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A 000	Initial Comments This is a 16 bed Specialty Care Assisted Living Facility (SCALF) with a census of 10 August 10, 2023. There were four (4) complaints investigated during this unannounced licensure survey and complaint investigation. LC#20230719017, LC#20230710017, LC#20230705007 and LC#20211028004 were substantiated. 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 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practices resulted in actual harm to four residents of the facility and placed all ten residents of the facility at significant risk of harm and neglect.	A 000		
A 301	420-5-20-.03 (1) (a) (b) (c) (d) Administration. (1) The Specialty Care Assisted Living Facility Governing Authority. (a) A specialty care assisted living facility shall have an identified sole proprietorship, corporation, partnership, limited partnership, or other business entity that is its governing authority, or it shall have a designated individual or group of designated individuals who serve as its governing authority. A facility must give complete information to the Department identifying: 1. Each person who has an ownership	A 301		

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interest of 10 percent or more of the governing authority.

2. Each person or entity who has an ownership interest of 10 percent or more in the real property or building used by the specialty care assisted living facility to offer its services.

3. Each officer and each director of the corporation if the governing authority is a 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.

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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 rules for SCALFs. The governing authority's lack of adequate oversight resulted in widespread deficient practices. These deficient practices resulted in actual harm to four residents and placed all ten residents of the facility at significant risk for harm due to this failure of the governing authority 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 four complaints which were substantiated during the onsite survey which was conducted July 24-26, 2023, August 2-3, 2023 and August 7-8, 2023. The complaint allegations included ineligible residents, a lack of management at the facility, food supply and portions of food served were inadequate, there was no Registered Nurse (RN) at the facility, resident assessments 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#22 became administrator of

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the facility on December 1, 2022 and resigned from the facility in May 2023. EI#23 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. There had been no RN/Director of Nursing (DON) at the facility since May 2023. EI#21, RN/DON resigned from the facility on August 25, 2022. EI#24, RN, was employed at the facility from October 2022 until January 2023. EI#25, RN, was employed at the facility from February 2023 until May 2023. Although EI#23 was also an RN in addition to being administrator, EI#23 was employed at the facility for only twelve days. 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 surveyor that he (EI#1) had been owner of the facility since August 2022.

The local ombudsman had visited the facility on July 17, 2023. Multiple concerns were reported by the ombudsman, including inadequate food supply, a bill not paid, ineligible residents, inadequate portions of food served, lack of staff training and lack of management. Some of these same concerns were 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

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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 DON and Executive Director coming on board. An RN was available on call (EI#5) and the phone number for the RN was posted in the facility. A previous RN (EI#21) was coming that evening to perform assessments of the memory care residents (as requested by the surveyor). 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". EI#1 said when he (EI#1) thought he (EI#1) had a new director, 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 day, it is hard." On August 3, 2023, EI#1 informed the surveyor the DON 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#23, previous administrator, had spoken with the local ombudsman about four weeks ago

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regarding the ombudsman's concerns at the facility. However, EI#1 was not notified of the "action items" provided by the ombudsman to EI#23 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. It was explained to EI#1 by the surveyor that multiple staff (EI#3, EI#8, EI#11, EI#12, EI#17 and EI#18) 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 were noted taped to the nurses' desk, the ombudsman reported to the 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 7, 2023, EI#4 informed the surveyor that she (EI#4) was hired only two weeks prior and was hired to work primarily at The Pearl, a sister facility owned by EI#1.

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

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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#27, Owner. EI#27 stated he (EI#27) had been unable to work and be at the facility recently and EI#1 had been the managing partner of the ownership. EI#27 added that, beginning immediately, he (EI#27) would take over the management of the facility. On the afternoon of August 10, 2023, the surveyor received an email from EI#1 stating EI#27 would be handling all management duties at the facility. EI#1 added that EI#27's phone number had been posted at the facility and EI#1's phone number had been removed. On August 25, 2023, EI#27 informed the surveyor that the entire bill had been paid to the facility's food supplier. EI#27 also stated he (EI#27) 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

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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). The facility was not staffed at all times to meet the care and safety needs of the residents. 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 - There was no RN to devote adequate time to completing RN duties. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.
406 - 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 at all times. Agency phone numbers and the most recent state survey results were not posted. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.
508- Incidents were not reported to the ADPH.
601 - Physician's orders were not followed for a resident's medication administration. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.
604 - Health supervision and assessments of residents were inadequate. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.
611 - Residents' care plans were not current or non-existent. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.
616 - The facility failed to maintain a system to account for controlled substances in its possession.
617 - Medication disposition was not adequately

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A 301	Continued From page 8 documented following discharge of residents. Medications of a resident who had been discharged were not destroyed timely. 621 - Residents were retained at the facility who did not meet the requirements for residents of a SCALF. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 703 - The facility's food supply was inadequate resulting in weight loss to four residents. Portions of food served to residents were inadequate. Snacks were not provided to residents. Weekly menu and meal times were not posted. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 804 - A refrigerator was not properly maintained. 1101 - Fire drills were not conducted as required. 1203 - Fire extinguishers were not checked monthly. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON APRIL 10, 2019. 1206 - Exit door locks did not release automatically upon activation of the fire alarm system.	A 301		
A 302	420-5-20-.03 (e) Administration. (e) Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). All residents shall be informed of new policies or changes in existing policies that may have bearing on the resident. All residents shall be provided a copy of such policies at least 30	A 302		

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days prior to the policies taking effect. Policies shall cover the following:

(i) Facility responsibility to protect all residents from abuse, neglect, and exploitation.

(ii) How allegations of abuse, neglect, and exploitation will be handled by the facility.

(iii) Resident confidentiality.

(iv) Admission and continued stay criteria.

(v) Discharge criteria and notification procedures for residents and sponsors.

(vi) Facility responsibility when a resident's personal belongings are lost.

(vii) What services the facility is capable and not capable of providing.

(viii) Medication management.

(ix) Infection control.

(x) Meal service, timing, menus and food preparation, storage, and handling.

(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.

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(xiv) Dietary Policies. The dietitian, with the approval of the administrator, shall develop written policies and procedures for the guidance of all personnel handling food as outlined by the most current Food and Drug Administration Food Code published by the U.S. Department of Health and Human Services. The facility shall develop and implement dietary policies and procedures to meet the needs of the residents in the facility. In addition to other matters deemed necessary by the facility, dietary policies shall address:

(I) Sanitation of dishes, utensils, and service equipment, and sanitary food preparation and handling.

(II) The attire and cleanliness of staff members who prepare, handle, or serve food.

(III) A schedule of meals, which shall include between-meal nourishment or snacks, and fluids.

(IV) Food substitutions or alternatives.

(V) Method to ensure an adequate dietary plan is implemented for any resident with a 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

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A 302	Continued From page 11 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. Findings: According to the facility's Medication Administration - SCALF Policy and Procedure, "...The facility shall maintain a system to account for all controlled substances in its possession...". The facility failed to utilize the system in place to account for controlled substances in its possession. Refer to deficiency 616 for additional information. According to the facility's Incident/Accident and Unusual Occurrences Policy and Procedure, "...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 to ADPH as required. Refer to deficiency 508 for	A 302		

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additional information.

According to the facility's Staffing - SCALF Policy and Procedure, "...The facility must be sufficiently staffed to ensure the evacuation of residents in the event of a fire or emergency...Additional staff is provided according to the needs of the residents...". The facility failed to provide staffing to meet the care and safety needs of the residents. Refer to deficiency 401 for additional information.

According to the facility's Meal Timing, Service and Menus Policy and Procedure, "...The meals shall be of the quality and quantity necessary to meet the resident's needs, and shall be in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences...Snacks shall be available between meal service and upon request...The current week's menu shall be posted in the dining room and food service area...". The facility failed to provide a sufficient quantity of food during meal time and between meal snacks. In addition, the facility failed to post the menu in the food service area. Refer to deficiency 703 for additional information.

According to the facility's Monitoring Resident Nutritional Status Policy and Procedure, "...When weight loss or intake issues are identified the Administrator will ensure a plan of care is developed to meet the residents' immediate needs...". The facility failed to ensure residents' care plans were updated when significant weight loss occurred and residents were monitored for further weight loss. Refer to deficiencies 604 and 611 for additional information.

