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HERITAGE ASSISTED LIVING	11682 COUNY LINE ROAD MADISON, AL 35756

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A 000	Initial Comments This is a 31 bed Assisted Living Facility (ALF) with a census of 24 on August 10, 2023. There were three (3) complaints investigated during this unannounced licensure and complaint investigation survey. LC#20200717007 was unsubstantiated. LC#20230719016 and LC#20200429002 were substantiated and deficiencies were cited as a result of the complaint investigations. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities. The deficient practices placed all 24 residents of the facility at significant risk of harm and require a plan of correction.	A 000		
A 301	420-5-4-.03 (1) (a) (b) (c) (d) Administration. The Assisted Living Facility Governing Authority. (a) An 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	A 301		

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ownership interest of 10 percent or more in the real property or building used by the assisted living facility to offer its services.

3. Each officer and each director of the corporation if the governing authority is a 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 observations, interviews and record reviews, the governing authority failed to ensure the facility operated in compliance with the SBOH

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rules for ALFs. The governing authority's lack of adequate oversight resulted in widespread deficient practices which placed all 24 residents of the facility at significant risk for harm due to this failure to apply the SBOH rules for the day to day operations of the facility.

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

Findings:

The Alabama Department of Public Health received two complaints which were substantiated during the onsite survey. The complaints alleged residents were ineligible, there was a lack of management at the facility, food supply and portions of food served were inadequate, repairs to building were not completed and staff had to purchase food for residents. Numerous additional deficient practices were identified during the onsite survey.

At the time the surveyor entered the facility on July 24, 2023, there was no current administrator. In fact, the only management in the facility was Employee Identifier (EI)#3, Office Manager. EI#2 was previously employed as administrator at the facility but had resigned from the facility on August 15, 2022. EI#21 became administrator of the facility on December 1, 2022 and resigned from the facility in May 2023. EI#22 became administrator of the facility on May 25, 2023 and resigned from the facility on June 6, 2023. There had also been no maintenance director at the facility since August 2022. A dietary manager began employment at the facility just prior to the state survey on July 20, 2023. The facility had been without a dietary manager since August 2022. On August 3, 2023, EI#1 reported to the

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surveyor that he (EI#1) had been owner of the facility since August 2022.

The local ombudsman had visited the facility multiple times during the month of July 2023. Multiple concerns were reported by the ombudsman, including inadequate food supply, building leaks and repairs not completed timely, bill not paid, ineligible residents, inadequate portions of food served, lack of staff training and lack of management. Some of these same concerns were also reported in the complaints received by the Alabama Department of Public Health. The ombudsman reported EI#1 had failed to meet with her to discuss concerns at the facility in spite of multiple attempts and requests from the ombudsman.

EI#1 was not present at the facility during the first visit by the state surveyor which was July 24-26, 2023. On August 3, 2023, EI#1 informed the surveyor that he (EI#1) lived only about 1 1/2 hours away from the facility. On the afternoon of July 26, 2023, the surveyor attempted to contact EI#1 by phone but there was no answer. EI#1 left the following phone message for the surveyor that same afternoon. He (EI#1) had been made aware of some issues at the facility by EI#2. There was a new Food Service Director on board and a new Director of Nursing and Executive Director coming on board. A RN was available on call (EI#5) and the phone number for the RN was posted in the break room. The RN from a sister facility (EI#4) could be sent to assist if needed. EI#1 wanted the surveyor to know that he (EI#1) was working hard and it looked like everything had "hit the fan". When he (EI#1) thought he (EI#1) had a new director, then the director quit with no notice in less than ten days. EI#1 stated "I am not trying to make excuses. As I learn every

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day, it is hard." On August 3, 2023, EI#1 informed the surveyor the Director of Nursing had not been hired.

EI#1 was interviewed on the morning of August 3, 2023, during the surveyor's second visit to the facility. When asked about the widespread deficient practices at the facility, EI#1 stated he (EI#1) had been working hard to get things in order. EI#1 stated all food concerns had been addressed and EI#6, Dietary Manager, had been rehired. In addition, a new Executive Director had been hired and began employment that day. EI#1 denied that he (EI#1) had any knowledge of food issues until informed by EI#2. EI#2 had also made EI#1 aware that gloves were not supplied to staff consistently. EI#1 stated EI#7 had been in charge of ordering food and gloves and was not ordering sufficient amounts timely. EI#1 stated that EI#22, previous administrator, had spoken with the local ombudsman about four weeks ago regarding the ombudsman's concerns at the facility. However, EI#1 was not notified of the "action items" provided by the ombudsman to EI#22 but began working on the items as soon as he (EI#1) became aware. EI#1 again stated that EI#5, RN, was available by phone and could come to facility as needed to perform resident assessments. The surveyor explained to EI#1 that multiple staff (EI#3, EI#8 and EI#10) had reported to the surveyor that there was no one on call and no RN available. On August 8, 2023, EI#3, Office Manager, stated that she (EI#3) took calls frequently at night because there was no nurse available on call. EI#3 added that she (EI#3) was aware of EI#5's phone number being posted but was unsure what types of issues that EI#5 was to be contacted for. Although EI#5's name and phone number was noted taped to the nurses' desk, the ombudsman reported to the

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surveyor (on August 8, 2023) that this information was just posted within the past two weeks after the ombudsman's visits and recommendations to the facility. During the interview on August 3, 2023, EI#1 stated EI#4, RN, would be at the facility Monday, Wednesday and Friday until a new RN/DON was hired.

On August 3, 2023, the surveyor requested from EI#1 a statement/bill indicating payment to the facility's current food supplier. This had previously been requested two times from EI#3 on July 24 and 25, 2023 but had not been provided. EI#1 provided the statement that same day which showed a 0-30 day balance of $4799.60 and a 31-60 day balance of $1031.44. When asked about the 60 day balance, EI#1 stated there was a 60-day revolving account and the bill was not past due if paid within 60 days.

On the afternoon of August 7, 2023, EI#1 left a phone message for the surveyor stating he (EI#1) would be at the facility later that evening. The surveyor was at the facility on August 7 and 8, 2023 and EI#1 did not come to the facility during that time. On August 8, 2023 around 2:00 PM, the surveyor and EI#2 attempted to call EI#1 to discuss deficiencies and conduct a survey exit. There was no answer and no return call from EI#1.

On the morning of August 10, 2023, the surveyor received a phone call from EI#2 and EI#26, Owner. EI#26 stated he (EI#26) had been unable to work and be at the facility recently and EI#1 had been the managing partner of the ownership. EI#26 added that, beginning immediately, he (EI#26) would take over the management of the facility. On the afternoon of August 10, 2023, the surveyor received an email from EI#1 stating that

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EI#26 would be handling all management duties at the facility. EI#1 added that EI#26's phone number had been posted at the facility and EI#1's phone number had been removed. On August 25, 2023, EI#26 informed the surveyor that the entire bill had been paid to the facility's food supplier. EI#26 also stated he (EI#26) was unsure why EI#1 had not paid the bill.

The following deficient practices were cited during the onsite survey due to a lack of management and oversight of the facility by EI#1.

302 - The facility failed to follow its own policies and procedures.
303 - There was no administrative designee in writing. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.
401 - The facility was not staffed at all times by at least one individual certified in cardiopulmonary resuscitation (CPR). THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.
402 - Employees were not screened prior to hire and prior to resident contact.
405 - Employees were not properly trained. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.
504 - The facility failed to provide a safe and decent environment for residents and visitors at all times. Residents were not provided with personal dignity and privacy. Community standards of care were not followed for residents' care. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.
505 - Financial Agreements were not completed for residents upon admission.
506 - Personal Effects Inventories were not completed upon admission of residents.
507 - Residents' admission records were

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incomplete.
508 - Incidents were not reported timely or not reported at all to the ADPH. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.
601 - Residents' medications were not administered according to physicians' orders.
602 - Residents' Medical Examinations were incomplete or not completed at all.
604 - Health supervision of residents was inadequate.
611 - Residents' care plans were not current and were not followed. Care of residents was not consistent with community standards of care.
613 - A resident who was unable to protect himself/herself from a medication error was not promptly discharged. No licensed nurse was provided to administer medications to a resident who could not protect himself/herself from a medication error. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.
614 - Residents were not given the opportunity to identify their medications.
616 - A system was not maintained to account for controlled substances in the facility's possession.
621 - The facility retained a resident who was unable to direct his/her own care and required skilled nursing care to administer medications. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.
703 - The facility's food supply was inadequate. Portions of food served to residents were inadequate. Snacks were not provided to residents. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.
804 - Temperatures were not monitored consistently in the medication refrigerator.
1101 - Fire drills were not conducted as required.
1203 - Fire extinguishers were not checked

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A 301	Continued From page 8 monthly. Repairs, including leaks, were not repaired timely. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.	A 301		
A 302	420-5-4-.03 (1) (e) Administration. Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). All residents shall be informed of new policies or changes in existing policies that may have bearing on the residents. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies shall cover the following: (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	A 302		

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A 302	Continued From page 9 resident's personal belongings are lost. (vii) What services the facility is capable and not capable of providing. (viii) Medication management. (ix) Infection control. (x) Meal service, timing, menus and food preparation, storage, and handling. (xi) Fire safety and emergency plan, fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness. (xii) Staffing and conduct of staff while on duty. (xiii) Oxygen administration and storage if used in the facility. (xiv) Dietary Policies. The dietitian, with the approval of the administrator, shall 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.	A 302		

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A 302	Continued From page 10 (II) The attire and cleanliness of staff members who prepare, handle, or serve food. (III) A schedule of meals, which shall include between-meal nourishment or snacks, and fluids. (IV) Food substitutions or alternatives. (V) Method to ensure an adequate dietary plan is implemented for any resident with a therapeutic diet or special dietary needs. (VI) Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food. (VII) Provision of necessary services to any resident requiring adaptive devices to eat. (VIII) Procedure for the handling of potentially hazardous foods such as meat, milk, ice, and eggs. (IX) Storage of food. (X) Procedure for food service in the event of a disaster. Disaster menus shall be developed. The policy shall address how food will be obtained and maintained at safe temperatures if electricity is not available. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to follow its own policies for the daily management and operation of the facility.	A 302		

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A 302	Continued From page 11 Findings: According to the facility's Medication Assistance Policy and Procedure, "...Any resident requiring staff assistance with the self-administration of medication must have a reasonable lay person's understanding of the unit dose packaging system in use by the facility such that the resident could likely protect himself or herself from medication errors if unit dose packages are brought to the resident by facility staff...Specific procedures for assisting with medications: Ask the resident to look at the unit dose package and confirm the label...Is this your name?...Is this your medication?...Is it the time you are supposed to take this medication?...No medication shall be left in a resident's room...Upon discharge, all medications shall be returned to the resident and/or sponsor. A statement listing the pharmacy, prescription number, date, resident's name and strength of the medication and amount being returned to the resident must be signed by the family member or responsible party at discharge...Staff shall use the 'Medication Disposition Record of Discharged or Transferred Residents' to record the above...". The facility failed to ensure residents were able to utilize the unit dose packaging system and protect themselves from a medication error. Medications were left in a resident's room. Medication Disposition Records were not completed as required. Refer to deficiencies 504, 613 and 614 for additional information. According to the facility's Incident/Accident and Unusual Occurences Policy and Procedure, "...When an incident...occurs in an assisted living...facility, the facility administrator shall be immediately notified, the facility shall conduct an investigation, and appropriate interventions shall	A 302		

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be devised and implemented immediately. A detailed and accurate report shall be completed within 24 hours of the incident...Report the incident/accident to the Alabama Department of Public Health's Assisted Living Report Hotline within twenty-four (24) hours of the occurrence, if it meets the following criteria: A fracture or an injury resulting in hospitalization, death, EMS activation or a visit to the emergency room...". The facility failed to report incidents as required. Refer to deficiency 508 for additional information.

