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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CHASE OF HUNTSVILLE SPECIAL C	4801 WHITESPORT CIRCLE HUNTSVILLE, AL 35801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments On July 6, 2023, an unannounced complaint investigation was conducted for this 52 bed Specialty Care Assisted Living Facility (SCALF) with a census of 32. There was one (1) complaint investigated during this survey. LC#20230627007 was unsubstantiated. Deficiencies were cited as a result of the complaint investigation. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practices resulted in the potential for harm to all residents and require a plan of correction.	A 000		
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 1	A 401		

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 cardiopulmonary resuscitation (CPR).

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A 401	Continued From page 2 (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 observations and interviews, the facility was not staffed to meet the minimum staffing requirements 24 hours a day, 7 days at week.	A 401		

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A 401	Continued From page 3 THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged a resident had symptoms which caused suspicion of possible abuse, resulting in the resident being sent to the the hospital for evaluation and police called to the facility. The following deficient practice was cited as a result of the investigation of this complaint. The SCALF unit of the facility was divided into two sections, one located on the first floor and one located on the third floor of the building. An onsite complaint investigation was conducted on the third floor section of the SCALF unit. This section contained sixteen available beds and fifteen current residents. The first floor section of the SCALF contained thirty rooms with seventeen current residents (one resident was out of the facility). The following residents were observed in the third floor section of the SCALF unit. Resident Identifier (RI)#1 was basically bedbound and required total care including turning every two hours, incontinent care and a total lift by at least two people to transfer. Refer to deficiencies 508, 604, 611 and 621 for additional information on RI#1. RI#2 wandered most of the day and night and would enter other residents' rooms, sitting on their furniture and lying in their beds. RI#2 required almost constant supervision due to wandering behaviors and the need for redirection. RI#3 was new to the facility (admitted May 24, 2023) and staff reported he/she had been uncooperative with personal care, sometimes	A 401		

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being verbally aggressive to staff and requiring two people to assist with care. RI#3 required the use of a wheelchair for mobility as well as assistance to stand and was currently receiving physical therapy to increase strength and mobility.

Review of facility staffing schedules for May, June and July 2023 revealed two Care Partners were scheduled to work on the third floor SCALF at all times. In addition, a nurse was scheduled to work at all times between the first and third floor SCALF units. However, interviews with staff on July 5 and 6, 2023 revealed there were not always two Care Partners on the unit and were not always two staff members on the unit. Interviews with EI#3 (Registered Nurse), EI#6 (Licensed Practical Nurse) and EI#7 (Licensed Practical Nurse) revealed the nurses were always assigned to work both of the SCALF units (first and third floors). During an interview on July 5, 2023, EI#3 stated that, if there was a cancellation and only one Care Partner was left on a unit, the nurse was assigned to be on that unit as the second person. When the nurse left the assigned unit to assist on another unit, a staff member from another unit was to come to the third floor and assist until the nurse returned. However, EI#3 stated this did not always happen and the unit would be left with only one staff member. During an interview on July 5, 2023, EI#7, Licensed Practical Nurse, stated that she (EI#7) had been assigned to be the second staff member on the third floor at times when a Care Partner canceled. EI#7 further stated that she (EI#7) would leave the third floor unit and go to first floor as needed, leaving only the one Care Partner on third floor during that time. During interviews on July 5 and 6, 2023, EI#8, EI#12 and EI#13 all stated they had worked alone for

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A 401	Continued From page 5 varying periods of time on the third floor SCALF when the second Care Partner canceled a shift and the nurse had to leave the unit. The facility failed to maintain even the minimum staffing ratio at all times. In addition, at least two residents of the third floor SCALF required two person assistance and at least one resident required frequent monitoring due to wandering behaviors. All residents of the third floor SCALF were at increased risk of harm or injury due to inadequate staff available to meet the care and safety needs of the residents. On July 6, 2023, these staffing concerns were discussed with EI#1 and EI#2. Both EI#1 and EI#2 agreed at least two staff should be available on the unit at all times and provided the surveyor with an updated schedule which included proper staffing.	A 401		
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 unknown origin that was unusual or suspicious in nature such as extensive bruising, pain, or injury	A 508		

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A 508	Continued From page 6	A 508		

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 Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or

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A 508	Continued From page 7 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 incident occurred.	A 508		

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A 508	Continued From page 8 (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 connection with the investigation.	A 508		

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(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.

