June 18, 2024, EI#5 acknowledged there were no activities being offered to residents and that was deficient practice.	A 612		
A 701	420-5-20-.07 (1) Food Service. (1) General. (a) Direction and Supervision. The services of a Dietitian shall be provided to any	A 701		

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A 701	Continued From page 67 resident of a specialty care assisted living facility who requires a therapeutic diet. A congregate specialty care assisted living facility shall be under the direction and supervision of a full or part-time professionally qualified dietitian or a consulting dietitian that is licensed in the State of Alabama. Responsibility for the supervision of dietary services shall be delegated to a responsible employee who is a graduate of a Dietary Managers course or has completed an approved course that includes basic sanitation. The facility shall provide meals, fluids, and snacks to the residents that meet the Dietary References Intakes from the basic food groups. The meals shall be of the quality and quantity necessary to meet the residents' needs, and must be in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide services of a professionally, qualified dietician. Findings: A review of the dietitian's contract signed by EI#17, the former dietitian, revealed her agreement included reviewing monthly weights and providing recommendations as needed. The contract was signed May 1, 2017. The surveyor reviewed four resident records (RI#1, RI#8, RI#9 and RI#10) for weight loss. The records revealed all four residents experienced unplanned weight loss. Two of the residents	A 701		

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A 701	Continued From page 68 (RI#1 and RI#8) sustained significant weight loss. There was no dietician available to review the residents' weight loss and make any necessary recommendations to prevent further weight loss. During an interview on the morning of June 17, 2024, EI#17 said she had not been serving the facility since January 2024. EI#17 said she told EI#2 and EI#10 she would not be back to the facility until she was paid. EI#17 said she was still owed $1800.00 for services she had provided. When asked what had been done to retain her services, EI#17 said nothing. During an interview on the morning of June 14, 2024, EI#6 reported the facility did not have a dietitian. EI#6 said EI#17 had been the dietitian but there were no dietitian notes since January 2024. During an interview on the afternoon of June 17, 2024, EI#6 said her understanding was there was no dietitian because the bill had not been paid. EI#6 said of the 4 residents with weight loss, none were reviewed by the dietician therefore, no recommendations had been made. On the afternoon of June 18, 2024, EI#5 acknowledged the services of a qualified dietitian were not provided to residents and that was a deficient practice.	A 701		
A 805	420-5-20-.08 (5) Physical Facilities. (5) Recreational. (a) Living and Recreational Room(s). Each specialty care assisted living facility shall provide adequate living and recreational room(s)	A 805		

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A 805	Continued From page 69 for group activities, and for social events, such as holiday celebrations, without crowding. The following shall be included: 1. Small living room(s) of a personal or family type so that residents may read or visit with relatives and friends in private. This requirement may be met when private bedrooms are large enough for use as small sitting rooms and are furnished for this use. Furniture for small living rooms and sitting spaces in bedrooms shall include clean comfortable chairs, tables, and lamps of good repair. 2. Central living or recreational room in which group activities can take place. This requirement may be met by combining the resident dining room with a central living or recreational room. (i) The living and recreational room shall be furnished according to the activities offered. Furniture shall include clean comfortable chairs, tables, and lamps of good repair. (b) Yards and Gardens. Each specialty care assisted living facility shall provide safe space for outside activities. (c) Hobbies or Leisure Activities. Each specialty care assisted living facility shall provide adequate space(s) for hobbies and leisure activities. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to provide a safe space for outside activities.	A 805		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 805	Continued From page 70 THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: On the morning of June 10, 2024, during a tour of the facility, the surveyor observed the following. 1) When facing the building, on the left side of the entrance, adjacent to the drain pipe, there was an electrical Romex wire with unsecured wire nuts, taped with electrical tape, exposed across the curb of the sidewalk. 2) The facility flower bed areas and grass areas were overgrown with vegetation to a height exceeding twenty-four (24) inches. Refuse was dispersed through out the garden and lawn area. An air filter for a vehicle was disposed of in the garden area. Various debris of plastic, metal and unknown material was disbursed on the grounds potentially posing a trip hazard for residents. 3) Broken shutter pieces and broken exhaust vent valves were disbursed throughout the lawn and garden areas adjacent to walkways potentially creating a trip hazard for residents. 4) The atrium pool area was fenced and secured but the pool was full with an unknown substance growing in the water. The water had a thick green-blue hue with insect activity on the surface of the water. 5) Four large insect mounds were observed in the lawn and garden areas outside the building and one insect mound was observed within the atrium.	A 805		

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A 805	Continued From page 71 On the afternoon of June 12, 2024, the surveyor asked EI#11 if anyone used the courtyard. EI#11 said facility residents could utilize the atrium/courtyard if they were escorted. EI#11 said she (EI#11) had not seen anyone use the pool in over a year. On the afternoon of June 17, 2024, EI#9, Maintenance Director, said he (EI#9) was responsible for the maintenance needs of the facility. When asked why there was such disrepair and unkept grounds, EI#9 said there was not enough help and it was overwhelming. On the afternoon of June 18, 2024, EI#5 acknowledged the facility grounds were unkept and it was a deficient practice.	A 805		
A 901	420-5-20-.09 (1) (2) Laundry. (1) General. (a) Direction and Supervision. Responsibility for laundry services shall be assigned to an employee. (b) Linen. Linens shall be handled, stored, processed, and transported in a manner consistent with generally accepted infection control practices. (2) Location and Space Requirements. (a) Each specialty care assisted living facility shall have laundering facilities unless commercial laundries are used. An on-site laundry shall be located in a specifically designated area, and there shall be adequate rooms and spaces for sorting, processing, and	A 901		