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A 302	Continued From page 13 When interviewed on August 8, 2023, EI#2 agreed the facility's policies had not been followed.	A 302		
A 303	420-5-20-.03 (2) (a) Administration. (2) The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the specialty care assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an administrator shall meet all applicable statutory requirements. 4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days. 5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age. 6. The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character.	A 303		

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A 303	Continued From page 14 7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week. 8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment and adequate care actually being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement. 9. The facility administrator is responsible for ensuring that required training is provided to all staff. 10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting. 11. The administrator shall ensure that facility staff members observe each resident for 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	A 303		

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A 303	Continued From page 15 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. EI#8, Care Coordinator, informed the surveyor there was no administrator, no DON and no RN. A letter, posted on a bulletin board behind the nurses' desk, listed EI#2 (former administrator) as the current administrator and also listed the former RN/DON (EI#21) 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#21 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		

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A 401	420-5-20-.04 (1) (2) Personnel. (1) A specialty care assisted living facility shall ensure adequate personnel are employed and on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. No specialty care assisted living facility shall have fewer staff on duty than specified in Table A below. Even if this minimum staffing ratio is met, the governing authority of a specialty care assisted living facility shall have additional staff on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. Facilities with resident bedroom wings separated from the remainder of the facility by a lockable door shall maintain dedicated staff to these areas adequate to meet all care and safety needs of the residents in these areas at all times.	A 401		

Table A

Staff Number	7 AM - 3 PM	3 PM - 11 PM	11 PM - 7 AM
2	1 -16 Residents	1 - 16 Residents	1 - 16 Residents
3	17 - 24 Residents	17 - 36 Residents	17 - 48 Residents
4	25 - 32 Resident	37 - 48 Residents	49 - 64 Residents
5	33 - 40 Residents	49 - 60 Residents	65 - 80 Residents
6	41 - 48 Residents	61 - 72 Residents	81 - 96 Residents
7	49 - 56 Residents	73 - 84 Residents	97 - 112 Residents
8	57 - 64 Residents	85 - 96 Residents	113 - 128 Residents
9	65 - 72 Residents	97 - 108 Residents	129 - 144 Residents

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A 401	Continued From page 17 10 73 - 80 Residents 109 - 120 Residents 145 - 160 Residents 11 81 - 88 Residents 120 - 132 Residents 161 - 176 Residents 1 Additional Staff For each 8 residents, or any fraction thereof, by which the census exceeds 88 For each 12 residents, or any fraction thereof, by which the census exceeds 132 For each 16 residents, or any fraction thereof, by which the census exceeds 176 (a) A specialty care assisted living facility shall be staffed at all times by at least one individual who has a current certification in cardiopulmonary resuscitation (CPR). (b) A specialty care assisted living facility must be sufficiently staffed to ensure the safe evacuation of all residents in the event of a fire or emergency. (2) Employee Schedule. A specialty care assisted living facility shall post a schedule of employees indicating names and days and hours scheduled to work. This schedule shall be retained in the facility for 6 months after use. In the event of an unplanned staff shortage which would make it otherwise impossible to meet the staffing requirements imposed by these rules, a facility may employ a certified nurse aide who has not received the training specified in these rules. For the purposes of this subsection, a certified nurse aide is defined as an individual who has been deemed or determined to be competent by the Alabama Nurse Aide Registry	A 401		

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A 401	Continued From page 18	A 401		

maintained by the Alabama Department of Public Health. This individual may not work unless accompanied at all times by an individual who is appropriately trained in accordance with these rules. Such employment shall last only until the facility has employed staff trained in accordance with the above. In no event may the period during which such staff is employed in a facility exceed 120 consecutive hours.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility was not staffed at all times by at least one individual who had current certification in CPR. In addition, staffing was not sufficient at all times to meet the care and safety needs of the residents.

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.

CPR Certified Staff on Duty

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 had been certified in CPR at the time the surveyor entered the facility

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A 401	Continued From page 19	A 401		

on July 24, 2023. The one employee who was currently CPR certified (EI#8) was the Care Coordinator. A CPR certification class was held on August 1, 2023 and six additional staff members obtained CPR certification (after the surveyor entered the facility). Prior to 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#8 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.

Insufficient Staffing to Meet Care and Safety Needs of Residents

On July 24, 2023, the census of the facility was 10 residents. Of these 10 residents, one {Resident Identifier (RI)#7}was bedbound and required total care, including feeding, incontinent care and turning/repositioning at least every two hours. Four additional residents (RI#5, RI#6, RI#8 and RI#10) required two-person assistance to stand and transfer from the bed to the wheelchair. Once seated in a wheelchair, only one of these four residents (RI#6) was able to propel the wheelchair when instructed to do so. All four of these residents were incontinent and required incontinent care at least every two hours. Two residents (RI#1 and RI#4) would attempt to get up alone and had a history of falls, requiring frequent monitoring to prevent additional falls. Four residents (RI#5, RI#6, RI#7 and RI#10)

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A 401	Continued From page 20 required feeding assistance. Review of employee schedules for the past two months, on July 24, 2023, revealed the facility was staffed with a minimum of two staff members at all times. On the day shift (6:00 AM-2:00 PM) and evening shift (2:00 PM-10:00 PM) there were usually two Personal Care Attendants (PCAs) and a nurse. However, on the night shift (10:00 PM-6:00 AM) only two PCAs were scheduled and no nurse was available in the facility. On the morning of July 26, 2023, the surveyor interviewed PCAs on the night shift. Both EI#17 and EI#18 stated they were unsure if they would be able to timely evacuate residents of the facility in the event of a fire due to the five residents with severe mobility impairments who required two staff members to transfer. The facility was not adequately staffed at all times to meet the care and safety needs of the residents. On July 24, 2023, residents' care and safety concerns were discussed with EI#2 and EI#3. An immediate plan of action was requested by the surveyor to increase staffing to meet the residents' care and safety needs at all times. An updated schedule was received from EI#3 with a minimum of three staff on duty at all times. In addition, 30-day discharge notices were issued to four residents who did not meet the criteria for SCALF residents.	A 401		
A 402	420-5-20-.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	A 402		

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A 402	Continued From page 21	A 402		

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. Specialty care assisted living facilities shall immunize employees in accordance with current recommended Centers for Disease 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) A specialty care 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 review 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.

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A 402	Continued From page 22 EI#8, EI#11 and EI#16 did not have a documented physical examination certifying they were free of signs and symptoms of infectious skin lesions and diseases capable of transmission to residents through normal staff to resident contact. Also, EI#16 did not have documentation of screening for tuberculosis. EI#8 had documentation of screening through the ADPH Aide Abuse Registry but the screening was completed on May 12, 2023, after EI#8's hire date of May 9, 2023. 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 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	420-5-20-.04 (6) (7) (8) Personnel. (6) Medical Director. Each specialty care assisted living facility shall have a medical director who is a physician currently licensed to practice medicine in Alabama. The medical director is responsible for implementation of resident care policies, and the coordination of medical care in the facility. The medical director shall participate in quality assurance activities in the facility. A nurse practitioner or physician's assistant shall not serve as the medical director of a specialty care assisted living facility. (7) Registered Professional Nurse. Each facility shall have at least one RN. An RN may also serve as the administrator or as the care coordinator, but not as both. In all instances	A 405		

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A 405	Continued From page 23	A 405		

where the facility's RN is assigned other duties as an administrator or care coordinator the facility must assure that the RN devotes sufficient time and effort to all clinical duties.

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

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

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

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

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

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

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

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

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A 405	Continued From page 24 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide an RN who devoted sufficient time and effort to all clinical duties. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged there was no RN at the facility and RN duties had not been fulfilled. The surveyor was able to substantiate this complaint during the onsite survey. When the surveyor entered the facility on July 24, 2023, there was no RN at the facility. EI#8, Care Coordinator, informed the surveyor there had been no RN at the facility since May 2023. EI#2 and EI#3 informed the surveyor there had been no RN at the facility since the last administrator (EI#23) left on June 6, 2023. EI#3 reported that EI#23 had only worked at the facility for 12 days. Prior to EI#23, EI#24 was employed at the facility as the RN from October 2022 until January 2023 and EI#25 was employed at the facility as the RN from February 2023 until May 2023. Review of resident records, on July 25 and 26, 2023, revealed comprehensive assessments and monthly assessments had not been completed as required. In addition, residents were not assessed prior to admission and care plans were not current. In fact, two residents did not even have a care plan. Refer to deficiencies 604 and 611. On July 25, 2023, four residents were identified by the surveyor who did not meet the criteria for	A 405		

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retention in a SCALF. The surveyor requested RN assessments of these residents from EI#2 and EI#3. In response to this request, a previous RN at the facility (EI#21) was brought to the facility to perform these assessments. The surveyor interviewed EI#21 on the afternoon of August 6, 2023. EI#21 informed the surveyor she (EI#21) had only been contracted to complete assessments of four residents and did not have any other contracts to work with the facility.

On July 24, 2023, the surveyor observed a letter taped to the desk at the nurses' station which contained EI#5's name and phone number. The letter listed EI#5 as a "corporate nurse" but did not direct staff as to EI#5's availability or what type of questions or situations would warrant a call to EI#5. EI#8, EI#11, EI#12, EI#17 and EI#18 stated there was not an RN available or on call at the facility. On the morning of August 3, 2023, the surveyor asked EI#1 about the lack of an RN at the facility. EI#1 stated EI#5 had been "on call" at the facility for the past two weeks and was available for assessments. EI#1 added that staff had been informed of EI#5's availability multiple times. On August 8, 2023, the local ombudsman confirmed that the letter containing contact information for EI#5 had only been posted in the facility approximately two weeks prior to the survey, following the ombudsman's visits and recommendations to the facility. On August 8, 2023, EI#2 provided the surveyor with a "RN Coverage Agreement" form, dated October 12, 2022 and signed by EI#1 and EI#5. The agreement stated EI#5 agreed to "provide Consultation services for...Heritage Assisted Living Facilities. Consultation services may include assessments, medical delimas[sic] (on call basis), and compliance with state regulations...".