(iv) A fire, earthquake, storm, other act of

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A 508	Continued From page 10 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 the following:	A 508		

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A 508	Continued From page 11 (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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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to timely complete an investigation of an incident involving suspected abuse of a resident. In addition, the facility failed to implement actions to prevent the occurrence of similar incidents in the future.

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

Findings:

The Alabama Department of Public Health received a complaint which alleged a resident had symptoms which caused suspicion of possible abuse, resulting in the resident being sent to the the hospital for evaluation and police called to the facility. The following deficient practice was cited as a result of the investigation of this complaint.

Review of facility records, hospice records and hospital records as well as observations on July 5 and 6, 2023 revealed the following information.

Resident Identifier (RI)#1 had resided at the facility since May 26, 2021 and had diagnoses which included hypertension, hypothyroidism, vitamin D deficiency, congestive heart failure, cognitive decline and chronic kidney disease. RI#1 was basically bedbound, requiring a total lift to transfer from the bed to a wheelchair. RI#1 was unable to reposition self in the bed and required turning every two hours as well as incontinent care and bathing. RI#1 had a history of recurrent vaginal infections since May 2023

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and had previously been treated for the infections at the facility. RI#1 was currently receiving hospice services at the facility. Refer to deficiencies 401, 604, 611 and 621 for additional information on RI#1.

On June 23, 2023, a visit was made to RI#1 by the hospice nurse. During the visit, vaginal drainage with odor was noted as well as bruising to the left arm and bilateral shoulders. Employee Identifier (EI)#3 was called to the room to observe the findings and the nurse practitioner was notified of findings by phone. Arrangements were made to send RI#1 to the emergency department for further testing due to "not having supplies needed for tests that need to be done". 911 was called and arrangements made for non-emergency transport to the hospital. A physician's order was later obtained to transfer RI#1 to the hospital "for further evaluation of vaginal infection not resolved with oral antibiotics".

Following evaluation of RI#1 in the emergency department and discussion with RI#1's family, a decision was made to treat RI#1 for vaginitis and a urinary tract infection and abuse was not substantiated.

On July 6, 2023, the surveyor interviewed EI#1 and EI#2 regarding the above incident and allegation of abuse. Both EI#1 and EI#2 stated the facility was unaware of an abuse allegation until the police and emergency transport arrived at the facility on June 23, 2023. EI#2 stated he (EI#2) requested and received a physician's order from hospice to transport RI#1 to the hospital before RI#1 was sent out. When questioned by the surveyor on July 6, 2023, EI#2 stated an investigation of the incident which occurred on

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HARBOR CHASE OF HUNTSVILLE SPECIAL C	4801 WHITESPORT CIRCLE HUNTSVILLE, AL 35801

(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 508	Continued From page 14 June 23, 2023 had not been completed and actions had not been implemented to prevent a recurrence of the incident. EI#2 also stated the incident had not been reported to the Department of Human Resources as required. EI#2 had been employed at the facility for only four weeks at the time of the onsite survey. EI#2 stated he (EI#2) had attempted to submit a report of the incident to the Alabama Department of Public Health but was unsure if the report had gone through to the Department. The report was not found on the Department's Online Incident Reporting System.	A 508		
A 604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility RN or care coordinator shall screen prospective residents for eligibility for admission into the specialty care assisted living facility. The screening shall include a clinical history, a mental status examination to include aphasia screening, a geriatric depression screen, a physical self-maintenance screen, and a behavior screen. Appendix A herein, contains the Physical Self Maintenance Scale (PSMS) form and the Behavior Screening form. These forms shall be completed to screen physical functioning and behaviors. The PSMS and Behavior Screen assessments shall be completed by the RN or care coordinator upon admission, annually, and when there is a change in the resident's status. The facility RN shall perform a comprehensive assessment of each prospective	A 604		

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A 604	Continued From page 15	A 604		

resident for facility eligibility. This assessment shall document identified care needs and serve as a baseline for the RN plan of care and future assessments.