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A 901	Continued From page 72 storage of soiled material. Laundry rooms shall not open directly into resident rooms or food service areas. Domestic washers and dryers which are for the exclusive use of residents may be provided in resident areas, provided they are installed in such a manner that they do not cause a sanitation problem or offensive odors. (b) Each specialty care assisted living facility shall have a system in place to keep clean linen and dirty linen separated and to prevent the re-use of dirty linen before it is cleaned. Dirty linens and clothing shall not be stored, even temporarily, in the area set aside for clean linen. (c) Ventilation of Laundry. Provisions shall be made for proper mechanical ventilation of the laundry, if located within the specialty care assisted living facility. Provisions shall also be made to prevent the re-circulation of air in commercial equipment laundries into heating and air conditioning systems outside the laundry area. (d) Lint Traps. Adequate, effective, and clean lint traps shall be used in all dryers. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure the dryer lint traps were clean. Findings: On the afternoon of June 13, 2024, the surveyor observed the laundry room dryer lint traps were not clean and were piled up with lint.	A 901		

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A 901	Continued From page 73 On the afternoon of June 18, 2024, EI#5 acknowledged dryer lint traps not being cleaned can create a fire hazard. EI#5 said this was deficient practice.	A 901		
A1001	420-5-20-.10 (1) Sanitation and Housekeeping. (1) Sanitation. (a) Water Supply. 1. If at all possible, all water shall be obtained from a public water supply. If it is impossible to connect to a public water system, the private water supply shall meet the approval of the local County Health Department. 2. Water under pressure of not less than 15 pounds per square inch shall be piped within the building to all sinks, toilets, lavatories, tubs, showers, and other fixtures requiring water. Tubs, showers, sinks, lavatories, and other fixtures used by residents shall have hot water supplied. Hot water accessible to residents shall in no case exceed 110 degrees Fahrenheit. (b) Disposal of Liquid and Human Wastes. 1. There shall be installed within the building a properly designed waste disposal system, connecting to all fixtures to which water under pressure is piped. 2. All liquid and human waste, including floor wash water and liquid waste from refrigerators, shall be disposed through trapped drains into a public sewer in localities where such system is available.	A1001		

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A1001	Continued From page 74 3. In localities where a public sanitary sewer is not available, liquid and human waste shall be disposed through trapped drains into a sewage disposal system approved by the local County Health Department. The sewage disposal system shall be of a size and capacity based on the number of residents and personnel housed and employed in the institution. Where the sewage disposal system is installed at an existing facility prior to granting of a license, it shall be inspected and approved by the local County Health Department. (c) Premises. The premises shall be kept neat and clean. The property shall be free of rubbish, weeds, ponded water, or other conditions, which may create a health, safety, or sanitation hazard. (d) Control of Insects, Rodents, and other Pests. Each facility shall be kept free of ants, flies, roaches, rodents, and other pests. Proper and lawful methods for their eradication or control shall be used. Droppings shall be evidence of infestation by pests. (e) Toilet Room Cleanliness. Floors, walls, ceilings, and fixtures of all toilet rooms shall be kept clean and free of objectionable odors. These rooms shall be kept free of an accumulation of rubbish, cleaning supplies, toiletry articles. The use of a common towel and common bar soap is prohibited. (f) Garbage Disposal. 1. Garbage must be kept in water-tight suitable containers with tight-fitting covers.	A1001		

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A1001	Continued From page 75 Garbage containers must be emptied at frequent intervals and shall be thoroughly cleaned and aired before using again. 2. Garbage and waste shall be disposed of in accordance with local and state regulations. (g) Control of Odors. The facility shall be free of objectionable odors. This Rule is not met as evidenced by: Based on observations and interview, the facility failed to ensure the premises was clean and neat, free of pests and other conditions that could create a health or safety hazard. In addition, hot water temperatures exceeded the allowable temperature of 110 degrees Fahrenheit. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: Premises not Clean and Free of Pests On the morning of June 10, 2024, the surveyor observed the swimming pool, in the center of the atrium, was filled with stagnant water and green, slimy unknown growth. The pool filter system was unserviceable. The pool was a reservoir for insect breeding as various insects were observed on the water and in the pool area. The pool was fenced and secured from resident and employee access. Two of the surveyors watched a video provided by EI#25 of a raccoon wandering around the enclosed courtyard during daytime hours. EI#25	A1001		

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said the video was taken a month or so prior to the survey.

EI#9 agreed the pool not being cleaned attracted flies, gnats and mosquitos. EI#9 said the pest control contract was canceled in March of 2024, for non-payment. After March 2024, EI#9 said he (EI#9) went to Lowe's and bought Home Defense and sprayed for bugs if residents reported bugs.

On the morning of June 13, 2024, the surveyor observed the laundry area with commercial dryers. The ceiling tiles were stained, some ceiling tiles were removed, there was insulation hanging down from the ceiling and lint build up on the floor and areas behind the dryers. Lint traps were not cleaned of residue lint.

On the morning of June 13, 2024, the surveyor observed the beauty shop area had stained ceiling tiles, missing ceiling tiles, and insulation hanging down from the ceiling. The beautician told the surveyor EI#2 was aware of the issues in the beauty shop and had been aware of the problems for quite some time.