According to the facility's Meal Timing, Service and Menus Policy and Procedure, "...Policy: To provide meals, fluids, and snacks to the residents that meet the recommended daily dietary allowances from the basic food group pyramid. The meals shall be of the quality and quantity necessary to meet the residents' needs...The diet shall be well-balanced, palatable, properly prepared and sufficient in quantity and quality to meet the nutritional needs of the residents...Snacks shall be available between meal service and upon request...". Snacks were not provided consistently and meals were not always of sufficient quantity. Refer to deficiency 703 for additional information.

According to the facility's Sprinkler and Fire Extinguisher Checks Policy and Procedure, "...Fire drills shall be conducted at least once per month, quarterly on each shift...A visual inspection of each fire extinguisher shall be conducted monthly by the administrator or designated staff and documented on the attached extinguisher tag by the administrator or designated staff...". Fire drills were not conducted monthly and quarterly on each shift. Fire extinguishers were not visually inspected monthly. Refer to deficiencies 1101 and 1203 for

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A 302	Continued From page 13 additional information. According to the facility's Monitoring Resident Nutritional Status Policy and Procedure, "All staff will receive annual training on nutrition and hydration needs of the elderly...When weight loss or intake issues are identified the Administrator will ensure a plan of care is developed to meet the residents' immediate needs...Ongoing assessment and evaluation will take place to ensure interventions are working or need revision. This will be documented on the residents' plan of care and progress notes...". A resident who sustained significant weight loss did not have appropriate interventions documented to prevent additional weight loss and to evaluate the resident's status. Refer to deficiencies 604 and 611 for additional information. When policies were discussed on August 8, 2023, EI#2 agreed the facility's policies had not been followed.	A 302		
A 303	420-5-4-.03 (2) (a) Administration. The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an	A 303		

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A 303	Continued From page 14	A 303		

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.

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

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

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

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

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

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

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A 303	Continued From page 15 transferred or discharged to an appropriate setting. 11. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when needed. 12. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan. 13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained. This Rule is not met as evidenced by: Based on observations and interviews, no administrative designee had been authorized, in writing, to act for the administrator. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged no one was designated to be in charge at the facility. This was confirmed during the onsite survey. At the time the surveyor entered the facility, on July 24, 2023, no one was available to inform the surveyor of who was in charge. A letter, posted on a bulletin board behind the front desk, listed EI#2	A 303		

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A 303	Continued From page 16 (former administrator) as the current administrator and also listed the former RN/DON (EI#20) as the administrative designee. EI#2 resigned from the administrator position and from the facility on August 15, 2022. EI#2 became a consultant at the facility in July 2023. EI#20 resigned from the RN/DON position and from the facility on August 25, 2022. There was no administrator at the time the surveyor entered the facility. An administrator was hired prior to the end of the onsite survey. No individual was authorized in writing to act in the absence of an administrator. EI#2 and EI#3 agreed there was no administrative designee authorized in writing.	A 303		
A 401	420-5-4-.04 (1) (2) Personnel. Personnel. (1) An assisted living facility shall ensure personnel are employed and on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. (a) An assisted living facility shall be staffed at all times by at least one individual who has a current certification in cardiopulmonary resuscitation (CPR). (b) An assisted living facility must be staffed to ensure the safe evacuation of all residents in the event of a fire or emergency. (2) Employee Schedule. An 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.	A 401		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility was not staffed at all times by at least one individual who had current certification in CPR.

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

Findings:

The Alabama Department of Public Health received a complaint which alleged employees were not properly trained. The surveyor was able to substantiate this complaint during the onsite survey.

On August 3, 2023, the surveyor reviewed an employee schedule and a CPR certification list which was provided by EI#3. Only one of the 37 employees at the facility was certified in CPR at the time the surveyor entered the facility on July 24, 2023. The one employee who was currently CPR certified (EI#18) provided activities and worked at the facility during the day shift five days per week. Five staff members had been employed at the facility for less than 90 days and were not required to be CPR certified. However, these staff members worked with other staff members who were not CPR certified, leaving no one in the facility who had current CPR certification. Also, on July 26, 2023, EI#10, Personal Care Attendant (PCA) reported that she (EI#10) had worked alone at the facility on the night of July 14, 2023. EI#10 did not have current certification in CPR. A CPR certification class was held on August 1, 2023 and six additional staff members obtained CPR certification. Prior to

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A 401	Continued From page 18 August 1, 2023, most shifts were not staffed with at least one individual who was currently certified in CPR. In fact, any shift when EI#18 was not working was not staffed with an individual who was currently CPR certified. When interviewed on August 3, 2023, EI#3 stated that CPR certification had not been maintained for employees. An immediate plan of action was requested by the surveyor and obtained from EI#3 to ensure the facility was staffed at all times by at least one individual who was currently certified in CPR.	A 401		
A 402	420-5-4-.04 (3) Personnel. (3) Employee Screening. (a) Prior to any resident contact, such as but not limited to assistance with activities of daily living, newly employed personnel shall have a physical examination certifying that the employee is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to residents through normal staff to resident contact. Employees who develop signs or symptoms of infectious skin lesions or diseases that would be capable of transmission to residents through normal staff to resident contact shall not be permitted to have resident contact until free from such signs and symptoms. (b) Not more than 30 days prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis. (c) Vaccines. Assisted living facilities shall immunize employees in accordance with current recommended Centers for Disease	A 402		

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Control and Prevention (CDC) guidelines (www.cdc.gov/vaccines). Any particular vaccination requirement may be waived or delayed by the State Health Officer in the event of a vaccine shortage.

(d) An assisted living facility shall not hire an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry.

This Rule is not met as evidenced by:
Based on record reviews and interview, employees were not screened for hire as required.

Findings:

On August 2, 2023, employee files were reviewed and the following deficient practices identified.

EI#10 did not have a documented physical examination certifying that EI#10 was free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to residents through normal staff to resident contact.

EI#11 did not have a documented physical examination certifying that EI#11 was free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to residents through normal staff to resident contact. Also, EI#11 did not have documentation of screening for tuberculosis.

Employee files were discussed with EI#3 on the morning of August 3, 2023. EI#3 stated she (EI#3) was responsible for employee screening

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A 402	Continued From page 20 and files. EI#3 added that some physical examinations and tuberculosis screenings had been completed but were sent to the email of a previous administrator which she (EI#3) was unable to access.	A 402		
A 405	420-5-4-.04 (6) Personnel. (6) Training. (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. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained in the facility. 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 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.	A 405		

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A 405	Continued From page 21 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environment safety. 10. Special needs of the elderly, mentally ill, and mentally retarded. 11. Safety and nutritional needs of the elderly. 12. Identifying signs and symptoms of dementia. (b) Cardiopulmonary Resuscitation. An 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 an 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. An assisted living facility equipped with an automated external defibrillator (AED) 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 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 American Red Cross in CPR or AED utilization. (c) If the facility admits or retains	A 405		

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A 405	Continued From page 22 residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training. (d) 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 reviews and interview, employees did not receive required training. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged employees were not properly trained. The surveyor was able to substantiate this complaint during the onsite survey. Employee files were reviewed on August 2, 2023 and the following deficient practices identified. EI#10 had been employed at the facility since June 12, 2023. EI#10 had not completed initial ALF training including the following: State law and rules on ALFs; facility policies and procedures; resident rights; identifying and reporting abuse, neglect and exploitation; basic first aid, advance directives, protecting resident confidentiality; resident fire and environmental safety; special needs of the elderly, mentally ill and mentally retarded; safety and nutritional needs of the elderly; identifying signs and symptoms of	A 405		

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dementia; diabetes training. The facility currently had residents with a diagnosis of diabetes mellitus. During an interview on July 26, 2023, EI#10, PCA, reported she (EI#10) had worked alone at the facility on the night of July 14, 2023 when Resident Identifier (RI)#12 was found by EI#10 on the floor, injured and bleeding. EI#10 reported she (EI#10) was unsure what to do or whom to call for guidance. EI#10 contacted another PCA who was working in the Specialty Care Assisted Living Facility and was instructed by the PCA to call 911. EI#10 stated she (EI#10) had not been trained on how to respond in this situation, placing all residents of the facility at increased risk of harm if treatment was delayed. In fact, EI#10 had not been trained in CPR or even basic first aid.

EI#11 had been employed at the facility since January 28, 2023. EI#11 had not completed initial ALF training including the following: State law and rules on ALFs; facility policies and procedures; resident rights; identifying and reporting abuse, neglect and exploitation; basic first aid, advance directives, protecting resident confidentiality; resident fire and environmental safety; special needs of the elderly, mentally ill and mentally retarded; safety and nutritional needs of the elderly; identifying signs and symptoms of dementia; diabetes training. The facility currently had residents with a diagnosis of diabetes mellitus. EI#11 also did not have current CPR certification.

EI#16 had been employed at the facility since December 2, 2019 and did not have current certification in CPR.

EI#17 had been employed at the facility since June 27, 2018 and did not have current

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A 405	Continued From page 24 certification in CPR. Employee files were discussed with EI#3 on the morning of August 3, 2023. EI#3 stated she (EI#3) was responsible for employee training and files. EI#3 also stated that only seven of the 37 employees were currently certified in CPR and six of the seven employees who were currently CPR certified had completed that certification on August 1, 2023, after the surveyor entered the facility. EI#3 confirmed that initial training and special needs training had not been completed for all employees.	A 405		
A 504	420-5-4-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate. 1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility. 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.	A 504		

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A 504	Continued From page 25 3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy. 4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time. 5. Every resident shall have freedom to participate in and benefit from social, religious, and community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. 6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the premises, an individual account record for each resident shall be maintained by the administrator and an up-to-date record shall be maintained for all transactions. 7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so. 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.	A 504		

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A 504	Continued From page 26 9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident. 10. Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to receive or reject medical care, dental care, or other health care services except those required to control communicable diseases. 11. Every resident shall have the right to at least 30 days prior written notice of involuntary relocation or termination of residence from the facility unless the resident is a patient in a facility providing a higher level of care and no longer meets the eligibility and continued stay requirements in these rules, or for medical reasons the resident is considered by a physician to require an emergency relocation to a facility providing a more skilled level of care, or unless the resident engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record. 12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person without restraint, interference, coercion, discrimination, or reprisal. 13. Every resident shall have the right to	A 504		

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confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file.

14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the facility, provided that:

(i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care.

(ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation; and

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

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

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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 504	Continued From page 28 admission, of all rules and regulations governing residents' conduct and responsibilities. 17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll-free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll-free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area. 18. All state inspection reports and any resulting corrective action plan from the past 24 months shall be posted in a prominent location. If there has been no inspection in the past 24 months, then the results of the most recent inspection and any resulting corrective action plan shall be posted. 19. Every resident shall have the right to 30 days prior written notice to both resident and sponsor of any increase of fees or charges. 20. Every resident shall have the right to 30 days prior written notice of any involuntary change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. 21. Every resident shall have the right to wear his or her own clothes, to keep and use his or her own personal possessions including toilet articles except for personal possessions too large	A 504		

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A 504	Continued From page 29 to be stored in the resident's room. 22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings. 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours and to freely come and go from the home. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide a safe and decent environment for all residents at all times, failed to recognize the need for personal dignity and the need for privacy of each resident and failed to provide health care consistent with established and recognized community standards. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: Safe and Decent Environment The Alabama Department of Public Health received complaints which alleged staff were not	A 504		

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A 504	Continued From page 30	A 504		

properly trained, residents did not meet the requirements to live in an ALF, food served to residents was inadequate and repairs to the building were not completed timely. The survey was able to substantiate these complaints during the onsite survey.

The following deficient practices, which were observed and/or reported by staff during the onsite survey, deprived residents of their right to a safe and decent environment.

Staff were not adequately trained to include training in CPR. The facility was not staffed at all times by at least one individual certified in CPR. Refer to deficiency 401 for additional information.

Medications were not administered to residents according to physicians' orders. Refer to deficiency 601 for additional information.

Residents' were not given the opportunity to identify medications and protect themselves from a medication error. A resident who was unable to identify his/her medications was not promptly discharged and a licensed nurse was not provided to administer medications to this resident. Refer to deficiencies 613 and 614 for additional information.

Residents were not provided bath assistance for as long as five days. Refer to deficiency 611 for additional information.

Residents were not always provided with snacks and adequate portions of food. Refer to deficiency 703 for additional information.

Fire drills were not conducted monthly and fire extinguishers were not checked monthly. Refer to

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A 504	Continued From page 31	A 504		

deficiencies 1102 and 1203 for additional information.

Repairs were not completed timely, including a leak onto wires in the electrical room. Refer to deficiency 1203 for additional information.

Health supervision of residents was inadequate. Residents who sustained significant weight loss or gain were not monitored to determine the effectiveness of the plan of care. Refer to deficiency 604 for additional information.

Due Recognition of Personal Dignity and the Need for Privacy

On August 2, 2023, RI#8 reported he/she had resided in their current room for about three weeks. During the three weeks, RI#8 did not have a bedroom door or a bathroom door to allow for privacy in these areas. In fact, the doors were not installed until August 10, 2023. Refer to deficiency 1203 for additional information.

On August 2, 2023, the surveyor observed medication assistance by EI#8, LPN. Medication assistance was provided to ten residents. The medication cart was left at the nurses' desk. On top of the medication cart was a laptop which contained each resident's personal information, including Medication Assistance Records. With each medication assistance, EI#8 removed the medications from the cart and took the medications to the resident's room. Each time that EI#8 was away from the medication cart, the laptop containing residents' personal information was left open on top of the cart. Anyone passing by was able to read the confidential information on each resident. When interviewed on August 2, 2023, EI#2 agreed the laptop should have been

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A 504	Continued From page 32 closed each time that EI#8 walked away. Health Care Consistent With Established and Recognized Community Standards On August 2, 2023, during observation of medication assistance by EI#8, the surveyor observed two small plastic cups on a table in RI#1's room. One cup contained 12 tablets which RI#1 identified as Fiberlax and the other cup contained 2 tablets which RI#1 identified as a probiotic. RI#1 stated staff would bring the medications to RI#1's room and leave the medications but RI#1 did not want to take them. Facility staff had not followed community standards of care by observing RI#1 swallow the medications with each dose or removing the medications from the room, documenting and notifying RI#1's physician if RI#1 refused the doses. At least two residents did not receive bath assistance for five days. Refer to deficiency 611 for additional information. Facility staff failed to follow community standards of care by not providing adequate personal hygiene to residents. During discussion of deficiencies on August 8, 2023, EI#2 agreed these deficient practices violated residents' rights.	A 504		
A 505	420-5-4-.05 (3) (e) Records and Reports. (e) Financial Agreement. 1. Prior to, or at the time of admission, the administrator and the resident or the resident's sponsor shall execute a written financial agreement. This agreement shall be	A 505		

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A 505	Continued From page 33	A 505		

prepared and signed in two or more copies with at least one copy given to the resident, or sponsor, if the resident did not sign the agreement, and one copy retained in the assisted living facility. This document shall be made readily accessible to personnel from the State Board of Health during inspections.

2. In addition to any information otherwise required by the facility's policies and procedures this agreement shall contain the following:

(i) A complete list of the facility's basic charges (room, board, laundry and personal care and services).

(ii) The period covered by the financial agreement.

(iii) A list of services not covered under basic charges and for which additional charges will be billed.

(iv) The policy and procedures for refunds of any payments made in advance.

(v) The provisions governing termination of the agreement by either party.

(vi) The facility's bed-hold policy, procedures, and charges.

(vii) Documentation that the resident and sponsor understand that the facility is not staffed and not authorized to perform skilled nursing services nor to care for residents with severe cognitive impairment and that the resident and sponsor agree that if the resident should need skilled nursing services or care for a severe

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A 505	Continued From page 34 cognitive impairment as a result of a condition that is expected to last for more than 90 days, that the resident will be discharged by the facility after prior written notice. (viii) A reminder to the resident or sponsor that the local ombudsman may be able to provide assistance if the facility and the resident or family member are unable to resolve a dispute about payment of fees or monies owed. (ix) Signatures of both parties or authorized representatives. 3. Prior to execution of the financial agreement the facility shall ensure that the resident or sponsor fully understands its provisions. In the event that a resident is unable to read the agreement due to illiteracy or infirmity, the administrator shall take special steps to ensure communication of its contents to the resident (for example, by having the administrator or sponsor read the agreement to a vision-impaired or illiterate applicant). This Rule is not met as evidenced by: Based on record reviews and interviews, Financial Agreements were not completed upon admission of residents to the facility. Findings: Review of resident records on August 7 and 8, 2023 revealed the following information.	A 505		

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A 505	Continued From page 35 RI#3 was admitted to the facility on March 17, 2023 and had diagnoses which included left ventricular failure, chronic kidney disease, osteoarthritis, cardiac arrhythmias, anemia, nonrheumatic valve insufficiency, atherosclerotic heart disease, vitamin D deficiency, macular degeneration, hypertensive heart and chronic kidney disease and intervertebral disc degeneration of the lumbar region. Refer to deficiencies 506 and 604 for additional information on RI#3. No Financial Agreement was found in RI#3's facility record. RI#12 was admitted to the facility around July 11, 2023 (the date was unclear as RI#12's resident file was incomplete). On July 24, 2023, EI#3 reported RI#12 had been discharged from the facility but the exact discharge date was also unclear. According to EI#3, RI#12 previously resided at the facility, was discharged home and returned to the facility and was re-admitted. RI#12 had diagnoses which included malignant neoplasm of the brain, encephalopathy, Parkinson's disease, paroxysmal atrial fibrillation, hypothyroidism, history of falls and gastroesophageal reflux disorder. Refer to deficiencies 506, 507 and 508 for additional information on RI#12. No Financial Agreement was found in RI#12's facility record. On August 8, 2023, the surveyor discussed these missing Financial Agreement forms with EI#3, Office Manager. EI#3 stated the forms should be on residents' facility records and probably had not been completed if they were not in the records.	A 505		
A 506	420-5-4-.05 (3) (f) Records and Reports. (f) Inventory of Personal Effects.	A 506		

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A 506	Continued From page 36 1. Upon admission to the assisted living facility, all personal property of the resident with a value in excess of $150, as well as any other property designated by the resident, shall be inventoried by the administrator or by a designee of the administrator in the presence of the resident. 2. All inventories shall be entered on an Inventory of Personal Effects Record. Inventory forms shall be signed by both the administrator, the resident, or if appropriate, the sponsor. One copy of the inventory shall be filed in the resident's individual file and one copy given to the resident or sponsor. 3. In the event the resident has no personal effects, this fact shall be entered on the Inventory of Personal Effects Record. 4. Amendments or adjustments shall be made on all copies of the Inventory of Personal Effects Record each time personal property valued in excess of $150 is brought to the facility, or when personal property is brought to the facility and the resident or sponsor requests that it be added to the Inventory of Personal Effects Record, or when any item on the Inventory of Personal Effects Record is removed from the facility. All amendments shall be signed by the administrator and the resident or sponsor. This Rule is not met as evidenced by: Based on record reviews and interviews, personal property of residents was not inventoried upon	A 506		

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A 506	Continued From page 37 admission to the facility. Findings: Review of resident records on August 7 and 8, 2023 revealed the following information. RI#3 had resided at the facility since March 17, 2023. Refer to deficiencies 505 and 604 for additional information on RI#3. No Inventory of Personal Effects was found in RI#3's facility record. RI#7 was admitted to the facility on July 22, 2023 and had diagnoses which included altered mental status, hypothyroidism, malignant neoplasm of the skin and glaucoma. An Inventory of Personal Effects form was present in RI#7's facility record but the form was not completed. RI#12 was admitted to the facility around July 11, 2023 (the date was unclear as RI#12's resident file was incomplete). Refer to deficiencies 505, 507 and 508 for additional information on RI#12. No Inventory of Personal Effects form was found in RI#12's facility record. On August 8, 2023, the surveyor discussed these missing Inventory of Personal Effects forms with EI#3, Office Manager. EI#3 stated the forms should be on residents' facility records and probably had not been completed if they were not in the records.	A 506		
A 507	420-5-4-.05 (3) (g) Records and Reports. (g) Admission Record. A permanent record shall be developed for each resident upon his or her admission to the facility and updated as	A 507		

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A 507	Continued From page 38 necessary to remain current. This record shall be typewritten or legibly written in ink. In addition to any information otherwise required by the facility's policies and procedures, it shall include the resident's: 1. Name. 2. Date of birth. 3. Sex. 4. Marital status. 5. Social security number. 6. Veteran status. 7. Name, address, and contact information of the resident's sponsor, responsible party, or closest living relative. 8. Name, address, and contact information of any person or agency providing assistance to the resident. 9. Name, address, and contact information of the resident's attending physician. 10. Preferred pharmacy or pharmacist. 11. Date of admission. 12. Date of discharge. 13. Facility, setting, or location to which discharged. 14. Date of death.	A 507		

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A 507	Continued From page 39 15. Cause of death, if known. 16. Religious preferences. 17. Information from insurance policies regarding funeral arrangements and burial provisions. 18. Written documentation that the facility has devised a plan to transfer the resident to a hospital, nursing home, specialty care assisted living facility, or other appropriate setting if and when the facility becomes unable to meet the resident's needs. The resident's preference, if any, with respect to any particular hospital, nursing home, or specialty care assisted living facility shall be recorded. The facility shall keep written documentation that demonstrates the transfer plan has been thoroughly explained to the resident or sponsor, as appropriate, and that the resident or sponsor understands the transfer plan. 19. The written documentation of the procedure to follow in case of serious illness, accident, or death to the resident (including the name and telephone number of the physician to be called, the names and telephone numbers and addresses of family members or sponsor to be contacted, the resident's or, if appropriate, the sponsor's wishes with respect to disposition of personal effects, and the name and telephone number of the funeral home to be contacted). This Rule is not met as evidenced by: Based on record reviews and interviews,	A 507		

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A 507	Continued From page 40 residents' Admission Records were incomplete. Findings: Review of residents' facility records, on August 7 and 8, 2023, revealed the following information. RI#12 was admitted to the facility around July 11, 2023 (the date was unclear as RI#12's resident file was incomplete). Refer to deficiencies 505, 506 and 508 for additional information on RI#12. The following items were not found in RI#12's facility record: admission date; discharge date; written documentation of a plan to transfer to an appropriate setting if necessary; written documentation of the procedure to follow in case of serious illness, accident or death. On August 8, 2023, the surveyor discussed these missing items with EI#3, Office Manager. EI#3 stated the information should be on residents' facility records and probably had not been completed if the items were not found in the records.	A 507		
A 508	420.5.4-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in an assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review.	A 508		

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A 508	Continued From page 41 1. Incidents which require investigation are: (i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as bruising, pain, or injury that is not consistent with actions necessary in providing day to day care to a resident or for which medical treatment was sought. (ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid, including but not limited to: a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office. (iii) The onset of wandering behavior by any resident who is not fully cognitively intact. (iv) Elopement by a resident. (v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. (vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules. (vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules. (viii) An outbreak (for purposes of	A 508		

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A 508	Continued From page 42	A 508		

these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I of Alabama Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or Staphylococcus aureus).