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A 405	Continued From page 26 RN assessments and care plans had not been completed and updated at the facility. Ineligible residents had been retained without a current assessment of their functional status. There was no RN who devoted sufficient time and effort to completing the duties that required an RN. When interviewed on August 3, 2023, EI#1 was unable to explain why RN duties had not been fulfilled.	A 405		
A 406	420-5-20-.04 (9) Personnel. (9) 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. An RN shall identify staff training needs and shall provide or arrange for needed training. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that, prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on specialty care assisted living facilities. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire. 5. Identifying and reporting abuse,	A 406		

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A 406	Continued From page 27 neglect, and exploitation. 6. Basic first aid. 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environmental safety. (b) Prior to providing any resident care, all staff shall complete The Dementia Education and Training Act (DETA) Care Series Training developed by the Alabama Department of Mental Health or equivalent training approved by the State Health Officer. All licensed staff shall complete DETA Brain Series Training, The Pharmacological Management of Dementia, and the Dementia Assessment Series provided by the DETA Program or equivalent training approved by the State Health Officer prior to resident contact. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained. (c) All staff who have resident contact shall be able to demonstrate diversional methods and redirection. All staff shall be able to demonstrate an understanding of the implications of caring for residents with agnosia, amnesia, aphasia, and apraxia. All staff shall be able to demonstrate an understanding of the facility's fire and evacuation plan and all other policies regarding safety, including policies for preventing elopements, responding to elopements, and fall prevention.	A 406		

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A 406	Continued From page 28 (d) Cardiopulmonary Resuscitation. A specialty care assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of a specialty care assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within 90 days of hire. A specialty care assisted living facility equipped with an automated external defibrillator (AED) shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or the American Red Cross in CPR or AED utilization. (e) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training. (f) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above. This Rule is not met as evidenced by: Based on record reviews and interview, employees did not receive required training.	A 406		

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A 406	Continued From page 29 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#8 had been employed at the facility since May 9, 2023. EI#8 had not completed initial SCALF training including the following: State law and rules on SCALFs; 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; safety and nutritional needs of the elderly; diabetes training; hospice training. The facility currently had residents with a diagnosis of diabetes mellitus as well as residents who were receiving hospice services. EI#11 had been employed at the facility since April 5, 2023. EI#11 had not completed initial SCALF training including the following: State law and rules on SCALFs; 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; safety and nutritional needs of the elderly; diabetes training; hospice training. The facility currently had residents with a diagnosis of diabetes mellitus as well as residents who were	A 406		

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A 406	Continued From page 30 receiving hospice services. EI#11 also did not have current CPR certification. 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 added that the newer employees had completed DETA Brain and Care but likely did not complete the other required initial training.	A 406		
A 504	420-5-20-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission, of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate. 1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility. 2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints. 3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and	A 504		

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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.

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

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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 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

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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.

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

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

16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities.

17. Every resident shall have the right to

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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, and to keep and use his or her own personal possessions, including toilet articles, except for personal possessions too large to be stored in the resident's room.

22. Every resident shall have the right to be afforded privacy for sleeping and for storage

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A 504	Continued From page 35 of personal belongings. 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file. 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. In addition, required agency names and telephone numbers, as well as the most recent inspection report, were not posted in the facility. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received complaints which alleged residents did not meet the criteria for a SCALF, staff were not properly trained, medications were not administered as ordered, food portions and supply were inadequate and health supervision of residents was inadequate. The surveyor was able to substantiate these complaints during the onsite survey.	A 504		

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A 504	Continued From page 36 Safe and Decent Environment 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. The facility was not staffed at all times to meet the care and safety needs of the residents. 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 always provided with snacks and adequate portions of food, resulting in actual weight loss and harm to four residents. Refer to deficiencies 604 and 703 for additional information. Fire drills were not conducted monthly and fire extinguishers were not checked monthly. Refer to deficiencies 1101 and 1203 for additional information. Health supervision of residents was inadequate. Residents who sustained significant weight loss were not monitored to determine the effectiveness of the plan of care. Resident care plans were not current or non-existent. Refer to deficiencies 604 and 611 for additional information. Ineligible residents were retained at the facility without adequate staff to meet the care and safety needs of these residents. Refer to	A 504		

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A 504	Continued From page 37 deficiency 621 for additional information. Telephone Numbers Not Posted/Inspection Report Not Posted During a tour of the facility on July 24, 2023, the following required agency names, addresses and telephone numbers were not posted: Department's Bureau of Health Provider Standards, 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. In addition, the most recent state inspection report was not posted in a prominent location. During discussion of deficiencies on August 8, 2023, EI#2 agreed these deficient practices violated residents' rights and resulted in harm to residents.	A 504		
A 508	420-5-20-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in a specialty care assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review. 1. Incidents which require investigation are:	A 508		

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(i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as extensive bruising, pain, or injury that is not consistent with actions necessary in providing day-to-day care to a resident or for which medical treatment was sought.

(ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid including but not limited to a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office.

(iii) The onset of wandering behavior by any resident who is not fully cognitively intact.

(iv) Elopement by a resident.

(v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules.

(vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules.

(vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules.

(viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including

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those listed in Appendix I to 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.

(iii) When the administrator was notified (date and time).

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A 508	Continued From page 40 (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. (xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images,	A 508		

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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.

(ii) Elopement by a resident.

(iii) Suspected, alleged, confessed, witnessed, or actual abuse, neglect, or exploitation of a resident or residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents

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A 508	Continued From page 42	A 508		

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

(x) Any indication of a malfunction of the sprinkler system, fire alarm system, or a door locking device.

4. The report to the Department's

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A 508	Continued From page 43 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. (i) Vital Statistics Reports. A record shall be kept of all births, deaths, and stillbirths that occur within the specialty care assisted living facility. By the fifth day of each month, the administrator shall make a report of such births, deaths, and stillbirths for the preceding month on such forms as the State Board of Health shall provide to the county health officer, or in counties without a county health officer, to the State Registrar. This report shall be in addition to the official birth, death, and stillbirth certificates. If there are no births, deaths, or stillbirths in any month, a report shall be made stating that fact to	A 508		

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A 508	Continued From page 44 the county health officer. This Rule is not met as evidenced by: Based on record reviews and interviews, incidents were not reported to the ADPH Online Incident Reporting System (OIRS) as required. Findings: Review of facility records and review of the ADPH OIRS on July 24, 25 and 26, 2023 revealed the following information. RI#2 was admitted to the facility on March 5, 2017 and had diagnoses which included iron deficiency anemia, dementia, vitamin D deficiency, history of falls, asthma and hyperlipidemia. Refer to deficiency 604 for additional information on RI#2. RI#2's facility care plan contained the following documentation, "...5/9/23 Fall head injury with confusion sent to ER...". No report of this fall and injury to RI#2 was received by the ADPH OIRS. RI#4 was admitted to the facility on January 16, 2023 and had diagnoses which included Alzheimer's disease, dementia and history of falls. Refer to deficiencies 604, 611 and 703 for additional information on RI#4. RI#4 was admitted to the hospital on April 13, 2023 with right distal radius, right superior/inferior pubic rami and right sacral fractures. The hospital record read, "...The patient ...was transferred from (his/her) SCALF to the HH ER on 4/13/23 after (he/she) was found on the floor due to a presumed fall...". No report of this fall with injury	A 508		

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A 508	Continued From page 45 to RI#4 was received by the ADPH OIRS. Review of the ADPH OIRS on July 26, 2023 revealed no incidents had been reported by the facility since December 24, 2022. On August 8, 2023, EI#2 agreed incidents had not been reported to ADPH as required.	A 508		
A 601	420-5-20-.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 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 other emergency call). (b) Back-up Physician Support. Each specialty care 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	A 601		

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A 601	Continued From page 46 practitioner or physician's assistant shall not serve as the back-up physician in a specialty care 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 case shall exceed 30 days following entry of the order. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to follow physician's orders for a resident's medications. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged residents' medications were not administered as ordered by the resident's physician.	A 601		

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A 601	Continued From page 47 RI#1 was admitted to the facility on April 21, 2022 and had diagnoses which included hypothyroidism, hypertension, major depressive disorder, chronic kidney disease stage 2, anemia, sleep apnea, gout, osteoarthritis, disc degeneration, venous insufficiency and atherosclerotic heart disease. Refer to deficiency 604 for additional information on RI#1. RI#1 had a physician's order for Gabapentin 300 milligrams one capsule by mouth two times a day. RI#1's Medication Administration Record (MAR) was reviewed for the month of July 2023. The MAR read, "...Gabapentin cap 300 mg Take 1 capsule by mouth twice daily (on demand, please request refill 3-5 days before current supply runs out)...". The following doses of Gabapentin were documented as not given on the MAR and the initials were circled to indicate the doses were not given in July 2023: July 21 - evening dose; July 22 - morning and evening dose; July 23 - morning and evening dose; July 24 - morning dose. The reason for the missed doses was "other". No specific reason was recorded to explain why the doses were omitted. On the evening of July 24, 2023, Gabapentin 300 milligrams was administered to RI#1 by EI#9. EI#9 explained that the omitted doses were due to the medication not being available at the facility because no one had obtained a new prescription from the physician as directed prior to the current supply running out. EI#9 stated RI#1 should not have gone without the Gabapentin and added RI#1 had behaviors the previous day which were possible withdrawal effects of the Gabapentin.	A 601		
A 604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents.	A 604		

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A 604	Continued From page 48	A 604		

(3) Health Supervision.