On the morning of June 13, 2024 the surveyor observed the recreation room (Cozy Corner) and observed refuse on the floor, stained ceiling tiles, and insulation dislodged and hanging down from ceiling. The temperature of Cozy Corner was 84 degrees Fahrenheit.

On the morning of June 13, 2024, the surveyor observed the toilet room in the laundry area to be unserviceable. The toilet was not functioning, there was waste material in the bowl, and there was no water service to the toilet at the time of the observation. During an interview with EI#25 on the afternoon of June 11, 2024 when asked

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how long the toilet had been that way, EI#25 stated, "A long time, they just told us not to use it".

On the afternoon of June 17, 2024, EI#9, the maintenance director, said he was responsible for the maintenance needs of the facility. When asked why there was such disrepair, EI#9 said there was not enough help and it was overwhelming.

On the afternoon of June 18, 2024, EI#5 acknowledged the facility grounds were unkept and that was a deficient practice.

Hot Water Temperatures

On the morning of June 11, 2024, random water temperature checks indicated the following rooms did not meet the rules requirement that hot water shall not exceed 110 degrees Fahrenheit:

ROOM	TEMPERATURE
220	112.8 Fahrenheit
215	111.7 Fahrenheit
218	111.7 Fahrenheit
213	111.3 Fahrenheit
217	111.2 Fahrenheit
221	111.3 Fahrenheit
229	112.8 Fahrenheit
240	112.8 Fahrenheit
242	114.8 Fahrenheit
246	114.1 Fahrenheit
274	116.8 Fahrenheit
272	114.6 Fahrenheit
255	no water in sink facets
253	114.8 Fahrenheit

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A1002	Continued From page 78	A1002		
A1002	420-5-20-.10 (2) Sanitation and Housekeeping. (2) Housekeeping and Physical Plant Maintenance. The facility must provide a safe, functional, decent, sanitary, and comfortable environment for residents, staff, and the public. (a) Equipment and Supplies. The home shall maintain an adequate quantity of housekeeping and maintenance equipment and supplies. (b) Bathtubs and Lavatories. Bathtubs and lavatories shall be kept clean and in proper working order, and shall not be used for laundering. (c) Resident Bedrooms. Resident bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance. (d) General Storage. 1. Broken beds, extra mattresses, mop buckets, and dust rags shall not be kept in hallways, closets, corners, or occupied resident rooms. Such items must be stored neatly and orderly in designated storage rooms. 2. The use of attics for storage of combustible materials shall be prohibited unless protected by an automatic sprinkler system and then only in small quantities so as not to create a hazardous condition. 3. Basements used for storage shall meet acceptable standards for storage and shall be designed and constructed in a manner that	A1002		

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A1002	Continued From page 79 protects against fire hazards. 4. Flammable materials such as gasoline, motor fuels, lighter fluid, turpentine, acetone, and oil based paint shall not be stored in the facility. Unless prohibited by a facility's own policies, however, a cognitively intact resident who uses lighter fluid to fill a personal cigarette lighter, or one who uses flammable materials such as paint or glue in connection with a personal hobby, may store small quantities of those materials in a safe and secure manner within his or her own room. 5. Poisonous or External Use Substances. Facility cleaning supplies and poisons shall be attended at all times or shall be kept in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a decent and comfortable environment by storing mattresses, furniture and other items belonging to prior residents in resident rooms. Findings: On the morning of June 11, 2024, observations were made of vacant rooms as follows. Room 246 - food items, clothes scattered about the room, a rocking chair, a twin bed with mattress and box springs, a chest of drawer, a suitcase and decorations were observed scattered throughout the room.	A1002		

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A1002	Continued From page 80 Room 258 - a headboard, bed frame, mattress and box springs were disassembled and standing against a wall, two lawn trash bags of clothes, a trash can stuffed with clothes, and a rollator were observed in the room. Room 243 - two bags of garbage were on the floor. EI#6 said the room had been vacant for 2 months. On the evening of June 11, 2024, EI#11, the admissions coordinator, was asked what happened when residents vacated a room. EI#11 said she was supposed to notify the maintenance director (EI#9) and he was supposed to handle it. EI#11 added it falls on deaf ears. On the evening of June 11, 2024, EI#9, was asked what is done with items left in rooms after a resident leaves the facility. EI#9 said he had no idea. EI#9 was asked who was responsible for the removal of former residents items. EI#9 answered the family.	A1002		
A1101	420-5-20-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All specialty care assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each	A1101		

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A1101	Continued From page 81 shift. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs. (d) Roller latches are prohibited on doors separating corridors from adjacent spaces. (e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that: 1. Minimizes leaks and spills. 2. Adequately protects against inappropriate access. 3. Complies with the requirements of the currently adopted Life Safety Code. (f) Fire Alarm and Sprinkler System. 1. Fire Alarm System. Where fire alarm	A1101		