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

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

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

(xii) A medication error, overdose, or over sedation.

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

(xiv) Any indication of malfunction of the sprinkler system, or fire alarm system.

2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following:

(i) Names of all residents involved.

(ii) Names of all staff involved including person in charge at the time of the incident.

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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 508	Continued From page 43 (iii) When the administrator was notified (date and time). (iv) Circumstances under which the incident occurred. (v) When the incident occurred (date and time). (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken. (viii) The extent and description of injury, if any, to the affected resident or residents. (ix) Immediate treatment rendered. (x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified. (xi) Names, telephone numbers, and addresses of witnesses. (xii) Date and time relatives or sponsor were notified. (xiii) Out-of-facility treatment. (xiv) Follow-up care. (xv) Outcome resolution. (xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future.	A 508		

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A 508	Continued From page 44 (xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation. (xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request. (xix) The entire investigative file and documentation of all corrective action taken shall be retained for a period of not less than 3 years after the resident is discharged or dies. (xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff. 3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident: (i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention as defined in these rules. (ii) Elopement by a resident. (iii) Suspected, alleged, confessed, or witnessed abuse, neglect, or exploitation of a resident or residents by staff, visitors, or other 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	A 508		

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A 508	Continued From page 45	A 508		

exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file.

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

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

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

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

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

(ix) Notifiable diseases and health conditions listed in Appendix I of the Alabama Administrative Code Sec. 420-4-1-.04. shall be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1-.04. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than 3 years.

(x) Any indication of malfunction of the

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A 508	Continued From page 46 sprinkler system, or fire alarm system. 4. The report to the Department's Online Incident Reporting System shall include the following: (i) Facility name and direct phone number. (ii) Time and date of the report. (iii) Reporter's name. (iv) Name of resident(s), staff, or visitor(s) involved in the incident. (v) Names of staff on duty at the time of the incident. (vi) Date and time of the incident. (vii) A brief description of the incident. (viii) Any injury or injuries to resident(s). (ix) Action taken by the facility in response to the incident. This Rule is not met as evidenced by: Based on record reviews and interviews, incidents were not reported timely or not reported at all to the ADPH Online Incident Reporting System (OIRS).	A 508		

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A 508	Continued From page 47 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 fell at the facility and no one was available for staff to contact for direction in seeking treatment for the resident. The complaint was substantiated during the onsite survey and the following deficient practices were identified as a result of the complaint investigation. RI#6 RI#6 was admitted to the facility on July 19, 2021 and had diagnoses which included cerebrovascular accident, hypertension, history of syncope and right sided weakness. Refer to deficiency 611 for additional information on RI#6. Review of RI#6's facility record, on August 8, 2023, revealed RI#6 was sent to the emergency department on September 16, 2022 due to a fall and injury to the toe and ankle. The incident was not reported to the ADPH OIRS. RI#11 RI#11 was admitted to the facility on December 31, 2021 and had diagnoses which included atrial fibrillation, osteoarthritis, hypertension, dementia, narcolepsy, hemiplegia, diabetes mellitus II and hyperlipidemia. An incident involving theft of RI#11's possessions occurred while RI#11 resided at the facility on June 9, 2023. The incident was not reported to the ADPH OIRS until June 13, 2023. RI#12	A 508		

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A 508	Continued From page 48 RI#12 was admitted to the facility around July 11, 2023 (the date was unclear as RI#12's resident file was incomplete). Refer to deficiencies 505, 506 and 507 for additional information on RI#12. On July 14, 2023, RI#12 fell at the facility and sustained a head injury which required admission to the hospital. The ADPH became aware of the incident on July 17, 2023 when the surveyor received an email from the administrator at a sister facility, stating that no one at the facility knew the facility identification number to report the incident. The incident was not reported to ADPH until July 20, 2023, three days after the incident occurred. A follow-up email was sent to the facility asking the reason for the late report and the following response was received from the facility, "They did not have facility password to report online". These reportable incidents were discussed with EI#2 on August 8, 2023. EI#2 agreed the incidents should have been reported. Review of incidents reported to the ADPH OIRS on July 24, 2023 showed no incidents were reported from May 7, 2022 until June 9, 2023, greater than one year.	A 508		
A 601	420-5-4-.06 (1) Care of Residents. (1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician. (a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her choice. If the resident is unable to designate an attending physician, or does not wish to	A 601		

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A 601	Continued From page 49	A 601		

designate an attending physician, the facility shall assist the resident in identifying an attending physician who will serve the resident. A resident shall be permitted to change the designation of his or her attending physician at any time. Whenever a resident requires medical attention, an attempt shall first be made to contact the resident's attending physician, except in medical emergencies requiring activation of the local EMS system (911 or another emergency call).

(b) Back-up Physician Support. Each assisted living facility shall have an agreement with one or more duly licensed physicians to serve in those instances when a resident's own attending physician cannot be reached, and to provide temporary medical attention to any resident whose attending physician is temporarily not available. A nurse practitioner or physician's assistant shall not serve as the back-up physician in an assisted living facility.

(c) All physician orders shall be written in accordance with community standards. If verbal orders are used, they are to be used infrequently. A physician verbal order shall only be accepted by an RN or LPN employed by the facility and authorized to do so by facility policy and procedures and state law. All verbal orders shall be reduced to writing on the physicians' order sheet by a licensed facility nurse and shall be dated and signed by the nurse receiving the order. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, or another practitioner who is responsible for the care of the resident and authorized to write orders by facility policy. All verbal orders must be authenticated within such time period as provided by facility policy, but in no

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A 601	Continued From page 50 case shall exceed 30 days following entry of the order. This Rule is not met as evidenced by: Based on record reviews and interviews, residents' medications were not administered as ordered by the residents' physicians. Findings: Review of resident records on August 7 and 8, 2023 revealed the following information. RI#1 RI#1 was admitted to the facility on March 13, 2023 and had diagnoses which included sleep apnea, left diastolic heart failure, hypertensive heart disease, congestive heart failure, anxiety, chronic obstructive pulmonary disease and atrial fibrillation. Refer to deficiency 604 for additional information on RI#1. Review of RI#1's Medication Assistance Records (MARs) for the months of July and August 2023 revealed 82 doses of medications were not taken by RI#1 during July 2023 and 14 doses of medications had not been taken by RI#1 during August 2023. Of the 82 doses of medications not taken by RI#1 in July 2023, 46 were documented as "resident refused" and the other 36 medications were documented as "other" with no specific reason given as to why the medication was not taken. The employees' initials were circled with each omitted dose. There was no documentation that RI#1's physician was aware of the omitted doses. RI#2	A 601		

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A 601	Continued From page 51	A 601		

RI#2 was admitted to the facility on January 25, 2022 and had diagnoses which included anemia, hypertension, osteoarthritis, chronic kidney disease II, chronic obstructive pulmonary disease, low back pain, coronary artery disease, osteoporosis, history of compression fracture and vitamin D deficiency. Refer to deficiency 604 for additional information on RI#2. Review of RI#2's MARs for the months of July and August 2023 revealed 56 doses of medications were not taken by RI#2 in July 2023 and 3 doses of medications had not been taken by RI#2 in August 2023. Of the 56 doses of medications not taken by RI#2 in July 2023, 15 were documented as "resident refused" and the other 41 medications were documented as "other" with no specific reason given as to why the medication was not taken. The employees' initials were circled with each omitted dose. There was no documentation that RI#2's physician was aware of the omitted doses.

Review of RI#2's MARs also revealed the following deficient practice. RI#2 had a physician's order for Gabapentin 100 milligrams three times daily for neuropathy. The Gabapentin was scheduled as morning, midday and afternoon, according to EI#8, Licensed Practical Nurse, with the morning time of 6:01 AM-10:00 AM and the midday time of 10:01 AM-2:59 PM. On August 2, 2023, the morning dose of Gabapentin was given at 11:31 AM, 1 and 1/2 hours after the designated time frame. On July 31, 2023, the morning dose of Gabapentin was given at 10:18 AM, after the designated time frame. EI#8 stated doses were sometimes given late due to medication technicians not showing up timely for work. The morning doses were given in the time frame for the midday doses, placing RI#2 at risk for side effects if doses were

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A 601	Continued From page 52 administered too close together. RI#4 RI#4 was admitted to the facility on May 17, 2016 and had diagnoses which included major depressive disorder, insomnia, seizure disorder, blindness, glaucoma, hypercholesterolemia, dry eyes and osteoarthritis. Refer to deficiencies 604, 611 and 614 for additional information on RI#4. Review of RI#4's MAR for the month of July 2023 revealed 55 doses of medications were not taken by RI#4 in July 2023. Of the 55 doses of medications not taken by RI#4 in July 2023, 11 doses were documented as "resident refused" and the other 44 doses were documented as "other" with no specific reason given as to why the medication was not taken. The employees' initials were circled with each omitted dose. There was no documentation that RI#4's physician was aware of the omitted doses. Review of RI#4's MARs also revealed the following deficient practice. RI#4 had a physician's order for Lacosemide 100 milligrams twice daily and Lacosemide 250 milligrams at bedtime. The twice daily Lacosemide was scheduled as morning and midday, according to EI#8, Licensed Practical Nurse, with the morning time of 6:01 AM-10:00 AM and the midday time of 10:01 AM-2:59 PM. On August 2, 2023, the morning dose of Lacosemide was administered at 10:44 AM, after the designated time frame. On July 31, 2023, the morning dose of Lacosemide was administered to RI#4 at 10:37 AM, after the designated time frame. EI#8 stated doses were sometimes given late due to medication technicians not showing up timely for work. The morning doses were given in the time frame for the midday doses, placing RI#4 at risk for side	A 601		