(a) Initial Assessment. No more than 30 days prior to admission, the facility RN or care coordinator shall screen prospective residents for eligibility for admission into the specialty care assisted living facility. The screening shall include a clinical history, a mental status examination to include aphasia screening, a geriatric depression screen, a physical self-maintenance screen, and a behavior screen.

Appendix A herein, contains the Physical Self Maintenance Scale (PSMS) form and the Behavior Screening form. These forms shall be completed to screen physical functioning and behaviors. The PSMS and Behavior Screen assessments shall be completed by the RN or care coordinator upon admission, annually, and when there is a change in the resident's status.

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

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

(c) Comprehensive Assessment. The

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A 604	Continued From page 49 facility RN shall perform a comprehensive assessment and communicate with the resident's attending physician and with the resident's sponsor or responsible family member when a decline in health status or behavior occurs, or if the resident develops any of the following problems: 1. Weight loss: (i) Each month, the facility shall accurately weigh and record the weight of each resident. (ii) A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half percent or greater weight loss in a period of 3 months or less, or a 10 percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician. 2. Falls (two or more falls within a 30 day period). 3. Elopement. 4. Any sign and symptom of adverse drug reaction, interaction or over sedation, or circumstances which contraindicate medications that have been prescribed for the resident. 5. Unmanageable, combative, or potentially harmful behavior(s).	A 604		

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A 604	Continued From page 50 6. Any accident with injury. (d) Focused Assessments. The RN or LPN shall conduct focused assessments when necessary to identify changes in resident status. (e) Any change in resident status requires immediate documentation and implementation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, health supervision and assessments of residents were not completed as required. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged there was no RN at the facility. The surveyor was able to substantiate this complaint during the onsite survey. The following deficient practices were cited as a result of the complaint investigation and as a result of the facility's failure to provide an RN who devoted adequate time to RN duties at the facility. Review of resident records and observations of residents on July 24, 25 and 26, 2023 revealed the following information. RI#1 had resided at the facility since April 21,	A 604		

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2022. Refer to deficiency 601 for additional information on RI#1. EI#8 reported RI#1 had transferred from the assisted living facility to the SCALF but the exact date was unknown. An "Admission" comprehensive assessment of RI#1 was found in RI#1's facility record but no date and no signature were on the form. A Focused Assessment was documented for RI#1 on July 30, 2023 with the Reason for Focused Assessment as "returned to facility". No signature was on the Focused Assessment and there was no comprehensive assessment, PSMS and Behavior Screening to indicate a significant change.

RI#2 had resided at the facility since March 5, 2017. Refer to deficiency 508 for additional information on RI#2. A comprehensive assessment was documented for RI#2 on June 6, 2023 with Reason for Comprehensive Assessment "history of falls". No signature was on the form. No monthly assessment and weight were documented for RI#2 in May 2023. RI#2's monthly assessment in January 2023 was documented by a licensed practical nurse (LPN), not by an RN as required. RI#2 had increased confusion on July 5, 2023 and a urinalysis and culture with sensitivity was ordered. No comprehensive assessment, PSMS and Behavior Screening were documented for this significant change.

RI#3 was admitted to the facility on October 13, 2021 and had diagnoses which included dementia, chronic atrial fibrillation, atherosclerotic heart disease, essential hypertension, seizures, cerebrovascular accident and atelectasis. A comprehensive assessment of RI#3 was documented on June 5, 2023 but the assessment was not signed to indicate if it was completed by

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A 604	Continued From page 52 an RN. RI#4 had resided at the facility since January 16, 2023. Refer to deficiencies 508, 611 and 703 for additional information on RI#4. No comprehensive assessment, aphasia screening and depression screening were completed on RI#4 to determine facility eligibility. RI#4's monthly assessment in January 2023 was documented by an LPN, not by an RN as required. A comprehensive assessment of RI#4 was documented on May 16, 2023 but was not signed. No reason was documented for the assessment. In May 2023, RI#4 sustained a 10.6 per cent weight loss for one month (131 pounds in April 2023 and 117 pounds in May 2023). No comprehensive assessment, PSMS and Behavior Screening were documented for this significant change. RI#5 was admitted to the facility on October 10, 2019 and had diagnoses which included Lewy body dementia, hypertension, constipation and history of Covid-19. Refer to deficiencies 611 and 621 for additional information on RI#5. All staff reported to the surveyor that RI#5 had declined in functional status. On July 25, 2023, the surveyor observed staff toileting RI#5. Two staff members were required for the transfer and RI#5 did not propel the wheelchair purposefully when seated in it. A comprehensive assessment of RI#5 was documented on June 6, 2023 but no reason for the assessment was documented and there was no signature on the form. RI#5's monthly assessment in January 2023 was documented by an LPN, not by an RN as required. At the request of the surveyor, a comprehensive assessment, PSMS and Behavior Screening were completed for RI#5 on July 28, 2023. RI#5's PSMS showed a total score of 25 with a score of 4 in Physical	A 604		

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A 604	Continued From page 53 Ambulation (sits unsupported in chair or wheelchair, but cannot propel self without help). Both scores were above the level allowed for a resident of a SCALF. RI#6 was admitted to the facility on September 25, 2018 and had diagnoses which included history of falls, osteoarthritis, Alzheimer's dementia with behaviors, vitamin D deficiency, history of breast cancer, major depressive disorder, hypertension and hypoxemia. No monthly assessment was documented for RI#6 in May 2023. RI#6's monthly assessment in January 2023 was documented by an LPN, not by an RN as required. A comprehensive assessment was documented for RI#6 on June 6, 2023 but was not signed to indicate if it was completed by an RN. RI#7 was admitted to the facility on June 23, 2021 and had diagnoses which included atrial fibrillation, dementia without behavioral disturbance, heart failure, dysphagia, diabetes mellitus II, nontraumatic subdural hemorrhage, acute kidney failure, altered mental status and hypotension. Refer to deficiency 611 for additional information on RI#7. All staff reported RI#7 had recently declined and was bedridden. During the onsite survey, the surveyor observed RI#7 required 2 person assistance to turn side to side in the bed. RI#7 was receiving hospice services at the facility. No comprehensive assessment, PSMS and Behavior Screening had been documented for the decline in RI#7's condition. RI#7's monthly assessment in January 2023 was completed by an LPN, not by an RN as required. The most recent comprehensive assessment of RI#7 was documented on June 5, 2023 but the assessment contained no signature to indicate if it had been completed by an RN. RI#7 sustained	A 604		

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a significant weight loss of 5.9 per cent in June 2023 (167 pounds in May 2023 and 157 pounds in June 2023). No comprehensive assessment, PSMS and Behavior Screening were documented for this significant change. At the request of the surveyor, a current comprehensive assessment, PSMS and Behavior Screening were completed for RI#7 on July 28, 2023. RI#7's PSMS showed a total score of 26 with a score of 5 in Physical Ambulation (bedridden more than half the time). Both scores were above the level allowed for a resident of a SCALF.

RI#8 was admitted to the facility on July 6, 2021 and had diagnoses which included dementia, anemia, vitamin D deficiency, chronic kidney disease, major depressive disorder, falls and hypertension. Refer to deficiencies 611, 621 and 703 for additional information on RI#8. RI#8 was receiving hospice services at the facility. All staff reported RI#8 had declined in functional status. RI#8 was currently receiving hospice services at the facility. On July 25, 2023, the surveyor observed 2-person assistance was required for toileting RI#8 and RI#8 did not propel the wheelchair purposefully. A comprehensive assessment of RI#8 was documented on June 6, 2023 but the form was not signed to indicate if it was completed by an RN. RI#8's monthly assessment in January 2023 was documented by an LPN, not by an RN as required. RI#8 sustained a significant weight loss of 10.1 per cent for three months in July 2023 (108 pounds in April 2023 and 97 pounds in July 2023). No comprehensive assessment, PSMS and behavior screening were completed for this significant change in RI#8's condition. At the request of the surveyor, a current comprehensive assessment, PSMS and Behavior Screening were completed for RI#8 on July 28, 2023. RI#8's PSMS showed

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a total score of 27 with a 5 in Feeding (does not feed self at all and resists efforts of others to feed him/her), a 4 in Physical Ambulation (sits unsupported in chair or wheelchair, but cannot propel self without help) and a 5 in Bathing (does not try to wash self, and resists efforts to keep him/her clean). All four scores were above the level allowed for a resident of a SCALF.