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A1101	Continued From page 82 systems are required, a corridor smoke detection system shall be installed on each floor, including areas open to the exit access corridor, to comply with NFPA 72, connected to the facility's fire alarm system. In lieu of corridor smoke detection, smoke detectors connected to the building fire alarm system may be installed in each resident's room, open areas, and at smoke doors (except that corridor smoke detection shall not be deleted when its use is dictated by other requirements). 2. Fire alarm and sprinkler system outages of more than 4 hours require evacuation of the facility or the establishment of a continuous fire watch. The fire watch procedure must be coordinated with the Department and the local Fire Marshal. Outages and fire watch documentation shall be reported to the Department within 12 hours or no later than the next duty day, and shall be corrected expeditiously. 3. The fire alarm system and the sprinkler system shall be inspected by licensed, trained, and qualified personnel at least semiannually for compliance with the respective codes. Inspection and Testing reports shall be maintained in the facility for a period of at least 3 years. This Rule is not met as evidenced by: Based on observations, record review and interview, the facility failed to conduct fire drills monthly and quarterly on each shift, failed to ensure the fire alarm system and sprinkler system were inspected semi-annually for compliance with respective codes and failed to ensure the fire alarm system was operating as	A1101		

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A1101	Continued From page 83 per NFPA (National Fire Protection Association) standard 72. In addition, facility staff did not know how to utilize the fire alarm monitoring system. This failure put all 39 residents of the facility at significant risk for harm. THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEYS COMPLETED JULY 13, 2016 AND AUGUST 15, 2019 Findings: Fire Drills On the morning of June 10, 2024, EI#9 was asked to provide the fire drill logs. EI#9 said they had not been done. On the morning of June 13, 2024, EI#11 reported at least one fire drill had been done during her work hours in the three years she has worked at the facility. On the afternoon of June 17, 2024, EI#9 said he (EI#9) was responsible for conducting fire drills. When asked how often the system had been put in test mode for fire drills to be conducted, EI#9 answered none. EI#9 was asked what the concern was for staff and residents if fire drills were not conducted. EI#9 answered it was a danger because they may not know what to do in the event of a fire. Inspections A review of facility invoices for fire alarm and sprinkler system inspections revealed no semi-annual inspections had been performed from February 2023 until May of 2024.	A1101		

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A1101	Continued From page 84 During an interview on the morning of June 13, 2024, EI#9 admitted the inspections had not been done. On the afternoon of June 17, 2024, EI#9 was asked how many fire alarm system and sprinkler system inspections had been done in the past 2 years. EI#9 said there was an issue of non-payment. On the afternoon of June 18, 2024, EI#5 acknowledged that fire drills, fire alarm inspections and sprinkler system inspections had not been done. EI#5 said these were deficient practices. Fire alarm system failure On the morning of June 12, 2024, the fire alarm system was observed to be on battery back up mode and not receiving AC power from the power supply resulting in alarm status. The maintenance director, EI#9, was notified of the alarm status by facility staff. EI#9 was not on site but stated he (EI#9) notified Southeastern Fire Protection Systems of the alarm status. The surveyors requested the facility conduct a test of the fire alarm system to ensure the system was functioning properly in battery back up status. EI#5 stated the "test key" could not be located but someone would bring the key to the facility in thirty minutes. Since the system could not be tested to ensure proper function at that time, EI#5 initiated a fire watch until the key was located and the system could be tested. On the morning of June 12, 2024, the Fire Alarm System was found alarming with the code of	A1101		

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A1101	Continued From page 85 "SMOKE PWR RR". EI#14, Licensed Practical Nurse (LPN), on duty did not notify the Maintenance Director of the fault in the system per facility policy. EI#14 stated she (EI#14), "Tried to silence the alarm and checked the rooms to make sure it is not an issue". The surveyor asked EI#14 what she (EI#14) was supposed to do when the system alarms. EI#14 said, "Notify the Maintenance Director". EI#14 failed to notify the maintenance director of the alarm. The surveyor asked EI#14 why EI#9 was not notified. EI#14 stated "Because he is grumpy and sometimes doesn't even respond." The surveyor asked EI#14 how long had EI#9 quit responding to her, EI#14 stated "Quite a while, since the renovation." The surveyor asked what EI#14 meant by grumpy. EI#14 stated "He comes across grouchy and intimidating". On June 12, 2024, a technician with Coastal Fire Solutions inspected the fire alarm panel and trouble signal. The technician stated the system was fully functional in battery back up mode. Plans were made to repair or replace the fire alarm panel. A plan of action was requested and received from EI#5 to monitor the system and to ensure spare batteries were available onsite until the panel was repaired or replaced. Note: Previously Southeastern Fire Protection Solutions, Inc. serviced the fire alarm and sprinkler systems; however, they refused to provide service due to non-payment unless a cash payment was made up front. On June 13, 2024, at 8:15 AM, EI#5 contacted the Fire Marshal to end the fire watch as the fire alarm system was fully operational. On June 13, 2024, at 10:45 AM, the ALF unit supervisor called the Fire Marshal's office and	A1101		

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A1101	Continued From page 86 spoke with EI#23, Inspector, to discuss concerns regarding the fire alarm system. EI#23 said he (EI#23) would send an inspector to the facility for an inspection. On June 18, 2024 at 10:15 AM, EI#23 contacted the ALF unit supervisor and said an inspection was conducted at the facility and multiple violations were found. EI#23 said the facility was given two weeks to make all the necessary corrections. Violations included, gaps under the fire doors, missing ceiling tiles, sprinkler heads that were painted over, doors that did not release with activation of the fire alarm system and a blocked exit way. The fire alarm system panel was operational at that time. Fire Alarm Testing On the morning of June 13, 2024 at approximately 9:41 AM, EI#5 was asked to test the fire alarm system. EI#5 would be assisted by EI#11. EI#5 said, "I don't really know how to (test the system)." Four minutes later EI#11 was on the phone with EI#9's spouse getting instructions of how to put the system in test mode. At 9:48 AM, EI#11 reported it would be 30 minutes before they could get the key needed to put the system in test mode. EI#11 said EI#9 did not answer his (EI#9's) phone so EI#11 called EI#9's spouse. At 10:20 AM, EI#9's spouse presented with the key needed for the fire alarm monitoring test. EI#5 did not know what to do with the key. EI#9's spouse contacted EI#9 for instructions. At 10:28 AM, EI#5 called the fire monitoring company to have the system put in test mode. EI#5 did not know the zip code to provide to the monitoring company. At 10:32 AM, the fire alarm sounded.	A1101		