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A 601	Continued From page 53 effects if doses were administered too close together. RI#5 RI#5 was admitted to the facility on January 30, 2023 and had diagnoses which included cerebral infarction, confusional arousals, chronic kidney disease, chronic systolic congestive heart failure, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, essential hypertension, cognitive communication deficit, and dysphagia. Refer to deficiencies 602, 604, 611, 613, 614 and 621 for additional information on RI#5. Review of RI#5's MAR for the month of July 2023 revealed 60 doses of medications were not taken by RI#5 in July 2023. Of the 60 doses not taken by RI#5 in July 2023, 57 were documented as "resident refused", One was documented as "out of facility" and 2 were documented as "other" with no specific reason given as to why the medication was not taken. The employees' initials were circled with each omitted dose. There was no documentation that RI#5's physician was aware of the omitted doses. On August 8, 2023, the surveyor discussed these deficient practices in medication assistance with EI#2. EI#2 stated staff needed to be retrained. EI#2 also made telephone calls to residents' physicians to obtain specific times for medications to be taken to eliminate the possibility of medications being given too close together.	A 601		
A 602	420-5-4-.06 (2) (a) (b) (c) Care of Residents. (2) Medical Examination Record.	A 602		

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A 602	Continued From page 54 (a) Initial Physical Examination. Not more than 30 days prior to admission of any resident to an assisted living facility, the resident or prospective resident shall be examined by a physician. For purposes of the initial physical examination only, a currently licensed physician in good standing with the Medical Licensure Commission of any state may complete this physical assessment. The physician shall report his or her findings in writing to the facility. In addition to any information otherwise required by the facility's policies and procedures, and in addition to any other information the physician recommends or believes is pertinent, the initial physical examination record shall contain the following: 1. All of the physician's diagnoses, and the resident's baseline weight and vital signs. 2. Medication presently prescribed (name, dosage, and strength of drug, frequency, and route of administration). 3. A statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact. 4. Documentation of evaluation for tuberculosis within the previous 12 months. (b) Annual Physical Examination. In addition to the admission physical examination, each resident shall be examined annually by a physician, and findings from the annual physical examination shall be documented with a copy	A 602		

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A 602	Continued From page 55	A 602		

placed in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent, or recommended by the resident's attending physician, the annual physical examination shall contain the following:

1. The resident's weight and vital signs.

2. Changes in diagnoses.

3. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration).

4. Changes in treatment.

(c) Change of Condition Physician Examinations. Changes in the resident's condition that require a physician examination and result in a change in diagnoses, medications, or treatments shall be reported to the facility and documented in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent, or recommended by the resident's treating physician, this physical examination shall contain a listing of the following:

1. New diagnoses.

2. Changes in condition.

3. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration).

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A 602	Continued From page 56 4. Changes in treatment. This Rule is not met as evidenced by: Based on record reviews and interviews, residents' Medical Examination Records were not completed as required. Findings: Review of resident records on August 7 and 8, 2023 revealed the following information. RI#4 had resided at the facility since May 17, 2016. Refer to deficiencies 601, 604, 611 and 614 for additional information on RI#4. The most recent Annual Medical Examination for RI#4 was documented on March 25, 2022 (sixteen months prior to the survey). RI#5 RI#5 had resided at the facility since January 30, 2023. Refer to deficiencies 601, 604, 611, 613, 614 and 621 for additional information on RI#5. RI#5's Initial Medical Examination, dated December 28, 2022, did not contain RI#5's medication orders or a statement by the physician that RI#5 was free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact. When interviewed on August 8, 2023, EI#2 agreed residents' Medical Examinations were incomplete.	A 602		

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A 604	Continued From page 57	A 604		
A 604	420-5-4-.06 (3) (a) (b) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility shall assess prospective residents for facility eligibility. This assessment shall document identified care needs and serve as a baseline for future assessments. (b) Monthly Assessments. The facility shall assess each resident monthly and more often when necessary to identify changes in resident's status. In addition to other items that may be required by the facility's own policies and procedures, the monthly assessment shall: 1. Assess the resident's ability to safely self-manage medications or safely self-administer medications with assistance. 2. Accurately weigh and record the weight of each resident. A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half or greater weight loss in a period of three months or less, or a ten percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician. 3. Document identified changes in resident status. 4. Assess the appropriateness of each	A 604		

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(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 604	Continued From page 58 resident's plan of care. Any decline in resident status requires immediate implementation and documentation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide adequate health supervision of residents. Findings: Review of resident records on August 7 and 8, 2023 revealed the following information. RI#1 had resided at the facility since March 13, 2023. Refer to deficiency 601 for additional information on RI#1. No monthly assessments, including assessment of the resident's ability to safely self-administer medications with assistance and weights, were documented for RI#1 in May, June and July 2023. RI#2 had resided at the facility since January 25, 2022. Refer to deficiency 601 for additional information on RI#2. No monthly assessments, including assessment of the resident's ability to safely self-administer medications with assistance and weights, were documented for RI#2 in June and July 2023. RI#2 sustained a 24 pound weight gain in May 2023 and there was no documentation of followup weights following this significant change. RI#3 had resided at the facility since March 17, 2023. Refer to deficiencies 505 and 506 for	A 604		

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A 604	Continued From page 59	A 604		

additional information on RI#3. No monthly assessments, including assessment of the resident's ability to safely self-administer medications with assistance and weights, were documented for RI#3 in June and July 2023.

RI#4 had resided at the facility since May 17, 2016. Refer to deficiencies 601, 602, 611 and 614 for additional information on RI#4. No monthly assessments, including assessment of the resident's ability to safely self-administer medications with assistance and weights, were documented for RI#4 in May, June and July 2023.

RI#5 had resided at the facility since January 30, 2023. Refer to deficiencies 601, 602, 611, 613, 614 and 621 for additional information on RI#5. No monthly assessments, including assessment of the resident's ability to safely self-administer medications with assistance and weights, were documented for RI#5 in July 2023. On July 25, 2023, speech therapy was ordered for RI#5 to conduct a swallow study due to dysphagia. No results of the swallow study or speech therapy consult were documented in RI#5's facility record. On August 1, EI#2 and EI#3 stated they (EI#2 and EI#3) were unsure if the swallow study had been completed. EI#2 contacted home health and obtained results of the consult and swallow study which was completed on July 29, 2023. The facility had not followed up on the swallow study to determine if dietary changes or additional interventions were needed for RI#5.

RI#8 was admitted to the facility on September 16, 2022 and had diagnoses which included kyphosis, multiple myeloma, neuropathy, post pulmonary emboli, esophageal stricture, post retinal vein occlusion and prostate cancer. Refer to deficiency 1203 for additional information on

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A 604	Continued From page 60 RI#8. No monthly assessments, including assessment of the resident's ability to safely self-administer medications with assistance and weights, were documented for RI#8 in May, June and July 2023. RI#9 was admitted to the facility on April 30, 2019 and had diagnoses which included chronic obstructive pulmonary disease, hypertension, solitary pulmonary nodule, dementia, bipolar disorder, anxiety, abscess of the liver, hypokalemia, hyponatremia and hypomagnesium. Refer to deficiency 611 for additional information on RI#9. No monthly assessments, including assessment of the resident's ability to safely self-administer medications with assistance and weights, were documented for RI#9 in June and July 2023. In March 2023, RI#9 sustained a significant weight loss of 13 percent of his/her total body weight in one month (176 pounds in February and 153 pounds in March). RI#9 also sustained a significant weight loss of 17 percent for three months in April 2023 (182 pounds in January and 150 pounds in April) and a significant weight loss of 23 percent for six months in April 2023 (196 pounds in October 2022 and 150 pounds in April 2023). The facility failed to provide followup on RI#9's significant weight loss until requested by the surveyor during the onsite survey. RI#9's weight, on August 8, 2023, was 161 pounds. RI#10 was admitted to the facility on July 2, 2021 and had diagnoses which included coronary artery disease, chronic obstructive pulmonary disease, hypoxia, glaucoma, history of cerebrovascular accident, paroxysmal atrial fibrillation, lymphedema bilateral lower extremities, stasis dermatitis bilateral lower extremities, ischemic cardiomyopathy and	A 604		

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A 604	Continued From page 61 congestive heart failure. No monthly assessment, including assessment of the resident's ability to safely self-administer medications with assistance and weight, was documented for RI#10 in May, June and July 2023. When interviewed on August 8, 2023, EI#2 agreed health supervision of residents had not been adequate.	A 604		
A 611	420-5-4-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall be based on the initial medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be reviewed and updated based on the annual examination, and all other physician examinations, diagnoses, and recommendations of the resident's treating physician, and the resident's monthly assessments. The plan of care shall be developed and updated in cooperation with the resident and, if appropriate, the sponsor. All entries on the plan of care shall be accurately dated. 1. The plan shall at all times reflect the	A 611		

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A 611	Continued From page 62	A 611		

current condition of the resident and document the personal care and services required from the facility by the resident. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following:

2. A listing of the resident's individual needs or problems that require intervention by the facility.

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

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

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

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

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

(iii) Hair. Resident's hair shall be kept

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A 611	Continued From page 63 clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be provided assistance with personal safety. 6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide care and services consistent with community standards. The facility also failed to ensure a resident's care plan was current with appropriate interventions to meet the care and safety needs of the resident. Facility staff failed to follow the interventions outlined on a resident's care plan in providing care to the resident. Findings: Care and Services Consistent With Community Standards RI#5 had resided at the facility since January 30, 2023. Refer to deficiencies 601, 602, 604, 613, 614 and 621 for additional information on RI#5.	A 611		

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A 611	Continued From page 64 RI#5 was observed and reported to have periods of confusion. RI#5 used a walker to ambulate. An odor of urine was noted at times when interviewing RI#5 in his/her room. RI#5's facility care plan directed staff to provide one person shower assistance three times a week and as needed. Review of Shift Report forms, which were documented every shift by Personal Care Attendants, revealed RI#5 received the following shower assistance: August 2, 2023 - shower assistance provided; August 3, 2023 - no shower assistance; August 4, 2023 - no shower assistance; August 5, 2023 - no shower assistance; August 6, 2023 - no shower assistance, "no showers scheduled"; August 7, 2023 - shower assistance provided, "last shower was Wed. (08/02)". RI#6 had resided at the facility since July 19, 2021. Refer to deficiency 508 for additional information on RI#6. RI#6 used a walker to ambulate. RI#1's facility care plan directed staff to provide one person assistance with showers three times a week and as needed and to provide one person assistance with dressing and grooming. Interviews with RI#6 and a companion revealed RI#6 had not received assistance with bathing for at least five days. This was confirmed through review of Shift Report forms which were documented every shift by Personal Care Attendants. The following shower assistance was documented for RI#6: August 2, 2023 - assisted with shower; August 3, 2023 - no shower assistance; August 4, 2023 - no shower assistance, "waiting until tomorrow"; August 5, 2023 - no shower assistance; August 6, 2023 - no shower assistance, "no showers scheduled"; August 7, 2023 - shower assistance provided, "last shower was Wed. (08/02)".	A 611		