RI#9 was admitted to the facility on February 3, 2023 and had diagnoses which included anxiety, hypothyroidism, reactive hypoglycemia, osteoarthritis, osteopenia, venous insufficiency, kyphosis, lymphedema and history of urinary tract infection. No comprehensive assessment was completed for RI#9 prior to admission to determine eligibility. A comprehensive assessment was documented for RI#9 on June 6, 2023 due to increased confusion but the assessment did not contain a signature to indicate if it had been completed by an RN. No weights were documented for RI#9 in April and May 2023.

RI#10 was admitted to the facility on January 16, 2023 and had diagnoses which included dementia, Alzheimer's disease, essential hypertension, vitamin B deficiency, osteoporosis, senile degeneration of the brain and history of urinary tract infection. Refer to deficiencies 611, 621 and 703 for additional information on RI#10. RI#10 was currently receiving hospice services at the facility. All staff reported RI#10 required 2 staff members to assist with transfers and care. On July 25, 2023, the surveyor observed 2 staff members toilet and transfer RI#10. RI#10 would hold tightly to the grab bar and pull against staff making transfers difficult and unsafe. The only monthly assessment documented for RI#10 in 2023 was in July. RI#10 sustained a significant

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weight loss of 5.3 per cent for one month in July 2023 (116.2 pounds in June 2023 and 110 pounds in July 2023). The only weights documented for RI#10 in 2023 were in June and July. No comprehensive assessment, PSMS and behavior screening were completed when this significant change occurred in RI#10's condition. A comprehensive assessment of RI#10 was documented on June 6, 2023 due to admittance to hospice. The comprehensive assessment was not signed to indicate if it was completed by an RN. At the request of the surveyor, a comprehensive assessment, PSMS and Behavior Screening were completed for RI#10 on July 28, 2023. RI#10's PSMS showed a total score of 26 with a score of 4 in Physical Ambulation (sits unsupported in chair or wheelchair, but cannot propel self without help) and a score of 5 in Bathing (does not try to wash self, and resists efforts to keep him/her clean). All three scores were above the level allowed for a resident of a SCALF.

There had been no RN to devote sufficient time to the facility since at least May 2023. None of the 10 current residents had been properly assessed to determine their eligibility to reside in the facility. Monthly assessments had not been completed to determine if significant changes occurred in the resident's status which required changes in care interventions. In fact, four residents (RI#5, RI#7, RI#8 and RI#10) did not meet the criteria for retention in a SCALF but had not been assessed to determine their need for a higher level of care. The lack of proper assessment placed all residents at significant risk of harm and neglect due to the increased care needs of the residents. Four residents (RI#4, RI#7, RI#8 and RI#10) sustained actual harm in the form of significant weight loss which was not adequately assessed

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A 604	Continued From page 57 and addressed. On August 3, 2023, EI#1 stated EI#5, RN, had been available to provide this health supervision but the services of EI#5 had not been utilized by facility staff.	A 604		
A 611	420-5-20-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. The RN shall develop written plans of care for each resident prior to or at the time of admission. The plans of care shall be based on resident's assessments, diagnoses, and recommendations of the resident's physician. The plan of care shall be developed in cooperation with the resident, if appropriate, and the sponsor. The RN shall identify resident care problem areas and formulate written interventions to address those problems. The RN shall evaluate the implementation of the interventions and the resident's response to the interventions and modify the plan of care as necessary. 1. The plan shall at all times reflect the current condition of the resident. All entries on the plan of care shall be accurately dated. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following:	A 611		

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

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

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

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

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

(v) Shaving. Men shall be assisted with

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A 611	Continued From page 59 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, residents' facility care plans were not current and did not contain interventions to meet the care needs of the residents. In addition, some residents did not have care plans to direct staff in providing their care. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: Review of residents' facility records and observations during the onsite survey revealed the following information. RI#4 had resided at the facility since January 16, 2023. Refer to deficiencies 508, 604 and 703 for additional information on RI#4. RI#4 was currently receiving hospice services at the facility. RI#4 required 2-person assistance for transfers and for personal care and was unable to propel him/herself once seated in a wheelchair. RI#4 had to be fed. RI#4 sustained a significant weight loss of 10.6 per cent for one month in May 2023	A 611		

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(131 pounds in April 2023 and 117 pounds in May 2023). On July 25, 2023, the surveyor requested RI#4's current care plan from EI#8. EI#8 was unable to locate a care plan for RI#4. RI#4 was in need of frequent care and monitoring due to multiple care needs, including significant weight loss. No care plan was available to direct facility staff in providing this care and in keeping RI#4 safe.

RI#5 had resided at the facility since October 10, 2019. Refer to deficiencies 604 and 621 for additional information on RI#5. RI#5 had received hospice services at the facility since June 2021. RI#5 used a wheelchair for mobility and was unable to self-propel the wheelchair when instructed to do so. RI#5 required 2-person assistance to transfer to the wheelchair, as well as for bathing, and had to be fed due to tremors of the hands and head. RI#5's facility care plan, dated June 12, 2023, read "...Staff x 1 will assist with ADL's (activities of daily living) including dressing, grooming, toileting, etc...able to feed self after set up...". A PSMS was completed for RI#5 on July 28, 2023. Under Feeding, RI#5 scored a 4 (requires extensive assistance for all meals). Under Dressing, Grooming, Physical Ambulation and Bathing, RI#5 scored 4, indicating RI#5 required major assistance or total care in these areas and was unable to propel him/herself in the wheelchair.

RI#6 had resided at the facility since September 25, 2018. Refer to deficiency 604 for additional information on RI#6. RI#6 required the assistance of two staff members to transfer and for personal care. Once seated in a wheelchair, RI#6 was able to propel him/herself a short distance. RI#6 had a history of skin breakdown and of falls from the wheelchair. On July 25, 2023, the surveyor

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requested RI#6's current care plan from EI#8. EI#8 was unable to locate a care plan for RI#6. RI#6 was in need of frequent care and monitoring due to multiple care needs. No care plan was available to direct facility staff in providing this care and in keeping RI#6 safe.

RI#7 had resided at the facility since June 23, 2021. Refer to deficiencies 604, 621 and 703 for additional information on RI#7. RI#7 had received hospice services at the facility since June 2022. RI#7 was bedbound and required total care to include turning every two hours. RI#7 slept most of the time. RI#7 required 2-person assistance for incontinent care, bathing and turning. RI#7 was not observed eating during the onsite survey and was not offered solid food. However, RI#7 would drink Ensure when provided but would cough when drinking. RI#7 had a diagnosis of dysphagia and a documented history of swallowing difficulty at the facility. RI#7's facility care plan, dated June 12, 2023, read "...Staff x 1 will assist with shower and washing hair...Staff x 1 will assist with peri care for episodes of bladder and bowel incontinence...Staff will assist x 1 with toileting every 2 hours and changing depends as needed...Staff to ensure resident use of (his/her) walker...Diabetic diet, NAS (no added salt)...cut meat up for dental issues...Ensure with meals...". A PSMS was completed for RI#7 on July 28, 2023. Under Physical Ambulation, RI#7 scored a 5 (bedridden more than half the time). Under Feeding, Dressing, Grooming and Bathing, RI#7 scored 4, indicating RI#7 required major assistance or total care in these areas. In addition, RI#7 sustained a significant weight loss of 5.9 percent for one month in June 2023 (167 pounds in May 2023 and 157 pounds in June 2023). This significant weight loss was not addressed on RI#7's facility care plan with

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appropriate interventions to prevent further weight loss.

RI#8 had resided at the facility since July 6, 2021. Refer to deficiencies 604, 621 and 703 for additional information on RI#8. RI#8 had received hospice services at the facility since February 2023. RI#8 required a wheelchair for mobility and was unable to self-propel the wheelchair when instructed to do so. RI#8 required 2-person assistance for transfer to the wheelchair and to provide bathing and dressing. When a meal was presented to RI#8 in the dining room, RI#8 would sit and look at the food and would only drink Ensure. RI#8 was resistant when staff attempted to assist with feeding. RI#8 sustained a 10 per cent weight loss for 3 months in July 2023 (108 pounds in April 2023 and 97 pounds in July 2023). The significant weight loss was not addressed on RI#8's facility care plan with appropriate interventions to prevent further weight loss. The care plan was dated June 12, 2023 and read "...Staff x 1 to assist with shower and hair washing...Staff to assist x 1 with ADLs including dressing, grooming, toileting, etc...Assist x 1 with transfers...Resident to use wheelchair for ambulation...". A PSMS was completed for RI#8 on July 28, 2023. The total score was 27 with a 5 in Feeding (does not feed self at all and resists efforts of others to feed him/her), a 4 in Physical Ambulation (sits unsupported in chair or wheelchair, but cannot propel self without help) and a 5 in Bathing (does not try to wash self, and resists efforts to keep him/her clean).