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A1201	Continued From page 87	A1201		
A1201	420-5-20-.12 (1) Physical Environment. (1) Buildings and Grounds. (a) The specialty care assisted living facility including site and grounds must be constructed, arranged, and maintained to ensure the safety of the residents and building occupants. (b) Building Classification. 1. Group specialty care assisted living facilities shall be planned to serve the residents to be admitted and shall comply with Section (1), (2), (3), (5), (6), and (8) of AAC Rule 420-5-20.12. 2. Congregate specialty care assisted living facilities shall be planned to serve the residents to be admitted and shall comply with Sections (1), (2), (3), (7), and (8) of AAC Rule 420-5-20-.12. 3. Renovation within the exterior walls of a specialty care assisted living facility shall in no case be of such nature as to lower the character of the structure below the applicable building requirements for the classification of license held by the specialty care assisted living facility. 4. Dually licensed facilities. (i) For the purposes of meeting physical facility and building code requirements, a building housing both a regular assisted living facility and a specialty care assisted living facility shall be classified as a Group or Congregate facility in accordance with the combined licensed bed	A1201		

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A1201	Continued From page 88	A1201		

capacities of both facilities. For the purposes of meeting resident care and administrative requirements, the specialty care assisted living facility and the regular assisted living facility shall be separately considered, and each shall be classified as a Congregate facility or a Group facility in accordance with the licensed bed capacity of each, and the determination shall not be based on their combined bed capacity.

(ii) When a facility has a portion of a building licensed for specialty care residents, instead of the entire facility, the sleeping, bathing, dining, and activity areas shall be in a distinct and separate unit within the building, licensed for specialty care assisted living. Administrative, kitchen, and service areas may be shared between the two licensed portions.

(c) Location. Each specialty care assisted living facility established or constructed shall be located so that it is free from undue noises, smoke, dust, or foul odors. New assisted living facilities shall be located at least 1,000 feet from railroads, freight yards, or disposal plants. This distance can be reduced to 500 feet when facility is separated by a boarded fence at least 6 feet high. This rule shall not prevent enlargement or expansion of existing assisted living facilities.

(d) Local Restrictions. The location and construction of a specialty care assisted living facility shall comply with local zoning, building, and fire ordinances. Evidence to this effect, signed by local fire, building, or zoning officials, may be required as a condition of licensure. If a facility is to be located in an area that does not have any zoning, building, or fire authority review, a letter stating such shall be obtained from the

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A1201	Continued From page 89 local county commission through official board action or from the office of the probate judge. (e) Specialty Care assisted living facilities shall be located on publicly maintained streets or roads, and connected with driveways which shall be kept passable at all times. (f) Occupancy. No part of a specialty care assisted living facility may be rented, leased, or used for any commercial purpose not reasonably necessary for the residents of the facility. Only residents of the facility shall be permitted to utilize these services. The Department shall approve all plans for occupancy. (g) Basements. The basement shall be considered as a story if it meets criteria established by the codes for a story. (h) The specialty care assisted living facility must maintain adequate furnishings, fixtures, supplies, and equipment for its services. (i) Facilities, supplies, and equipment must be maintained in safe operating condition. (j) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This Rule is not met as evidenced by: Based on observations and interviews, the facility was not maintained in a safe operating condition. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.	A1201		

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A1201	Continued From page 90 Findings: On the morning of June 10, 2024, the surveyor observed the following. 1) The outside grounds were lacking sufficient maintenance to permit resident egress on side walks to adjoining grounds. Overgrown grass and weed foliage occupied areas of the side walks to a height greater than 24 inches inhibiting safe egress. When EI#9 was notified of the hazard, EI#9 stated, "We don't have a lawn service right now, but we are working on it". 2) Electrical Romex wire was laying across the outside curb and walkway, with exposed wire nuts and electrical tape covering the wire nuts. EI#9 was notified of the observation. 3) Seventy-two (72) windows on the first floor required screens, however, 28 screens were displaced in unserviceable condition on the grounds, resulting in 38.8 percent of required screening missing on the first floor. The second floor had 39 windows of which ten (10) window screens were displaced and unserviceable on the grounds, resulting in 25.6 percent of required screening missing on the second floor. 4) Eighteen (18) of the external air conditioning heat exchanger units were observed with foliage overgrowth that had infiltrated into the heat exchanger coils of all 18 units. 5) Sixty-one (61) percent of first story exhaust diverter vents were unserviceable or not functioning. 6) The swimming pool, in the center of the atrium,	A1201		