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A 611	Continued From page 65 These residents did not receive proper assistance with personal care to include showers, placing the residents at increased risk for skin breakdown and increased risk of harm if attempting to provide their own care without assistance. When interviewed on August 8, 2023, EI#2 stated staff would be retrained on following care plans and proper approach to residents to ensure the residents accept assistance with personal care. Resident Care Plans/Staff Failed to Follow Interventions on Care Plans RI#4 had resided at the facility since May 17, 2016. Refer to deficiencies 601, 602, 604 and 614 for additional information on RI#4. RI#4 required the use of tactile markers on medication packets for identification of medications. RI#4's facility care plan read "...LEGALLY BLIND-Medication strip packs to have raised crystal beads on each pack: Morning-one crystal; Noon-two crystals; Night-three crystals; PRN-four crystals - All eyedrops and nasal sprays to have bead identifiers...". During observation of medication assistance on the morning of August 2, 2023, none of RI#4's medications contained tactile identifiers as described on RI#4's facility care plan, placing RI#4 at increased risk of a medication error. RI#9 had resided at the facility since April 30, 2019. Refer to deficiency 604 for additional information on RI#9. In March 2023, RI#9 sustained a significant weight loss of 13 percent of his/her total body weight in one month (176 pounds in February and 153 pounds in March). RI#9 also sustained a significant weight loss of 17 percent for three months in April 2023 (182 pounds in January and 150 pounds in April) and a	A 611		

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A 611	Continued From page 66 significant weight loss of 23 percent for six months in April 2023 (196 pounds in October 2022 and 150 pounds in April 2023). RI#9's weight loss was not addressed on RI#9's facility care plan with appropriate interventions to monitor weights and prevent further weight loss. RI#9's facility care plan read "...weight monthly...". These care plan deficiencies were discussed with EI#2 on August 8, 2023. EI#2 agreed the care plans had not been appropriately updated.	A 611		
A 613	420-5-4-.06 (5) (a) (b) (c) (d) (e) Care of Residents. (5) Medications. (a) Medications as defined in these rules, may be administered to a resident of an assisted living facility only after the drugs have been prescribed specifically for the resident by an individual currently licensed to prescribe medications in Alabama. A currently licensed physician in good standing with the Medical Licensure Commission of any state may prescribe medications to a resident of an assisted living facility only during the initial physical examination. (b) A physician order is required for a resident to manage and have custody of his or her own medications. (c) A resident may have custody of and manage over the counter topical medications with the written approval of a physician. A physician order is not required for over the counter topical medications that are self-administered by residents and approved by the physician for	A 613		

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A 613	Continued From page 67 resident possession. (d) Nothing in these rules shall preclude a facility from using a licensed nurse employed by the facility or nursing agency to administer medication to any resident. An RN or LPN shall administer medications to residents in the assisted living facility only in accordance with physician orders and the Nurse Practice Act. (e) A resident who is incapable of recognizing his or her name, or understanding the facility unit dose medication system, or does not have the ability to protect himself or herself from a medication error shall require medication administration. Medication administration shall be provided only by a physician or by an RN or LPN. If the resident cannot understand or be trained to understand the unit dose medication system used by the facility or cannot protect himself or herself from medication errors by facility staff, the resident will be appropriately discharged. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to promptly discharge a resident who was unable to utilize the unit dose medication system. In addition, the facility failed to provide a licensed nurse to administer medications to a resident who was unable to protect themselves from a medication error. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received two complaints which alleged residents	A 613		

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A 613	Continued From page 68	A 613		

of the facility were not appropriate for an assisted living facility. The surveyor was able to substantiate this complaint during the onsite survey.

RI#5 had resided at the facility since January 30, 2023. Refer to deficiencies 601, 602, 604, 611, 614 and 621 for additional information on RI#5. RI#5 was observed to have periods of confusion during the onsite survey. The local ombudsman had visited the facility several times in the weeks prior to the onsite survey and reported that RI#5 was confused. All staff interviewed reported that RI#5 was confused at times. Shift Report forms were reviewed and the following documentation was noted regarding RI#5: August 3, 2023 - "confused and crying"; August 4, 2023 - "confused"; August 7, 2023 - "confused, crying". A Physician's Order, dated July 25, 2023, read "If pt. continues sun-downing, recommendations are for memory care". A Home Health Summary Note, written by the Speech Language Pathologist, dated May 4, 2023, read "SLP administered the Saint Louis University Mental Status (SLUMS) Exam with score of 10/30. Pt. could not recall if (he/she) had been given any medications today. Unable to sit to stand and unable to transfer without max assistance. Pt. did not know how to use facility call button. Unable to tell which was the call button and which was the remote...".

At the time of the surveyor's initial entrance to the facility on July 24, 2023, no 30-day discharge notice had been issued to RI#5. When the surveyor returned to the facility on August 2, 2023, EI#3 informed the surveyor that a 30-day discharge notice had been issued to RI#5 on July 27, 2023 due to RI#5's inability to protect himself/herself from a medication error. However,

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A 613	Continued From page 69 unlicensed staff continued to administer medications to RI#5 even though RI#5 was unable to protect himself/herself. Review of RI#5's Medication Assistance Record, on August 2, 2023, revealed unlicensed staff had administered medications to RI#5 on July 28, July 29, July 30, July 31 and August 1, 2023. EI#2 stated she (EI#2) had instructed EI#3 to schedule licensed staff to administer RI#5's medications but this had not been done. RI#5 was at increased risk of a medication error due to the facility's failure to promptly discharge RI#5 and failure to provide licensed nurses to administer RI#5's medications until RI#5 was discharged from the facility.	A 613		
A 614	420-5-4-.06 (5)(f)(g)(6)(7)(a)-(i) Care of Residents. (f) A resident may self-manage his or her medications. For the purposes of these rules, self-manage shall mean the resident is capable of maintaining possession and control of his or her medications, who does maintain possession and control of his or her medications, and self-administers his or her medications without creating an unreasonable risk to health and safety. (g) A resident that cannot self-manage his or her own medication without creating an unreasonable risk to health and safety may be assisted with self-administration of medication by any assisted living facility staff, including staff members who hold no professional licensure provided: 1. The resident can and does identify his or her name on the medication package and	A 614		

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A 614	Continued From page 70 has a reasonable understanding of the unit dose packaging system in use by the facility such that the resident could protect himself or herself from medication errors when unit dose packages are brought to the resident by facility staff. The resident shall have the opportunity to demonstrate his or her ability to correctly utilize the unit dose package system at every opportunity for medication use. (6) Assistance with self-administration of medication includes the following practices: (a) Reminding a resident that it is time to take a medication or medications, where such medications have been prescribed for a specific time of day, a specific number of times per day, specific intervals of time, or for a specific time in relation to mealtimes or other activities such as arising from bed or retiring to bed. (b) Physically assisting a resident by opening or helping to open a container holding medications. (c) Offering liquids to a resident to assist that resident in ingesting oral medications. (d) Physically bringing a container of medication to a resident. (7) Assistance with self-administration of medications shall under no circumstances include any of the following practices: (a) Medication administration as defined in these rules.	A 614		

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A 614	Continued From page 71	A 614		

(b) Determining the amount of medication to be given. If a medication is not available in unit dose packaging, unlicensed facility staff may measure the prescribed amount of medication only under the direction and control of the resident, provided that the resident is capable of determining the amount of medication to be given.

(c) Giving a resident injections of any kind.

(d) Telling or reminding a resident that it is time to take a PRN, or as needed medication.

(e) Placing medications in a feeding tube.

(f) Giving enemas or suppositories.

(g) Crushing or splitting medications, provided
that a physician has ordered a specific medication to be crushed or split and the resident is capable of self-managing his or her own medication or the resident is capable of medication self-administration with assistance and would be capable of crushing or splitting his or her own medications but for limitations of mobility or dexterity, may be assisted with crushing or splitting medications by unlicensed staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff.

(h) Mixing medications with food or

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A 614	Continued From page 72	A 614		

liquids, provided that a physician has ordered a medication to be mixed with food or liquid and the resident is capable of self-managing his or her own medications or the resident is capable of medication self-administration with assistance and would be capable of mixing his or her own medications with food or liquid but for limitations of mobility or dexterity, may be assisted with mixing medications with food or liquid by unlicensed staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff.

(i) Assisting with self-administration of eye drops, eardrops, nose drops, inhalers, nebulizers, or topical medications, provided that a resident who is capable of self-managing his or her own medication or a resident who is capable of medication self-administration with assistance and who would be capable of self-administration of his or her own medications but for limitations of mobility or dexterity, may be assisted with eye drops, ear drops, nose drops, inhalers, nebulizers, or topical medications by unlicensed facility staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, residents were not given the

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A 614	Continued From page 73	A 614		

opportunity to demonstrate their ability to correctly utilize the unit dose package system at every opportunity for medication use.

Findings:

On August 2, 2023, the surveyor observed medication assistance to the following residents, provided by EI#8, Licensed Practical Nurse.

RI#4 had resided at the facility since May 17, 2016. Refer to deficiencies 601, 602, 604 and 611 for additional information on RI#4. Prior to taking medications to RI#4, EI#8 informed the surveyor that RI#4 was legally blind and used to have jewels on medication packets for use in identifying medications. However, RI#4's medication packets did not currently contain any tactile identifiers to aid RI#4 in identifying medications. EI#8 removed RI#4's medications from the packets and took RI#4's medications to RI#4's room in a small plastic cup. RI#4 was informed by EI#8 what medications were being administered. The medications were administered to RI#4 without allowing RI#4 to identify the medications and protect himself/herself from a medication error.

RI#5 had resided at the facility since January 30, 2023. Refer to deficiencies 601, 602, 604, 611, 613 and 621 for additional information on RI#5. EI#8 removed RI#5's medication from the labeled package and placed the medication in a small cup, then delivered the medication to RI#5 in RI#5's room. The surveyor then asked EI#8 how RI#5 was expected to identify his/her medication. EI#8 left RI#5's room and returned to the medication cart where the medication packet was obtained and presented to RI#5. RI#5 was disoriented to time and unable to correctly identify

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A 614	Continued From page 74 that it was the correct time to take the medication but could identify his/her name on the packet. RI#5 had not been given the opportunity to identify his/her medication and protect himself/herself from a medication error prior to recommendation by the surveyor. When interviewed on the afternoon of August 2, 2023, EI#2 agreed these residents were not given the opportunity to correctly utilize the unit dose package system as required.	A 614		
A 616	420-5-4-.06 (7) (k) (l) (m) (n) (o) Care of Residents. (k) Medications kept under the control or custody of an assisted living facility shall be packaged by the pharmacy and shall be maintained by the facility in unit dose packaging. Medications kept under the control or custody of an assisted living facility that are not available in unit dose packaging must be packaged by the pharmacy and administered by a physician, RN, or LPN or self-administered with assistance under the total control and direction of the resident. (l) Unless a resident can and does self-manage his or her own medications, an assisted living facility shall require each resident to use a single pharmacy. This does not apply to emergency pharmacy services. All residents need not use the same pharmacy that is used by other residents unless express policy of the assisted living facility provides otherwise and all residents are informed of such policy and provided a copy of such policy prior to or at the time of admission. The assisted living facility shall require pharmacies used for medication supply	A 616		

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for residents not self-managing their medications to review all ordered medication regimens for possible errors or adverse drug interactions and to advise the facility and the prescribing health care provider when these are detected.

(m) If controlled substances prescribed for residents of any assisted living facility are kept in the custody of the assisted living facility, they shall be stored in a manner that is compliant with state and federal laws, the requirements of the Alabama State Board of Pharmacy, and any requirements prescribed by the State Board of Health. At a minimum, controlled substances in the custody of the facility shall be stored using a double lock system, under proper temperature and humidity controls and permit only authorized personnel access. The facility shall maintain a system to account for all controlled substances in its possession. All other medications in the custody of the facility shall be stored using at least a single lock, under proper temperature and humidity controls and permit only authorized personnel access. This shall include medications stored in a resident's room when the staff and not the resident have access to the medications. Medications may be kept in the custody of an individual resident who can safely manage his or her medications. Such medications may be stored in a locked container accessible only to the resident and staff, or may be stored and secured in the resident's living quarters, if the room is single occupancy and has a locking entrance.