RI#10 had resided at the facility since January 16, 2023. Refer to deficiencies 604, 621 and 703 for additional information on RI#10. RI#10 had received hospice services at the facility since June 2023. RI#10 required a wheelchair for

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A 611	Continued From page 63 mobility and was unable to self-propel the wheelchair when instructed to do so. RI#10 required 2-person assistance to transfer to and from the wheelchair and to provide bathing and dressing. RI#10 had to be fed. RI#10 sustained a weight loss of 5.3 per cent for one month in July 2023 (120 pounds in June 2023 and 110 pounds in July 2023). This significant weight loss was not addressed on RI#10's care plan with appropriate interventions to prevent further weight loss. RI#10's facility care plan, dated June 3, 2023, read "...Staff x 1 will assist with shower and washing hair 3 times a week...Eating/Diet Regular...Staff x 1 to assist resident with tray set-up. A PSMS was completed for RI#10 on July 28, 2023. The total score was 26 with a 4 in Physical Ambulation (sits unsupported in chair or wheelchair, but cannot propel self without help) and a 5 in Bathing (does not try to wash self, and resists efforts to keep him/her clean). These residents' care plans had not been updated to address the residents' current care needs and to include appropriate interventions to provide for safety of the residents and to prevent injury or weight loss. Two residents did not have care plans to direct staff in providing their care. When interviewed on August 3, 2023, EI#1 stated EI#5, RN, had been available to assess residents and update care plans but the services of EI#5 had not been utilized by facility staff.	A 611		
A 616	420-5-20-.06 (5) (i) (j) (k) (l) (m) Care of Residents. (i) Medications kept under the control or custody of a specialty care assisted living facility shall be packaged by the pharmacy and shall be maintained by the facility in unit dose packaging.	A 616		

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Medications kept under the control or custody of the specialty care 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.

(j) Unless a resident can and does self-manage his or her own medications, a specialty care 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 specialty care 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 specialty care assisted living facility shall require pharmacies used for medication supply 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.

(k) If controlled substances prescribed for residents of any specialty care assisted living facility are kept in the custody of the specialty care 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 Alabama 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

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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.

(l) Medication administration 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 3 years. They shall be available for inspection and copying on demand by agents of the State Board of Health. They shall be made available for inspection at reasonable times by residents, anyone authorized by the resident, and by the sponsors of residents.

(m) 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

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A 616	Continued From page 66 all controlled substances in its possession. Findings: On the afternoon of July 25, 2023, the surveyor observed a count of the facility's controlled substances by EI#8 and EI#9. After counting the medications, both EI#8 and EI#9 signed a Shift Count for Controlled Substances form. Review of these forms for the months of May, June and July 2023 revealed numerous times each month that the forms were not signed to indicate the controlled substances had been counted and that the count was correct. EI#9 explained that there was not a nurse at the facility during the night shift from 10:00 PM until 6:00 AM. EI#9 stated when she (EI#9) left the facility after the evening shift around 10:00 PM, she (EI#9) would count the medications alone and sign the form since there was no other nurse available to count. EI#9 added she (EI#9) would leave the keys to the controlled substance drawer and to the medication cart in the medication cart in the assisted living facility located in the same building. Each morning the oncoming nurse would obtain the keys from the assisted living facility and count the controlled substances alone. However, night shift was not the only time that the controlled substance count was not documented. May 8 and May 31, 2023, no counts were documented for the entire day. June 11, 17, 22, 23, 27, 28, 29 and 31, 2023, no counts were documented for the entire day. July 2, 4, 9, 15, 16 and 22, 2023, no counts were documented for the entire day. When interviewed on August 8, 2023, EI#2 agreed the facility had not properly accounted for controlled substances in its possession.	A 616		

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A 617	Continued From page 67	A 617		
A 617	420-5-20-.06 (6) Care of Residents. (6) Disposal of Medications. (a) Controlled substances and legend drugs dispensed to residents, that are expired or unused because the medication is discontinued or because the resident dies, shall be destroyed within 30 days. Unused legend drugs that are not expired may be donated to a charitable clinic pursuant to Alabama Administrative Code Chapter 420-11-11, et. seq. Under no circumstances shall expired, discontinued, or unused medications be stored or housed in the facility beyond 30 days. (b) Medications of residents who are discharged or transferred to another facility shall be returned to the residents. The responsible party will sign a statement that these medications have been received. The statement shall list the pharmacy, prescription number, date, resident's name, and strength of the medication and the amount. This statement shall be maintained in a file for at least three years. (c) When medications are destroyed on the premises of the specialty care assisted living facility, a record shall be made and retained for at least three years. This record shall include: the name of the specialty care assisted living facility, the method of disposal, the pharmacy, the prescription number, the name of the resident, the name, strength, and dosage of the medication, and the amount and the reason for the disposal. This record shall be signed and dated by the individual performing the destruction and by at least one witness.	A 617		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, disposition of medications was not documented following discharge or transfer of residents. In addition, a resident's medication was not not destroyed within 30 days after discharge of the resident from the facility.

Findings:

RI#11 was admitted to the facility on December 2, 2022 and had diagnoses which included dementia and chronic renal insufficiency. RI#11 was discharged from the facility on June 24, 2023 to a skilled nursing facility. On July 25, 2023, EI#8 provided a Medication Release Form for RI#11 to the surveyor when requested. The form did not contain a date, the prescription numbers of the medications and the name of the pharmacy. EI#8 agreed the form was incomplete.

RI#12 was admitted to the facility on March 1, 2021 and had diagnoses which included atrial fibrillation, coronary artery disease, chronic obstructive pulmonary disease, hypertensive heart disease, dementia with behavioral disturbance, adjustment disorder with depressed mood and oxygen dependence. RI#12 had been discharged from the facility but EI#8 was unable to provide the discharge date or place where RI#12 was discharged, stating it was before her (EI#8's) employment at the facility. EI#8 was unable to locate any documentation of the disposition of RI#12's medications at discharge. In addition, on July 25, 2023, a bottle of pills labeled as Trazadone 50 milligrams 1/2 tablets, for RI#12, was noted in the drawer of the medication cart where controlled substances

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A 617	Continued From page 69 were stored. A count of four 1/2 tablets was remaining. EI#8 explained that the medication had been kept at the facility for greater than 30 days because there was currently no DON to discard the medications. On August 8, 2023, EI#2 agreed the medication disposition records had not been completed as required and controlled substances had not been destroyed timely as required. EI#2 added that she (EI#2) would make sure the controlled substances were destroyed.	A 617		
A 621	420-5-20-.06 (9) (b) Care of Residents. (b) Retention. 1. A specialty care assisted living facility shall not allow any resident to return to the specialty care assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the specialty care assisted living facility is licensed to provide or the facility is capable of providing. 2. A specialty care assisted living facility shall not retain a resident that has a PSMS score greater than 23 or a score of five in feeding, dressing, grooming, bathing or a score of four or five in physical ambulation. 3. A specialty care assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility. 4. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in a	A 621		

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A 621	Continued From page 70 specialty care assisted living facility. 5. A specialty care assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless: (i) The individual is capable of performing and does perform all tasks related to his or her own care; OR (ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity but the individual has sufficient cognitive ability to direct his or her own care and the individual is able to direct facility staff and does direct facility staff to provide the physical assistance needed to complete such tasks, and the facility staff is capable of providing such assistance and does provide such assistance. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. 6. If a resident of a specialty care assisted living facility is diagnosed with a terminal illness and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90 days. If the facility is unable or becomes unable to meet the needs of a resident receiving hospice care, or if a resident receiving hospice care requires care beyond what the facility may lawfully provide pursuant to this section, then the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement in accordance with the	A 621		

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A 621	Continued From page 71 discharge procedures and prearranged plan required by these rules for specialty care assisted living facilities. The facility would in all cases remain responsible for ensuring the appropriate delivery of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility retained residents who did not meet the criteria for SCALF residents. 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 should be receiving a higher level of care. The surveyor was able to substantiate this complaint during the onsite survey. The following information was obtained through observations and interviews at the facility July 24, 25 and 26, 2023. RI#5 had resided at the facility since October 10, 2019. Refer to deficiencies 604 and 611 for additional information on RI#5. RI#5 had received hospice services at the facility since April 2021. RI#5 was unable to ambulate and required a wheelchair for mobility. RI#5 was unable to self-propel the wheelchair and required staff to	A 621		

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push the wheelchair throughout the facility. RI#5 had tremors of the hands and head and was unable to feed him/herself. Eight staff (EI#8, EI#11, EI#12, EI#13, EI#14, EI#15, EI#16 and EI#19) reported RI#5 required 2-person assistance for transfers, bathing and toileting and had to be fed. The surveyor observed several meals during the onsite survey and RI#5 was fed by staff each time. On July 25, 2023, the surveyor observed EI#13 and EI#14 toilet RI#5. RI#5 assisted very minimally with the transfers and required 2 people to safely transfer with one person on each side to lift RI#5. When instructed to propel the wheelchair, RI#5 was unable to do so. No PSMS had been documented for RI#5 since August 12, 2022 when the total score was 22. At the request of the surveyor, a PSMS was completed for RI#5 on July 28, 2023. The total score was 25 with a 4 in Physical Ambulation (sits unsupported in chair or wheelchair but cannot propel self without help). Both scores on the PSMS were above the level allowed for a resident of a SCALF.