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A1201	Continued From page 91 was filled with stagnant water and green, slimy, unknown growth. The pool filter system was unserviceable. The pool was a reservoir for insect breeding as various insects were observed on the water and in the area of pool. The pool area was fenced and secured from resident and employee access. 7) Refuse was piled up along sidewalks, driveways and a parking area in the rear of the building. The surveyor noted multiple metal bowls with various substances believed to be animal food along with refuse scattered throughout the entire area. 8) A rusted, battery powered, pole-chain saw appeared abandoned and imbedded in the soil and grass on the side of the building posing a trip hazard to residents. EI#9 was notified of observation. 9) The atrium egress door from the common area (dining area) was not functioning properly. The safety release bar was removed from inside the door, the latch did not secure the door, and the door itself was not aligned for proper opening and closing. 10) Mold or other type of growth was observed on window frames and sills of all exterior windows. 11) Four insect mounds were noted in the lawn and garden area adjacent to walkways. One insect mound was noted in the atrium lawn and garden area. 12) Multiple shutters were missing from windows and damaged shutters, with various sized holes, were observed.	A1201		

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A1201	Continued From page 92 13) A four (4) inch by 18 inch diameter divot depression was observed in the lawn garden area adjacent to the walkway posing a trip hazard to residents. 14) The restroom in the main lobby area had a hole in the wall above the toilet. The hole exposed a vent pipe with a two (2) inch hole that was open to the air exposing unpleasant odors. On the afternoon of June 17, 2024, EI#9 said he (EI#9) was responsible for the maintenance needs of the facility. When asked why there was such disrepair, EI#9 said there was not enough help and it was overwhelming.	A1201		
A1203	420-5-20-.12 (5) Physical Environment. (5) General Building Requirements - Group and Congregate. (a) Structural Soundness and Repair. The building shall be structurally sound, free from leaks and excessive moisture, in good repair, and painted with sufficient frequency to be reasonably attractive inside and out. The interior and exterior of the building shall be kept clean and orderly. (b) Temperature to be Maintained. The facility shall maintain a comfortable temperature. A comfortable range is between 71-81 degrees Fahrenheit. (c) Lighting. Each resident's room shall have artificial light adequate for reading and other uses as needed. All entrances, hallways, stairways, inclines, ramps, cellars, attics, storerooms, kitchens, laundries, and service units shall have sufficient artificial lighting to prevent	A1203		

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accidents and promote efficiency of service. Night lights shall be provided in all hallways, stairways, and bathrooms.

(d) Screens. All screen doors and operable windows shall be equipped with tight-fitting, full-length 16 mesh screens. Screen doors shall be equipped with self-closing devices.

(e) Emergency Lighting.

1. All specialty care assisted living facilities shall provide an emergency artificial lighting system to adequately illuminate halls, corridors, and stairwells in case of electrical power failure. As a minimum, dry cell battery-operated lighting shall be provided to light such spaces.

2. Emergency lighting must provide illumination in accordance with the currently adopted Life Safety Code for at least 90 minutes.

(f) Floors.

1. All floors shall be level, smooth and free of cracks, and finished so as to be easily kept clean. The basic requirement for floor finishes shall be wall-to-wall with such finishes as paint, stain, sealer, carpet, sheet vinyl, vinyl tile, hard tile, or other appropriate floor finish.

2. Any differences in floor levels shall not prevent a resident from navigating safely throughout the facility.

(g) Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface and shall be kept clean and in

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A1203	Continued From page 94 good repair. (h) Windows. Operable windows shall be so constructed and maintained so that they fit snugly, and are capable of being opened and closed easily. Windows in specialty care facilities may have devices which prevent full opening of the window. (i) Ceiling Height. Each room occupied by residents shall have a ceiling height of eight feet or more. Existing facilities with ceiling heights less than eight feet shall be acceptable when the height complies with the codes. (j) Handrails. If handrails are installed in halls or corridors, the handrails shall be mounted at 30 - 36 inches above the floor and returned to the wall at each end. (k) Stairways. Stairways shall be well lighted, kept in good repair, and have handrails. Open space under stairs shall not be used for storage purposes. All walls and doors under stairs shall meet the same fire rating as the stairwell. (l) Doors. 1. In each new specialty care assisted living facility, doors of resident bathrooms connected to resident bedroom shall swing into the bedroom. 2. Bedroom and bathroom doors may be equipped with hardware that will permit a resident to lock himself within the room, provided a master key is readily accessible for the staff at	A1203		

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A1203	Continued From page 95 a central location. 3. Resident bedroom and other exit access doors in specialty care assisted living facility shall be at least three feet wide. 4. Exterior egress doors except the main entry/exit door, may be equipped with a delayed egress locking system installed in accordance with NFPA 101. Other exterior egress doors may be arranged to prevent free and unhindered egress from specialty care assisted living facilities, in accordance with the Special Requirements portion of this section. 5. Exit doors swinging outward shall swing out over a landing having a minimum length and width equal to the door's width at the same level as the floor level, except existing doors shall not have more than a four inch step down. (m) Ventilation. The building shall be well ventilated at all times to prevent accumulation of objectionable odors. Kitchens, laundries, service rooms, toilets, and bathrooms shall be ventilated by windows, gravity vents, or mechanical means as necessary to prevent offensive odors from entering other parts of the facility. (n) Fire Extinguishers. Fire extinguishers shall be provided for each hall, kitchen, and laundry, of type and capacity appropriate to the need. 1. Each fire extinguisher shall receive an annual inspection with maintenance, and recharging when necessary, by a fire equipment	A1203		

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servicing representative. An annual servicing tag shall be attached to the extinguisher reflecting the name of the servicing company, representative, day, month, and year of maintenance.

2. A visual inspection of each fire extinguisher shall be conducted monthly by a designated staff of the facility and documented on the attached extinguisher tag by the designated staff person.