(b) Monthly Assessments. The RN shall assess each resident monthly and more often when necessary to identify changes in the resident's health status. The monthly assessment shall include a review of monthly weights, falls, incidents, elopements, behavioral symptoms, medications, changes in resident status, and appropriateness of the resident's plan of care.

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

1. Weight loss:

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

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

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A 604	Continued From page 16 such diet has been approved by the resident's attending physician. 2. Falls (two or more falls within a 30 day period). 3. Elopement. 4. Any sign and symptom of adverse drug reaction, interaction or over sedation, or circumstances which contraindicate medications that have been prescribed for the resident. 5. Unmanageable, combative, or potentially harmful behavior(s). 6. Any accident with injury. (d) Focused Assessments. The RN or LPN shall conduct focused assessments when necessary to identify changes in resident status. (e) Any change in resident status requires immediate documentation and implementation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility nurses failed to properly assess a resident following a significant change in the resident's condition. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings:	A 604		

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A 604	Continued From page 17	A 604		

The Alabama Department of Public Health received a complaint which alleged a resident had symptoms which caused suspicion of possible abuse, resulting in the resident being sent to the the hospital for evaluation and police called to the facility. The following deficient practice was cited as a result of the investigation of this complaint.

RI#1 had resided at the facility since May 26, 2021. Refer to deficiencies 401, 508, 611 and 621 for additional information on RI#1. RI#1 was sent to the hospital on June 23, 2023 for evaluation of vaginal discharge and suspicious bruising found by the hospice nurse during a visit to RI#1 at the facility. At the hospital, RI#1 was diagnosed with vaginitis, vulvovaginitis and a urinary tract infection and was placed on antibiotics.

Review of RI#1's facility record on July 5, 2023 revealed no comprehensive assessment, PSMS and Behavior Screening had been documented for RI#1 following this significant change in condition. The most recent comprehensive assessment of RI#1 was documented on May 17, 2023 when RI#1 was treated for a vaginal discharge. A PSMS for RI#1 was completed that same date and documented a total score of 22 with a score of 5 in Physical Ambulation (bedridden more than half the time) which is above the level allowed in a SCALF. RI#1 had also been treated for vaginal discharge again on June 7, 2023 but no comprehensive assessment, PSMS and Behavior Screening were documented at that time.

When interviewed on July 5, 2023, EI#3, Registered Nurse and Care Coordinator, stated some of the assessments had not been

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A 604	Continued From page 18 completed because she (EI#3) had been away from the facility.	A 604		
A 611	420-5-20-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. The RN shall develop written plans of care for each resident prior to or at the time of admission. The plans of care shall be based on resident's assessments, diagnoses, and recommendations of the resident's physician. The plan of care shall be developed in cooperation with the resident, if appropriate, and the sponsor. The RN shall identify resident care problem areas and formulate written interventions to address those problems. The RN shall evaluate the implementation of the interventions and the resident's response to the interventions and modify the plan of care as necessary. 1. The plan shall at all times reflect the current condition of the resident. All entries on the plan of care shall be accurately dated. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following: 2. A listing of the resident's individual needs or problems that require intervention by the facility.	A 611		

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3. A listing of interventions provided by the facility to address the resident's identified needs or problems.

4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider.

5. Activities of Daily Living. Residents of a specialty care assisted living facility shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident.

(i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested.

(ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips.

(iii) Hair. Residents' hair shall be kept clean, neat, and well groomed.

(iv) Manicure. Fingernails and toenails shall be kept clean and trimmed.

(v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed.

(vi) Personal Safety. Residents shall be

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A 611	Continued From page 20 provided assistance with personal safety. 6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility Registered Nurse failed to maintain a current and appropriate care plan for a resident. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged a resident had symptoms which caused suspicion of possible abuse, resulting in the resident being sent to the the hospital for evaluation and police called to the facility. The following deficient practice was cited as a result of the investigation of this complaint. RI#1 had resided at the facility since May 25, 2021. Refer to deficiencies 401, 508, 604 and 621 for additional information on RI#1. Review of RI#1's facility record, including care plan, and observations of RI#1 during the onsite survey revealed the following discrepancies on RI#1's facility care plan. RI#1's current care plan was dated February 28, 2023. RI#1 was bedbound except when totally lifted	A 611		