RI#7 had resided at the facility since June 23, 2021. Refer to deficiencies 604, 611 and 703 for additional information on RI#7. RI#7 had received hospice services at the facility since June 2022. RI#7 was completely bedbound at the time of the onsite survey. RI#7 slept most of the day but would awaken and speak few words. RI#7 was unable to turn him/herself in the bed and required 2-person assistance to turn and reposition. RI#7 was totally dependent of staff for all needs including feeding. RI#7 was only offered Ensure during the onsite survey. RI#7 had a diagnosis of dysphagia and would cough when drinking Ensure. Facility staff had been instructed by hospice to leave RI#7 in the bed. Facility Shift Report forms documented the following concerns

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about RI#7 as early as four months prior to the onsite survey: March 25, 2023 - "increased difficulty eating solid food. Difficulty swallowing. Episodes of regurgitation at dinner."; April 18, 2023 - "...needs to be reminded to swallow"; June 26, 2023 - "trouble swallowing...Hospice said we can give liquid through straw and soft diet like jello, pudding". RI#7 had documentation of difficulty swallowing for at least four months but had not been evaluated to determine an appropriate diet, placing RI#7 at high risk for choking. RI#7 sustained a significant weight loss of 5.9 percent for one month in June 2023 (167 pounds in May 2023 and 157 pounds in June 2023). The most recent documented PSMS for RI#7 was on December 31, 2022 when the total score was 22. At the request of the surveyor, a PSMS was completed for RI#7 on July 28, 2023 with a total score of 26 and a score of 5 in Physical Ambulation (bedridden more than half the time). Both scores were above the level allowed for a resident of a SCALF.

RI#8 had resided at the facility since July 6, 2021. Refer to deficiencies 604, 611 and 703 for additional information on RI#8. RI#8 had received hospice services at the facility since February 2023. RI#8 was unable to ambulate and required a wheelchair for mobility. RI#8 was unable to self-propel the wheelchair and had to be pushed throughout the facility by staff. Eight staff members (EI#9, EI#11, EI#12, EI#13, EI#14, EI#15, EI#16 and EI#19) reported RI#8 required 2-person assistance for transfers, bathing and toileting. On July 25, 2023, the surveyor observed EI#13 and EI#14 toilet RI#8. RI#8 would pull against staff and resist transfers, requiring 2 people to physically lift RI#8 from the wheelchair. During meals, RI#8's plate was placed in front of RI#8 and RI#8 would only look at the food and

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would not eat. If staff attempted to assist with eating, RI#8 resisted. RI#8 would only drink Ensure and had a significant weight loss of 10 per cent for 3 months in July 2023 (108 pounds in April 2023 and 97 pounds in July 2023). On May 28, 2023, the Shift Report documented "not interested in eating, no fluid intake at all". On June 18, 2023, the Shift Report documented "continues to refuse to eat solid, (he/she) also refused to drink water or any other drink". The most recent PSMS documented for RI#8 was on July 6, 2021 with a total score of 18. At the request of the surveyor, a PSMS was completed for RI#8 on July 28, 2023 with a total score of 27. In addition, RI#8 scored a 5 in Feeding (does not feed self at all and resists efforts of others to feed him/her), a 4 in Physical Ambulation (sits unsupported in chair or wheelchair, but cannot propel self without help) and a 5 in Bathing (does not try to wash self, and resists efforts to keep him/her clean). All four scores were above the level allowed for a resident of a SCALF.

RI#10 had resided at the facility since January 16, 2023. Refer to deficiencies 604, 611 and 703 for additional information on RI#10. RI#10 had received hospice services at the facility since June 2023. RI#10 was unable to ambulate and required a wheelchair for mobility. RI#10 was unable to purposefully self-propel the wheelchair and had to be pushed throughout the facility by staff. Eight staff members (EI#9, EI#11, EI#12, EI#13, EI#14, EI#15, EI#16 and EI#19) reported RI#8 required 2-person assistance for transfers, bathing and toileting and would resist staff at times. On July 25, 2023, the surveyor observed EI#13 and EI#14 toilet RI#10. The transfer required 2 people, one lifting on each side of RI#10, due to RI#10 holding tightly to the grab bar and pulling against staff. RI#10 would frequently

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yell out during the onsite survey. RI#10 had to be fed by staff. RI#10 sustained a significant weight loss of 5.3 per cent for one month in July 2023 (116.2 pounds in June 2023 and 110 pounds in July 2023). The most recent PSMS documented for RI#10 was on January 14, 2023 (pre-admission) with a total score of 15. At the request of the surveyor, a PSMS was completed for RI#10 on July 28, 2023 with a total score of 26. In addition, RI#10 scored a 4 in Physical Ambulation (sits unsupported in chair or wheelchair but cannot propel self without help) and a 5 in Bathing (does not try to wash self and resists efforts to keep him/her clean). All three scores were above the level allowed for a resident of a SCALF.

All four residents did not currently meet the eligibility requirements for a SCALF. The residents had not been assessed when a decline in condition occurred to determine the need for a higher level of care. When the surveyor entered the facility on July 24, 2023, no 30-day discharge notices had been issued. On July 26, 2023, 30-day discharge notices were issued to all four residents. Staffing was inadequate to meet the current care and safety needs of these residents (refer to deficiency 401). All residents of the facility were at increased risk of falls, injury, skin breakdown and altered nutritional status due to the inadequate staff and time required to meet the care needs of these four residents. In fact, three of these residents (RI#7, RI#8 and RI#10) sustained actual harm in the form of significant weight loss while being retained at the facility.

On August 3, 2023, EI#1 stated the facility was working on discharging these four residents and that he (EI#1) was trying to hire an RN to oversee the unit.

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A 703	420-5-20-.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 document the adjustment of its menu to accommodate the resident's needs.	A 703		

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A 703	Continued From page 77 (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. In addition, a weekly menu and meal times were not posted as required. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received two complaints 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. Insufficient Food	A 703		

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Interviews were conducted with staff and residents/sponsors during the onsite survey. Ten staff members (EI#7, EI#8, EI#10, EI#11, EI#12, EI#13, EI#14, EI#15, EI#18 and EI#19) 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). Five staff members (EI#10, EI#12, EI#14, EI#15 and EI#18) 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 report 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 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 food had to be ordered by truck deliveries to keep enough food in the facility. EI#6 added she (EI#6) planned to monitor portions at

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all meals and 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 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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better manage the food supply with small orders from the local grocery store.

Review of resident files on July 24, 25 and 26, 2023 revealed the following residents of the facility had significant weight loss during the past two months: RI#4 sustained a significant weight loss of 10.6 per cent for one month in May 2023 (131 pounds in April 2023 and 117 pounds in May 2023); RI#7 sustained a significant weight loss of 5.9 percent for one month in June 2023 (167 pounds in May 2023 and 157 pounds in June 2023); RI#8 sustained a significant weight loss of 10.1 per cent for three months in July 2023 (108 pounds in April 2023 and 97 pounds in July 2023); RI#10 sustained a significant weight loss of 5.3 per cent for one month in July 2023 (116.2 pounds in June 2023 and 110 pounds in July 2023). Refer to deficiencies 604 and 611 for additional information on residents' weight loss. The failure of the facility to provide adequate nutrition to residents resulted in harm to these four residents in the form of significant weight loss.

On August 8, 2023, EI#2 agreed residents had not been provided with adequate nutrition. Changes in dietary staff and food delivery were made during the onsite survey to resolve this deficient practice and prevent further weight loss of residents.

Posting of Menu and Meal Times

During a tour of the facility on July 24, 2023, no weekly menu and meal times were posted in the food service area. EI#7 posted the menu and meal times during the onsite survey.

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A 804	Continued From page 82	A 804		
A 804	420-5-20-.08 (4) Physical Facilities.	A 804		

(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. Group homes with residential stoves may use a residential hood sized for the stove. Commercial exhaust hoods shall be installed when commercial cooking equipment is used.

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A 804	Continued From page 83 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 with a soap dispenser and disposable towels, and shall be well lighted and ventilated. (g) Hand washing Facilities. Each Group and Congregate specialty care 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. (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. (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	A 804		

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A 804	Continued From page 84 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 Group specialty care assisted living facility, a residential use range is permitted. A Congregate specialty care assisted living facility shall have a heavy duty range suitable for institutional use with double oven, or equivalent. 2. Refrigerator. A Group specialty care assisted living facility may use a residential	A 804		

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A 804	Continued From page 85	A 804		

refrigerator. A Congregate specialty care assisted living facility shall have a heavy-duty refrigerator suitable for institutional use.

3. Fire extinguisher. Five-pound type BC for residential hoods and K type for commercial hoods.

4. Dishwashing. The dishwashing equipment for 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 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.