(o) Call System. A central electric or electronic call system shall be conveniently provided for each resident, usable in bedrooms and bathrooms. The call system shall be certified to meet the applicable Underwriters Laboratories standard.

(p) Manufactured homes/mobile homes are not permitted.

(q) Fireplaces and inserts shall be inspected and cleaned annually, and shall comply with the currently adopted building code. Openings shall be protected with screens or doors.

(r) Exit marking. In all facilities, a sign bearing the word "EXIT" in plain legible block letters shall be placed at each exit. Additional signs shall be placed in corridors and passageways wherever necessary to indicate the direction of exit. Letters of signs shall be at least four inches high. All exit and directional signs shall be kept clearly legible by continuous internal electric illumination and have battery back-up or emergency power.

(s) Heating, Lighting, and other Service

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A1203	Continued From page 97 Equipment. 1. Central or individual room gas heating systems shall be of the enclosed flame type equipped with automatic flame shut-off control and shall be vented directly to the outside. Heating units of any type shall be located to avoid direct contact with any combustible material and shall be maintained in accordance with manufacturer's recommendation. 2. Open flame and portable heaters are prohibited in specialty care assisted living facilities. This does not apply to a fire place with gas logs protected as noted elsewhere in these rules. 3. Lighting shall be restricted to electricity. Electric wiring, motors, and other electrical equipment in all specialty care assisted living facilities shall be in accordance with local electrical codes and the NFPA National Electrical Code. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building was free from leaks in the ceiling and that operable windows were equipped with screens. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: An observation was made on the morning of June 10, 2024, of a leak in the ceiling in the back	A1203		

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A1203	Continued From page 98	A1203		

hallway on the first floor. The ceiling tile was missing and several tiles nearby had large, brown stains. The leak was significant enough that a mop bucket had been placed under the leak to catch the water. The bucket was full of brown water and floating matter that appeared to be mold.

An interview was conducted with EI#18, Housekeeper, on the morning of June 10, 2024. EI#18 was asked about the bucket positioned under the leak in the hall. EI#18 said the ceiling was leaking when he (EI#18) came to work at the facility seven months earlier.

An interview was conducted on the morning of June 10, 2024, with EI#9. EI#9 said the ceiling had been leaking for over six months. EI#9 said a faucet upstairs had been fixed and now the drain trap was leaking. The surveyor observed degraded wood, water stained wood, and discoloration of wood under the upstairs dining room sink. The delaminating of plywood used in the cabinet construction under the sink demonstrated an ongoing issue. When asked why the stained tiles had not been fixed, EI#9 said it was because they were only five months old.

During an observation on the morning of June 10, 2024, it was noted that of the 72 windows on the first floor requiring screens, 28 screens were displaced in unserviceable condition on the grounds, resulting in 38.8 percent of required screening missing on the first floor. The second floor had 39 windows of which ten (10) window screens were displaced and unserviceable on the grounds, resulting in 25.6 percent of required screening missing on the second floor.

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A1203	Continued From page 99 On the afternoon of June 17, 2024, EI#9 said the concern of ceiling tiles missing was that fire and smoke may not be contained.	A1203		
A1205	420-5-20-.12 (7) Physical Environment (7) Building Requirements - Congregate Specialty Care Assisted Living Facility. (a) General. Congregate specialty care assisted living facilities licensed, constructed, or renovated under the currently adopted codes shall comply with the building code and the requirements for limited care facilities in the "New Health Care Occupancies" Chapter of the Life Safety Code (excluding NFPA 101A Alternative Approaches to Life Safety). Facilities or portions of facilities, built under previously adopted editions of the codes shall comply with the currently adopted requirements for limited care facilities in the "Existing Health Care Occupancies" Chapter of the Life Safety Code (excluding NFPA 101A Alternative Approaches to Life Safety). (b) Exit doors. Panic hardware shall be installed on all exit doors, except where electrically controlled door hardware is used in accordance with other provisions of these rules. (c) Corridors and Passageways. Corridors and passageways shall be unobstructed and shall not lead through any room or space used for a purpose that may obstruct free passage. (d) In new construction, the temperature of hot water accessible to residents shall be automatically regulated by tempering valves and	A1205		

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A1205	Continued From page 100 a circulating pump system, unless the water heater is dedicated to resident use. (e) Utility rooms shall be provided for each floor of Congregate specialty care assisted living facilities. The following equipment shall be provided: 1. Paper towel holder with an adequate supply of paper towels. 2. Wall cabinet or shelves. 3. Table or counter. 4. Soap dispenser with soap. 5. Sink - counter top, wall or floor mounted. 6. Space and facilities for cleaning equipment and supplies. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to have panic hardware in working order on a fire exit door and fire compartment doors did not seal. Findings: On morning of June 13, 2024, during a test of the fire alarm system, the surveyor observed that all fire doors did not seal as required. A 1/4 inch to 1/2 inch gap was present around door seals and joints on all fire doors in the hallways. An observation was made on the morning of June	A1205		