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A 611	Continued From page 21	A 611		

from the bed to the wheelchair by at least two people. RI#1 had to be turned and repositioned every two hours while in the bed and had to be transferred to the wheelchair by staff to obtain a weight on the chair scales. RI#1's PSMS scores on April 21, 2023, on May 10, 2023 and on May 17, 2023 documented a 5 in Physical Ambulation (bedridden more than half the time). RI#1's facility care plan stated RI#1 was "independent with transfers, independent with ambulation, used no assistive devices". RI#1 did not even have possession of a wheelchair needed for obtaining weights. When staff were observed on July 5, 2023 transferring RI#1 to the wheelchair, a wheelchair had to be borrowed from facility stock and taken to RI#1's room.

RI#1 was totally dependent on staff for bathing, dressing, toileting and grooming. A sign posted on the wall in RI#1's room instructed staff to turn RI#1 every two hours and change RI#1 every shift. RI#1's facility care plan indicated RI#1 required only minor hands-on assistance with bathing, dressing, grooming and toileting and needed verbal reminders every 2 hours while awake for toileting.

RI#1 was treated for vaginal discharge at least three different times on May 16, 2023, on June 7, 2023 and on June 23, 2023. Suspicious bruising was noted to RI#1's arm and shoulders on June 23, 2023, in addition to the vaginal discharge, and required evaluation at the hospital. These significant changes were not addressed on RI#1's facility care plan with appropriate interventions to prevent a recurrence.

When questioned about resident care plans on July 6, 2023, EI#3 stated she (EI#3) had not worked recently and residents' care plans may

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A 611	Continued From page 22 not have been updated.	A 611		
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 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.	A 612		

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A 612	Continued From page 23 (f) Appointments. Residents shall be assisted in making and keeping appointments. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to develop and implement a specific activity program for a resident whose wandering behaviors were unmanaged and infringed on the rights of other residents. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged a resident had symptoms which caused suspicion of possible abuse, resulting in the resident being sent to the the hospital for evaluation and police called to the facility. The following deficient practice was cited as a result of the investigation of this complaint. RI#2 was admitted to the facility on May 20, 2021 and had diagnoses which included seizures, hyponatremia, pulmonary emphysema, chronic obstructive pulmonary disease, Alzheimer's dementia with behavioral disturbance, hypertension, insomnia, anxiety, agitation and depression. RI#2 was observed very frequently during the onsite survey wandering about the facility. RI#2 would push on exit doors and enter other residents' rooms. RI#2 would also touch	A 612		

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other residents with his/her hands and poke them with his/her fingers. Other residents appeared to become agitated by these behaviors at times. All staff interviewed reported they had seen RI#2 in other residents' rooms. Multiple staff reported RI#2 had been found sitting in other residents' chairs in their rooms or lying down in their beds. In addition, staff reported RI#2 had been found asleep in RI#1's bed, lying across RI#1's legs at least two times. RI#1 was primarily bedridden, required total care and would be unable to call for assistance or remove self from the situation when this occurred. During observation of RI#1's incontinent care and transfer to wheelchair on July 5, 2023, RI#2 entered the room three different times and had to be redirected by staff to leave the room.

On the morning of July 6, 2023, RI#2 complained about being very tired and the care partners reported RI#2 had been up all night the previous night. RI#2 was observed to be cooperative with redirection but would immediately resume the wandering behavior when left alone. RI#2 had a history of agitation in February 2023 and required medication adjustments in an attempt to manage the agitation in April and June 2023. RI#2 was admitted to inpatient Behavioral Health for evaluation and treatment on March 12, 2023. RI#2 also had medication changes in May 2023 due to restlessness.

RI#2's facility care plan did not address RI#2's wandering. No interventions had been developed and implemented to manage RI#2's wandering and prevent injury to RI#2 or other residents or a possible elopement. When questioned about resident care plans on July 6, 2023, EI#3 stated she (EI#3) had not worked recently and residents' care plans may not have been updated.