(n) Medication administration or medication assistance records and written physician orders for all over-the-counter drugs, legend drugs, and controlled substances shall be retained for a period of not less than three years.

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A 616	Continued From page 76 They shall be made available for inspection at reasonable times by residents, anyone authorized by the resident, and by the sponsors of residents. (o) Labeling of Drugs and Medicines. All containers of prescribed medicines and drugs shall be labeled in accordance with the rules of the Alabama State Board of Pharmacy and shall include appropriate cautionary labels, such as, "Shake Well," or "For External Use Only." This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain a system to account for all controlled substances in its possession. Findings: On the afternoon of August 2, 2023, the surveyor reviewed the most recent Change of Shift Controlled Medication Count Sheet for the month of July with EI#8. Numerous times, the forms were not signed to indicate the controlled substances had been counted and the count was correct. EI#8 stated the forms should be signed each shift by the Medication Technician or nurse leaving and by the Medication Technician or nurse coming on duty. The counts were not documented for 23 shifts from July 1-17, 2023. EI#8 agreed the counts had not been completed and documented as required.	A 616		
A 621	420-5-4-.06 (11) (b) Care of Residents. (b) Retention	A 621		

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A 621	Continued From page 77 1. An assisted living facility shall not allow any resident to return to the assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the facility is licensed to provide or the facility is capable of providing. 2. An assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility. 3. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in an assisted living facility. 4. An assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless: (i) The individual is capable of performing and does perform all tasks related to his or her own care; OR (ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity BUT the individual has sufficient cognitive ability to direct his or her own care AND the individual is able to direct others and does direct others to provide the physical assistance needed to complete such tasks, AND the facility staff is capable of providing such assistance and does provide such assistance. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff.	A 621		

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A 621	Continued From page 78 5. If a resident of an assisted living facility is diagnosed with a terminal illness other than dementia and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90 days. If the facility is unable or becomes unable to meet the needs of a resident receiving hospice care, or if a resident receiving hospice care requires care beyond what the facility may lawfully provide pursuant to this section, then the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for assisted living facilities. The facility would in all cases remain responsible for ensuring the appropriate delivery of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident. 6. All skilled services provided in the facility, such as but not limited to wound care or insertion of a urinary catheter, shall be provided by the staff of properly licensed or certified agencies. Skilled services shall not be delegated to facility staff. 7. Residents that develop acute infectious pulmonary disease, such as active tuberculosis, or other diseases capable of transmission to other individuals through normal person-to-person contact shall be immediately transferred to an appropriate level of care until certified by a physician to be free of a contagious	A 621		

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A 621	Continued From page 79 condition. 8. No assisted living facility shall be operated in whole or in part in a manner that prevents free and unhindered egress from the facility by any of its residents. 9. An assisted living facility shall not retain any resident who cannot safely reside in the facility unless his or her egress from the facility is restricted. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility retained a resident who was unable to direct his/her own care and was in need of skilled nursing care to administer medications. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received two complaints which alleged residents of the facility did not meet the criteria for retention in an ALF. The surveyor was able to substantiate this complaint during the onsite survey. RI#5 had resided at the facility since January 30, 2023. Refer to deficiencies 601, 602, 604, 611, 613 and 614 for additional information on RI#5. RI#5 was observed to have periods of confusion during the onsite survey. The local ombudsman had visited the facility several times in the weeks prior to the onsite survey and reported that RI#5 was confused. All staff who were interviewed reported that RI#5 was confused at times. Shift Report forms were reviewed and the following	A 621		

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documentation was noted regarding RI#5: August 3, 2023 - "confused and crying"; August 4, 2023 - "confused"; August 7, 2023 - "confused, crying". A Physician's Order, dated July 25, 2023, read "If pt. continues sun-downing, recommendations are for memory care". A Home Health Summary Note, written by the Speech Language Pathologist, dated May 4, 2023, read "SLP administered the Saint Louis University Mental Status (SLUMS) Exam with score of 10/30. Pt. could not recall if (he/she) had been given any medications today. Unable to sit to stand and unable to transfer without max assistance. Pt. did not know how to use facility call button. Unable to tell which was the call button and which was the remote...".

On August 2, 2023, the surveyor observed medication assistance by EI#8. When presented with his/her medication packet, RI#5 was only able to identify his/her name and was unable to confirm the correct time to take the medication.

At the time the surveyor first entered the facility, on July 24, 2023, no 30-day discharge notice had been issued to RI#5. When the surveyor returned to the facility on August 2, 2023, EI#3 informed the surveyor that a 30-day discharge notice had been issued to RI#5 on July 27, 2023 due to RI#5's inability to protect himself/herself from a medication error. At the request of the surveyor, nurses were scheduled to administer RI#5's medications until RI#5 could be appropriately discharged from the facility.

RI#5 was at increased risk of a medication error due to inability to consistently direct his/her care and was in need of skilled nursing care to administer his/her medications. On August 2, 2023, EI#2 agreed RI#5 did not meet the

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A 621	Continued From page 81 requirements for continued stay in an ALF.	A 621		
A 703	420-5-4-.07 (3) Food Service. (3) Dietary Service. (a) Number of Meals. No fewer than three meals shall be provided each 24 hours. Food service shall be provided in a resident's room during temporary illness if necessary. The diet shall be well-balanced, palatable, properly prepared, and sufficient in quantity and quality to meet the nutritional needs of the residents in accordance with Dietary Reference Intakes of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The food must be adapted in type and preparation to the habits, preferences, and physical abilities of the residents. (b) Timing of Meals. A time schedule for serving meals to residents and personnel shall be established. Meals shall be served approximately five hours apart with no more than 14 hours between the evening meal and breakfast. The time schedule of meals shall be posted with the menu. The facility shall make evening snacks available after service of the evening meal. The facility shall provide fluids throughout the day and shall make between-meal nourishment (snacks) available. (c) Menu. The menu shall be planned and written at least 1 week in advance. The current week's menu shall be posted in the food service area and shall be kept on file for the following 2 weeks. For any resident with a physician's order for a therapeutic diet, the facility shall have a copy of the diet and the facility shall	A 703		

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A 703	Continued From page 82 document the adjustment of its menu to accommodate the resident's needs. (d) Alternate food selections or substitutes shall be made available to all residents. (e) A facility shall not obtain food from charitable organizations. A facility shall not avoid serving a meal by sending or transporting residents to missions, soup kitchens, or other charitable facilities for meals. (f) The amount of food on hand shall be sufficient to serve three meals per day to all residents for 3 days. Non-perishable food and potable water shall be maintained in the facility in sufficient quantity to serve three meals per day to all residents for 3 days. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide a diet for residents which was sufficient in quantity. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged food served to residents at meal times was insufficient and snacks were not always available to residents. The surveyor was able to substantiate this complaint during the onsite survey.	A 703		

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Interviews were conducted with staff and residents/sponsors during the onsite survey. Five staff members (EI#7, EI#8, EI#9, EI#14 and EI#15) and five residents/sponsors reported that inadequate portions of food had been served to residents during the past several weeks such as four green beans, two broccoli florets and one dumpling (chicken and dumplings). Three staff members (EI#9, EI#12 and EI#15) stated they had bought snacks for residents due to no snacks provided by the facility. The local ombudsman visited the facility several times in the weeks prior to the onsite survey by ADPH and reported an extremely limited supply of food in the kitchen including empty flour, sugar and cornmeal canisters.

On July 24, 2023, the surveyor observed the lunch meal which consisted of one-half stuffed bell pepper and a very small scoop of mashed potatoes. The evening meal that same day consisted of a grilled cheese sandwich (the cheese portion was smaller than the bread), a small bowl of tomato soup and a packaged cup of mixed fruit.

On the evening of July 24, 2023, the surveyor and EI#7 observed the kitchen and food supply. There was adequate food to service residents for three days and EI#7 stated he (EI#7) had been cleared by EI#1 to begin ordering food again from the facility's main food supplier. EI#7 explained that EI#1 had stopped him (EI#7) from ordering from the food supplier and that was when the issues started with the inadequate food supply. EI#7 stated he (EI#7) and one other employee had been the only dietary employees working during the past few weeks. EI#7 added he (EI#7) worked alone at times but added the previous dietary manager (EI#6) had been rehired and had started

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back to work that same day. During an interview on August 3, 2023, EI#7 was again questioned about the food supply at the facility. EI#7 stated EI#1 had called him (EI#7) a few weeks prior and told him (EI#7) there was a problem with the bill and EI#1 would take over ordering the food. EI#1 told EI#7 to let him (EI#1) know every few days what food was needed. EI#1 began ordering small shipments of food from a local grocery store and had the food delivered to the facility. Since ordering the food had been taken away from EI#7, he (EI#7) had no control over what food was delivered and received inadequate amounts. EI#7 stated "I did the best I could". EI#7 gave an example of one day when he (EI#7) only had six cans of chicken and dumplings for 30-40 residents. EI#7 stated "I told them I was sorry. A resident's daughter told me her mom only had one dumpling. Sometimes I would go buy food to add to what I had but I couldn't do it that day. I gave everyone a few beans and dumplings. I did the best I could". EI#7 further stated the problems in the kitchen had been resolved since the dietary manager had been rehired.

On August 3, 2023, the surveyor interviewed EI#6, recently rehired Dietary Manager. EI#6 stated she (EI#6) had previously worked at the facility for two years and had just been rehired on July 24, 2023. EI#6 stated EI#7 had informed her that he (EI#7) was not allowed by EI#1 to order food from the main food supplier because EI#7 went over budget. EI#6 stated the facility's primary food supplier was again delivering to the facility and a truck delivery was received on July 26, 2023 which provided a full supply of food in the kitchen for meals and snacks. EI#6 stated she (EI#6) had informed EI#1 that food had to be ordered by truck deliveries to keep enough food in the facility. EI#6 added she (EI#6) planned to

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A 703	Continued From page 85	A 703		

monitor portions at all meals until she (EI#6) was certain the portions were adequate at all times. On August 8, 2023, a well-stocked kitchen, including emergency food and water supply, was observed by the surveyor. In addition, food portions observed on August 2, 3, 7 and 8, 2023 were adequate and snacks were observed.

On August 3, 2023, the surveyor questioned EI#1 about the recent food shortage and inadequate portions of food at the facility. EI#1 stated he (EI#1) had let EI#7 handle ordering food and he (EI#7) had not been ordering enough. When EI#1 became aware of food issues, he (EI#1) asked EI#2 to hire EI#6 back but it took two weeks to get EI#6 started at the facility again. EI#1 stated EI#7 did not tell him (EI#1) everything that needed to be ordered, then EI#7 would call EI#1 at the last minute and tell him (EI#1) there was not enough food.