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A1205	Continued From page 101 17, 2024, of smoke barrier doors with to much space under the doors and an exit door adjacent to the back hallway elevator (by empty room 143) with missing panic hardware (the bar pushed to gain access and exit the building). During this observation, EI#24, Captain with the Mobile Fire Department's Community Risk Reduction unit, said the smoke compartment doors had to much of a gap under them for containment of smoke and fire. He added all fire exit doors are required to have panic hardware. On the afternoon of June 17, 2024, EI#9 said the concern of panic hardware missing from a fire exit door was that residents might look at the door and think it did not work.	A1205		
A1206	420-5-20-.12 (8) Physical Environment (8) Additional Requirements for Specialty Care Assisted Living Facilities. (a) Facilities shall be certified and licensed for housing residents with dementia, and must comply with these special requirements for the physical plant. Facilities should confirm local code requirements, which may vary from those indicated below. (b) Additional Smoke Detection. Smoke detectors (electrical or system type) shall be provided in the sleeping rooms and any bedroom suite sitting areas, which house dementia residents. These detectors shall initiate at least a local alarm or supervisory signal, through the fire alarm system or call system. (c) Windows in specialty care facilities	A1206		

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A1206	Continued From page 102 may have devices which prevent opening of the window. (d) Areas to Wander and Secure Perimeter. 1. Each facility shall have a secure boundary or perimeter to safely accommodate residents in all aspects of its physical plant. Exterior building walls and doors, and walled or fenced outdoor areas may form this boundary. Such walls or fences shall be at least six feet high. 2. Each walled or fenced area shall have at least one gate, located along the discharge path of travel from the building egress doors to the public way. Gates shall be readily unlockable from either side by the staff or by automatic means. "Automatic means" shall be in the same manner as locked or delayed-egress exit doors. 3. If the facility's emergency plan utilizes fenced or walled outdoor spaces as refuge areas for containment of residents, each refuge area shall be of sufficient size to accommodate all occupants at a distance of not less than 50 feet from the building while providing a net area of 15 square feet per person. A gate shall be located within this refuge area. 4. If the facility's emergency plan uses the fenced or walled outdoor spaces merely as areas that are immediately passed through and exited, not as refuge areas for containment of residents, there is no size or area requirement for the fenced or walled spaces.	A1206		

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A1206	Continued From page 103 5. An outdoor courtyard, which is completely surrounded by the building, must have at least two separate doorways, located remotely from each other, leading into separate smoke compartments of the building. (e) Locking of Exit Doors. Locks on exit doors of each specialty care assisted living facility, if installed, shall be electrical locked or electrical delayed-egress locking devices. Buildings shall be protected throughout by an approved supervised automatic sprinkler system connected to the fire alarm system. 1. Delayed-egress locks must comply with the requirements for "Special Locking Arrangements" found in NFPA 101 Life Safety Code. 2. Electrically locked doors shall comply with the following: (i) A control panel shall be provided at one or more stations with the capability to remotely unlock all exit doors, simultaneously. Locks may be arranged to unlock in Specialty Care compartments based on a zoning concept, where each zone is a rated fire or smoke compartment and the locks on all egress doors unlock within the alarmed zone or compartment. This zoning concept is permitted to apply to automatic functions required by the Life Safety Code. (ii) A key, code, or card release switch shall be provided inside the facility at each locked door, which shall override the locking system to allow exiting from the compartment or building.	A1206		

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A1206	Continued From page 104 (iii) All locks shall release automatically upon activation of the facility fire detection, or fire sprinkler system, or upon disablement of the fire alarm system. (iv) Locks shall release automatically upon loss of electric power controlling the lock. (v) The facility shall provide the residents sponsors with adequate information about the facility's door locking arrangements. (vi) The facility shall assure, at least monthly, that locked or delayed-egress exit doors function properly, in accordance with required fire safety provisions. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure all exit door locks released automatically upon activation of the fire alarm system, failed to ensure staff were able to utilize the fire alarm monitoring system and failed to ensure staff knew how to access the emergency release "kill switch." These failures put all 39 residents at risk for significant harm. Findings: On June 12, 2024 at 11:20AM, the surveyor asked EI#12, LPN, if she knew where the control panel with the "kill switch" that simultaneously unlocks all exit doors, was located. EI#12 said she did not know but she would call someone to ask. Later that morning, EI#5 was asked to activate the control panel "kill switch." EI#5 did not know the code to the nurses' station to	A1206		

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A1206	Continued From page 105 access the control panel. EI#5 was headed to her office to search for the code to the nurses' station when EI#16, a Resident Assistant, opened the door to the nurses' station. EI#5 entered the office and activated the switch. The surveyor observed the exit door adjacent to room 248 did not release when the "kill switch" was activated. On morning of June 13, 2024, during the fire alarm system test it was observed that the fire exit door adjacent to Room 248 did not release upon activation of the fire alarm system as required. On the morning of June 17, 2024, an observation was made of the fire doors during activation of the fire alarm system requested by the mobile fire department on-site inspectors. The fire doors on the hall with rooms 220s and 260s and the fire doors on the hall with rooms 230s and 250s did not automatically release and close as required. At that time EI#23, Captain with the Mobile Fire Department, said the smoke compartment doors should release automatically with fire alarm activation. On June 18, 2024 at 10:15 AM, EI#23 contacted the ALF unit supervisor and said an inspection was conducted at the facility and multiple violations were found. EI#23 said the facility was given two weeks to make all the necessary corrections. Violations included, gaps under the fire doors, missing ceiling tiles, sprinkler heads that were painted over, doors that did not release with activation of the fire alarm system and a blocked exit way. The fire alarm system panel was operational at that time.	A1206		

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A1206	Continued From page 106 CYNTHIA GRANGER, REGISTERED NURSE THERESA HARRISON, REGISTERED NURSE GREGORY ZEITLIN, REGISTERED NURSE	A1206		