1. A resident dining room, or rooms,

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A 804	Continued From page 86 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 of the automatic type. This Rule is not met as evidenced by: Based on observations and interviews, the refrigerator in the kitchen area of the facility was not properly maintained. Findings: On July 24, 2023, the surveyor observed the refrigerator/freezer in the kitchen area beside the nurses' office. There was a log on the door of the refrigerator for recording daily temperatures. However, no temperatures had been recorded for the month of July. In addition, the freezer section of the refrigerator/freezer contained a very thick layer of ice/frost buildup on the inside making it difficult to properly close the door. On July 25, 2023, EI#8 observed the refrigerator/freezer and agreed it had not been properly maintained.	A 804		
A1101	420-5-20-.11 (1) Fire and Safety (1) General.	A1101		

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A1101	Continued From page 87 (a) Fire Safety and Emergency Plan. All specialty care assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs. (d) Roller latches are prohibited on doors separating corridors from adjacent spaces. (e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that:	A1101		

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A1101	Continued From page 88 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 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	A1101		

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A1101	Continued From page 89 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: Review 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. EI#2 and EI#3 stated they 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	420-5-20-.12 (5) Physical Environment. (5) General Building Requirements - Group and Congregate. (a) Structural Soundness and Repair. The building shall be structurally sound, free from leaks and excessive moisture, in good repair, and painted with sufficient frequency to be reasonably attractive inside and out. The interior and exterior of the building shall be kept clean and orderly. (b) Temperature to be Maintained. The facility shall maintain a comfortable temperature. A comfortable range is between 71-81 degrees Fahrenheit.	A1203		

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A1203	Continued From page 90 (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 16 mesh screens. Screen doors shall be equipped with self-closing devices. (e) Emergency Lighting. 1. All specialty care assisted living facilities shall provide an emergency artificial lighting system to adequately illuminate halls, corridors, and stairwells in case of electrical power failure. As a minimum, dry cell battery-operated lighting shall be provided to light such spaces. 2. Emergency lighting must provide illumination in accordance with the currently adopted Life Safety Code for at least 90 minutes. (f) Floors. 1. All floors shall be level, smooth and free of cracks, and finished so as to be easily kept clean. The basic requirement for floor finishes shall be wall-to-wall with such finishes as paint, stain, sealer, carpet, sheet vinyl, vinyl tile, hard tile, or other appropriate floor finish.	A1203		

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A1203	Continued From page 91 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. Windows in specialty care facilities may have devices which prevent full opening of the window. (i) Ceiling Height. Each room occupied by residents shall have a ceiling height of eight feet or more. Existing facilities with ceiling heights less than eight feet shall be acceptable when the height complies with the codes. (j) Handrails. If handrails are installed in halls or corridors, the handrails shall be mounted at 30 - 36 inches above the floor and returned to the wall at each end. (k) Stairways. Stairways shall be well lighted, kept in good repair, and have handrails. Open space under stairs shall not be used for storage purposes. All walls and doors under stairs shall meet the same fire rating as the stairwell. (l) Doors. 1. In each new specialty care assisted living facility, doors of resident bathrooms	A1203		

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connected to resident bedroom shall swing into the bedroom.

2. Bedroom and bathroom doors may be equipped with hardware that will permit a resident to lock himself within the room, provided a master key is readily accessible for the staff at a central location.

3. Resident bedroom and other exit access doors in specialty care assisted living facility shall be at least three feet wide.

4. Exterior egress doors except the main entry/exit door, may be equipped with a delayed egress locking system installed in accordance with NFPA 101. Other exterior egress doors may be arranged to prevent free and unhindered egress from specialty care assisted living facilities, in accordance with the Special Requirements portion of this section.

5. Exit doors swinging outward shall swing out over a landing having a minimum length and width equal to the door's width at the same level as the floor level, except existing doors shall not have more than a four inch step down.

(m) Ventilation. The building shall be well ventilated at all times to prevent accumulation of objectionable odors. Kitchens, laundries, service rooms, toilets, and bathrooms shall be ventilated by windows, gravity vents, or mechanical means as necessary to prevent offensive odors from entering other parts of the facility.

(n) Fire Extinguishers. Fire

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A1203	Continued From page 93	A1203		

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

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

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

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

(r) Exit marking. In all facilities, a sign bearing the word "EXIT" in plain legible block letters shall be placed at each exit. Additional signs shall be placed in corridors and passageways wherever necessary to indicate the

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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 specialty care assisted living facilities. This does not apply to a fire place with gas logs protected as noted elsewhere in these rules.

3. Lighting shall be restricted to electricity. Electric wiring, motors, and other electrical equipment in all specialty care assisted living facilities shall be in accordance with local electrical codes and the NFPA National Electrical Code.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, fire extinguishers were not visually inspected monthly by designated staff of the facility.

THIS DEFICIENCY WAS CITED AS A RESULT

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A1203	Continued From page 95 OF A COMPLAINT INVESTIGATION. THIS IS REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON APRIL 10, 2019. Findings: 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 survey conducted on April 10, 2019.	A1203		
A1206	420-5-20-.12 (8) Physical Environment (8) Additional Requirements for Specialty Care Assisted Living Facilities. (a) Facilities shall be certified and licensed for housing residents with dementia, and must comply with these special requirements for the physical plant. Facilities should confirm local code requirements, which may vary from those indicated below. (b) Additional Smoke Detection. Smoke detectors (electrical or system type) shall be provided in the sleeping rooms and any bedroom suite sitting areas, which house dementia residents. These detectors shall initiate at least a	A1206		

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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
A1206	Continued From page 96	A1206		

local alarm or supervisory signal, through the fire alarm system or call system.

(c) Windows in specialty care facilities may have devices which prevent opening of the window.

(d) Areas to Wander and Secure Perimeter.

1. Each facility shall have a secure boundary or perimeter to safely accommodate residents in all aspects of its physical plant. Exterior building walls and doors, and walled or fenced outdoor areas may form this boundary. Such walls or fences shall be at least six feet high.

2. Each walled or fenced area shall have at least one gate, located along the discharge path of travel from the building egress doors to the public way. Gates shall be readily unlockable from either side by the staff or by automatic means. "Automatic means" shall be in the same manner as locked or delayed-egress exit doors.

3. If the facility's emergency plan utilizes fenced or walled outdoor spaces as refuge areas for containment of residents, each refuge area shall be of sufficient size to accommodate all occupants at a distance of not less than 50 feet from the building while providing a net area of 15 square feet per person. A gate shall be located within this refuge area.

4. If the facility's emergency plan uses the fenced or walled outdoor spaces merely as areas that are immediately passed through and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P4203	A. BUILDING: _____ B. WING _____	08/10/2023

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exited, not as refuge areas for containment of residents, there is no size or area requirement for the fenced or walled spaces.

5. An outdoor courtyard, which is completely surrounded by the building, must have at least two separate doorways, located remotely from each other, leading into separate smoke compartments of the building.

(e) Locking of Exit Doors. Locks on exit doors of each specialty care assisted living facility, if installed, shall be electrical locked or electrical delayed-egress locking devices. Buildings shall be protected throughout by an approved supervised automatic sprinkler system connected to the fire alarm system.

1. Delayed-egress locks must comply with the requirements for "Special Locking Arrangements" found in NFPA 101 Life Safety Code.

2. Electrically locked doors shall comply with the following:

(i) A control panel shall be provided at one or more stations with the capability to remotely unlock all exit doors, simultaneously. Locks may be arranged to unlock in Specialty Care compartments based on a zoning concept, where each zone is a rated fire or smoke compartment and the locks on all egress doors unlock within the alarmed zone or compartment. This zoning concept is permitted to apply to automatic functions required by the Life Safety Code.

(ii) A key, code, or card release switch

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A1206	Continued From page 98 shall be provided inside the facility at each locked door, which shall override the locking system to allow exiting from the compartment or building. (iii) All locks shall release automatically upon activation of the facility fire detection, or fire sprinkler system, or upon disablement of the fire alarm system. (iv) Locks shall release automatically upon loss of electric power controlling the lock. (v) The facility shall provide the residents sponsors with adequate information about the facility's door locking arrangements. (vi) The facility shall assure, at least monthly, that locked or delayed-egress exit doors function properly, in accordance with required fire safety provisions. This Rule is not met as evidenced by: Based on observations and interviews, exit door locks did not release automatically upon activation of the facility fire alarm system. Findings: On the morning of August 8, 2023 around 11:12 AM, a fire drill was performed at the facility with the assistance of the monitoring company for training new staff. Upon activation of the facility's fire alarm system, none of the exit door locks released automatically. A code had to be manually entered by staff on the keypads beside each door to release the door locks. The failure of the door locks to function was investigated by the	A1206		

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A1206	Continued From page 99 monitoring company when the problem was identified and it was determined to be a programing issue. EI#2 contacted the repair company and arrangements were made for repairs to the system to be completed to alleviate the problem. EI#2 reported all staff had been given the code to release the door locks manually until repairs could be completed. CONNIE CHERRY, REGISTERED NURSE	A1206		