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A 621	420-5-20-.06 (9) (b) Care of Residents. (b) Retention. 1. A specialty care assisted living facility shall not allow any resident to return to the specialty care assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the specialty care assisted living facility is licensed to provide or the facility is capable of providing. 2. A specialty care assisted living facility shall not retain a resident that has a PSMS score greater than 23 or a score of five in feeding, dressing, grooming, bathing or a score of four or five in physical ambulation. 3. A specialty care assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility. 4. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in a specialty care assisted living facility. 5. A specialty care assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless: (i) The individual is capable of performing and does perform all tasks related to his or her own care; OR (ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity	A 621		

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but the individual has sufficient cognitive ability to direct his or her own care and the individual is able to direct facility staff and does direct facility staff to provide the physical assistance needed to complete such tasks, and the facility staff is capable of providing such assistance and does provide such assistance. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff.

6. If a resident of a specialty care assisted living facility is diagnosed with a terminal illness and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90 days. If the facility is unable or becomes unable to meet the needs of a resident receiving hospice care, or if a resident receiving hospice care requires care beyond what the facility may lawfully provide pursuant to this section, then the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for specialty care assisted living facilities.

The facility would in all cases remain responsible for ensuring the appropriate delivery of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident.

This Rule is not met as evidenced by:
Based on observations, interviews and record

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reviews, the facility retained residents who did not meet the criteria for continued stay in a SCALF.

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

Findings:

The Alabama Department of Public Health received a complaint which alleged a resident had symptoms which caused suspicion of possible abuse, resulting in the resident being sent to the the hospital for evaluation and police called to the facility. The following deficient practice was cited as a result of the investigation of this complaint.

RI#1

RI#1 had resided at the facility since May 26, 2021. Refer to deficiencies 401, 508, 604 and 611 for additional information on RI#1. At the time of the onsite survey, RI#1 was primarily bedbound and required a total lift by two or three people to transfer from the bed to a chair. Once seated in the chair, RI#1 was supported with pillows to prevent leaning to one side. RI#1 was totally dependent on others for bathing, grooming, dressing and toileting. RI#1 required meal set up and some assistance to eat. RI#1 slept much of the time. RI#1 had scored a 5 in Physical Ambulation (bedridden more than half the time) on PSMS assessments since April 21, 2023 which is above the level allowed in a SCALF. RI#1 was currently receiving hospice services at the facility and was admitted to hospice in June 2022. No 30-day discharge notice had been issued to RI#1 at the time of the onsite survey. When interviewed on July 6, 2023, EI#3 stated she (EI#3) thought RI#1 was allowed to remain at

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HARBOR CHASE OF HUNTSVILLE SPECIAL C	4801 WHITESPORT CIRCLE HUNTSVILLE, AL 35801

(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 621	Continued From page 28	A 621		

the facility without meeting SCALF criteria since RI#1 was receiving hospice services.

RI#2

RI#2 had resided at the facility since May 20, 2021. Refer to deficiency 612 for additional information on RI#2. RI#2 wandered much of the time throughout the facility and entered other residents' rooms. RI#2 was observed pushing on exit doors and touching or poking other residents with his/her hands, sometimes causing other residents to become startled or agitated. All staff who were interviewed verbalized concern about RI#2's wandering as well as RI#2's safety due to becoming tired from walking and the potential for falls. In addition, staff verbalized concern that other residents may become verbally or physically aggressive toward RI#2 since RI#2 was frequently found in other residents' rooms sitting on their furniture or lying in their beds. EI#13 reported she (EI#13) had found RI#2 on two different occasions asleep across RI#1's legs in RI#1's bed. RI#2 had also been found in RI#1's bathroom and had turned on the shower causing the floor to flood. Although RI#2 could usually be easily redirected, RI#2 would resume the wandering behaviors as soon as staff left the area. RI#2 was also observed during the survey pouring a glass of water on the floor under the dining table and chewing on a large piece of bandage material.

At the time of the onsite survey, there were no measures documented for staff to follow for management of RI#2's behaviors. No 30-day discharge notice had been issued to RI#2. EI#1 stated the facility had discussed transferring RI#2 to the other SCALF unit in the same building which may be a better fit for RI#2. No definite

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P4501	A. BUILDING: _____ B. WING _____	C 07/06/2023

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A 621	Continued From page 29 plan had been implemented for RI#2 to protect RI#2 as well as other residents from injury or harm. CONNIE CHERRY, REGISTERED NURSE	A 621		