The surveyor requested a copy of the current bill for the facility's main food supplier from EI#2 on the afternoon of July 24, 2023 and again on the afternoon of July 25, 2023. EI#2 stated she (EI#2) would obtain the bill from EI#1. On August 3, 2023, the surveyor requested a copy of the bill for for the food supplier from EI#1. The bill was provided by EI#1 later that same day and showed a total balance of $5,831.04 as of August 3, 2023. The bill included a balance for "0-30 days" which was "$4,799.60" and a balance for "31-60 days" which was "$1,031.44". When asked about the balance that was due greater than 30 days, EI#1 stated the facility had a 60-day credit account with the food supplier so the bill was not late until after 60 days. EI#1 denied that the bill had been past due and stated he (EI#1) had taken over ordering food because EI#7 was not ordering what was needed from the food supplier and he could

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A 703	Continued From page 86 better manage the food supply with small orders from the local grocery store.	A 703		
A 804	420-5-4-.08 (4) Physical Facilities. (4) Food Service Facilities. (a) Floors. Floors in food service areas shall be of such construction as to be easily cleaned, sound, smooth, non-absorbent, without cracks or crevices, and shall be provided with approved and conveniently located facilities for the disposal of floor wash water. (b) Walls and Ceilings. Walls and ceilings of food service areas shall be of tight and substantial construction, and smoothly finished. The walls and ceilings shall be without horizontal ledges and shall be washable up to the highest level reached by splash and spray. Roofs and walls shall be maintained free of leaks. All openings to the exterior shall be provided with doors or windows which prevent the entrance of rain or dust during inclement weather. (c) Screens or Outside Openings. Openings to the outside shall be effectively screened, or suitable provisions made equal to screening (such as fly fans). Screen doors shall be equipped with self-closing devices. (d) Lighting. The kitchen, dishwashing area and the dining room shall have adequate light. (e) Ventilation. Vent/exhaust hoods, vented to the outdoors, shall be provided over cooking surfaces to aid in removing cooking odors. Existing recirculating vent hoods in Family	A 804		

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A 804	Continued From page 87	A 804		

facilities may remain in use when filters are cleaned or replaced regularly to prevent excess grease accumulation. Group assisted living facilities with residential stoves may use a residential hood sized for the stove. Commercial exhaust hoods shall be installed when commercial cooking equipment is used. Congregate facilities shall use a commercial exhaust hood system.

(f) Employee Toilet Facilities. Toilet rooms, if provided, shall not open directly into any room or space in which food is prepared, stored, displayed, or served, nor into any room in which utensils are washed or stored. Toilet rooms shall include a lavatory and shall be well lighted and ventilated.

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

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

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A 804	Continued From page 88 (i) Equipment and Utensil Construction. Equipment and utensils, except single service utensils, shall be so constructed as to be easily cleaned and shall be kept in good repair. No cadmium plated, lead, or readily corrodible utensils or equipment shall be used. (j) Separation of Kitchen from Resident Rooms and Sleeping Quarters. Any room used for sleeping quarters shall be separated from the food service area by a solid wall with no direct openings. Sleeping accommodations shall not be permitted within the food service area. (k) Clean Rooms. Floors, walls, and ceilings of rooms in the food service area shall be clean and free of an accumulation of rubbish, dust, grease, dirt, etc. (l) Clean Equipment. Equipment in the food service area shall be clean and free of dust, grease, dirt, etc. (m) Clean Counters, Tables, Tablecloths, and Napkins. Tables and counters, which are used for food service, shall be kept clean. Tablecloths and cloth napkins shall be laundered after each use. (n) Location and Space Requirements. Food service facilities shall be located in a specifically designated area and shall include the following rooms and space: kitchen, dishwashing, food storage, and dining room. (o) Equipment. Minimum equipment in the kitchen shall include the following: 1. Range. In a Family or Group assisted	A 804		

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A 804	Continued From page 89	A 804		

living facility, a residential use range is permitted. A Congregate assisted living facility shall have a heavy-duty
range suitable for institutional use with double oven, or equivalent.

2. Refrigerator. A Family or Group assisted living facility may use a residential refrigerator. A Congregate assisted living facility shall have a heavy duty refrigerator suitable for institutional use.

3. Fire extinguisher. A five-pound type BC for residential hoods, and K type for commercial hoods.

4. Dishwashing. The dishwashing equipment for Family and Group assisted living facilities shall be either residential type using cold water sanitizers or commercial type with a booster water heater. Dishwashing equipment for all Congregate assisted living facilities shall be commercial type using a booster water heater or an automatic dispensing sanitizing chemical system.

5. A three-compartment sink with a booster heater or chemical sanitizing system for the third compartment shall be provided in Congregate assisted living facilities.

6. Garbage cans with cover.

(p) Food Storage. A well-ventilated, cool food storage room, pantry, or cabinets shall be provided. Adequate shelving, bins, suitable cans, and raised platforms shall be provided and kept clean. Perishable food shall be stored at least six inches above the floor. The storeroom shall be of

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A 804	Continued From page 90 such construction as to prevent the invasion of rodents and insects, the seepage of dust and water, leakage, or any other source of contamination. (q) Dining Room. A resident dining room, or rooms, shall be provided which is large enough to seat not less than 100 percent of the bed capacity. (r) Water Heating Equipment. Equipment for heating an ample supply of water, under pressure, for all washing purposes shall be provided. Hot water shall be piped to all hand-washing facilities, and to each compartment of all dishwashing and laundry sinks. Water heaters shall be automatic type. This Rule is not met as evidenced by: Based on observation and record review, a refrigerator designated for medication storage was not monitored for proper function. Findings: On the morning of August 3, 2023, the surveyor observed the medication room behind the nurses' desk. There were two refrigerators in the medication room. Medications were stored in one refrigerator. A log was taped to the door of each refrigerator for documentation of daily temperature checks. The temperatures had not been documented for either refrigerator since July 7, 2023. On August 8, 2023, EI#2 agreed the temperatures should have been monitored and	A 804		

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A 804	Continued From page 91 recorded daily.	A 804		
A1101	420-5-4-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All 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 shift of Group and Congregate facilities. 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 currently adopted 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.	A1101		

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A1101	Continued From page 92 (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 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	A1101		

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A1101	Continued From page 93 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 record reviews and interviews, the facility failed to conduct fire drills as required. Findings: Reviews of the facility's fire drill documentation, on the afternoon of July 26, 2023, revealed no fire drills were documented in July 2022 and in January, February, March, April, May and June 2023. In addition, fire drills were not documented quarterly on each shift for the third quarter of 2022 and for the first and second quarters of 2023. On August 8, 2023, EI#2 and EI#3 stated they (EI#2 and EI#3) did not think the fire drills had been completed and also stated EI#1 had terminated the maintenance man who was responsible for conducting fire drills.	A1101		
A1203	420-5-4-.12 (5) Physical Environment. (5) General Building Requirements - Family, Group, and Congregate.	A1203		

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A1203	Continued From page 94 (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 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 insect screens. Screen doors shall be equipped with self-closing devices. (e) Emergency Lighting. 1. All assisted living facilities shall provide emergency artificial lighting to adequately illuminate halls, corridors, kitchens, dining areas, 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	A1203		

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A1203	Continued From page 95 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 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. (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	A1203		

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storage purpose. All walls and doors under stairs shall meet the same fire rating as the stairwell.

(l) Doors.

1. In each new assisted living facility, doors of resident bathrooms connected to resident bedrooms 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 a central location.

3. Resident bedroom and other exit access doors in each assisted living facility shall be at least three feet wide. Bedroom doors in Family assisted living facilities shall not be less than 32 inches 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 special locking arrangements are permitted only in specialty care assisted living facilities.

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. Exit doors of Family facilities may swing inward.

(m) Ventilation. The building shall be well-ventilated at all times to prevent accumulation of objectionable odors. Kitchens,

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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 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 designated staff of the facility and documented on the attached extinguisher tag by the designated staff person.

(o) Call System. Except in Family facilities, 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

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doors.

(r) Exit marking. In Group and Congregate 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 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 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 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 observations, interviews and record

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reviews, fire extinguishers were not visually inspected monthly by designated staff of the facility. In addition, leaks and building repairs were not completed timely.

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

THIS IS REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON APRIL 10, 2019.

Findings:

Leaks in the Building

The Alabama Department of Public Health received a complaint which alleged leaks in the facility had not been repaired. The surveyor was able to substantiate this complaint through interviews and observations during the onsite survey.

On July 17, 2023, the surveyor spoke with the local ombudsman who had made multiple visits to the facility to address recent concerns. The ombudsman reported there was a leak from the ceiling in the hallway near Resident Room 114 where there was an opening in the ceiling and a bucket in the floor to catch the water. The ombudsman reported this leak had been present for 2-3 weeks. The following day the ombudsman reported a leak in an electrical room near the end of the hallway to the left where water was dripping on electrical cords. The ombudsman had been made aware of this leak by a resident's family member.

On the evening of July 24, 2023, the surveyor and the local ombudsman observed the areas where leaks had occurred in the facility. The leak in the

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	D4209	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING	11682 COUNY LINE ROAD MADISON, AL 35756

(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
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hallway near Resident Room 114 had been repaired and the ceiling had been repaired. However, there was still a bucket in the floor containing several inches of water in the electrical room. There was a large opening in the ceiling and the carpet had been pulled back in the area of the leak. No active leaking was observed. EI#2 stated a company had been working on repairing the leaks but the source of the leak in the electrical room had not been identified. During the onsite survey an additional leak occurred in the hallway and a large garbage can was placed in the hallway to catch the water.

On the afternoon of August 7, 2023, the surveyor observed the electrical room with the family member who had initially reported the leak in that area. EI#2 reported that all leaks had been repaired at that time. However, there was still damaged carpet in the electrical room and the ceiling had not been repaired. During a telephone conversation on August 10, 2023, EI#2 reported repairs to the electrical room were being completed that day. During an interview on August 3, 2023, EI#1 stated he (EI#1) was working hard to get repairs done and worked on issues as soon as they were reported to him. However, leaks in the building had been present for several weeks at the time of the onsite survey and had not been repaired, creating an unsafe and unsanitary environment for residents and visitors.

Building Repairs

RI#8 had resided at the facility since September 16, 2022. Refer to deficiency 604 for additional information on RI#8. On the afternoon of August 2, 2023, the surveyor spoke with RI#8 in RI#8's apartment. There was a separate bedroom and

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living area in RI#8's apartment. The surveyor noted there was no door at the entrance to the bedroom and no door at the entrance to the bathroom. RI#8 stated he/she had moved into that apartment about three weeks prior due to issues with his/her prior room which included air conditioner not working and refrigerator not working. RI#8 stated doors were to be installed in his/her current apartment in two days. The surveyor spoke with EI#3 who stated maintenance was scheduled to install the doors the following day. On August 3, 2023, the surveyor spoke with EI#3 who stated the doors had not been installed that day due to the maintenance man being out sick. During a telephone conversation on August 10, 2023, EI#2 informed the surveyor the doors in RI#8's room were being installed at that time. Repairs to RI#8's room had been delayed several weeks, creating a lack of privacy and decent environment for RI#8.

Fire Extinguishers

On the afternoon of July 26, 2023, the surveyor checked all fire extinguishers in the facility. Observation of the tags attached to the fire extinguishers revealed no monthly checks of the fire extinguishers had been conducted since April 2023.

On August 8, 2023, EI#2 agreed the monthly inspections had not been conducted as required and stated the maintenance man had been terminated by EI#1 and maintenance was responsible for the monthly inspections. This same deficiency was cited during the State survey conducted on April 10, 2019.

CONNIE CHERRY, REGISTERED NURSE

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