

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>P4501</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/24/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LYNRIDGE OF HUNTSVILLE MEMORY CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4801 WHITESPORT CIRCLE HUNTSVILLE, AL 35801</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>On July 24, 2024, an unannounced licensure survey and complaint investigation was conducted for this 52 bed Specialty Care Assisted Living Facility (SCALF) with a census of 17.</p> <p>There were three complaints investigated during this survey. LC#20240620004, LC#20240617002 and LC#20240613007 were substantiated. Deficiencies were cited as a result of the complaint investigations.</p> <p>Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practices resulted in the potential for harm to all residents and require a plan of correction.</p>	A 000		
A 301	<p>420-5-20-.03 (1) (a) (b) (c) (d) Administration.</p> <p>(1) The Specialty Care Assisted Living Facility Governing Authority.</p> <p>(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:</p> <p>1. Each person who has an ownership interest of 10 percent or more of the governing authority.</p>	A 301		

Health Care Facilities  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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A 301	<p>Continued From page 1</p> <p>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.</p> <p>3. Each officer and each director of the corporation if the governing authority is a corporation.</p> <p>4. Each partner, including any limited partners, if the governing authority is a partnership.</p> <p>(b) The governing authority shall submit any changes to the information listed above to the Department within 15 days of the change.</p> <p>(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.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record</p>	A 301		

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A 301	<p>Continued From page 2</p> <p>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 which placed all 17 residents of the facility at significant risk for harm due to this failure to apply the SBOH rules for the day to day operations of the facility.</p> <p>THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.</p> <p>Findings:</p> <p>At the time surveyors entered the facility, on July 8, 2024, there was no administrator of record on file for the facility at the Alabama Department of Public Health. Employee Identifier (EI)#3, Business Director, reported to the surveyors that Sagora Senior Living had taken over management of the facility on May 15, 2024 and the previous administrator (EI#18) had left the facility on that same date. EI#2, Integrations Specialist for Sagora Senior Living, reported to surveyors that an interim executive director (EI#1) had been provided to the facility by Sagora. However, EI#1 was not licensed as a specialty care assisted living administrator for the state of Alabama. EI#2 also reported to the surveyors that Sagora Senior Living was the current governing authority for the facility. The facility had been without a properly licensed administrator for greater than 45 days. On July 17, 2024, after surveyors entered the facility, EI#3 became administrator of the facility.</p> <p>The Alabama Department of Public Health received three complaints which were substantiated during the onsite survey. The complaints all alleged that a resident of the facility</p>	A 301		

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A 301	<p>Continued From page 3</p> <p>had been abused by an employee of the facility. One complaint also alleged the resident's sponsor was not notified of the alleged abuse when the incident occurred. The facility had submitted an incident report to the Alabama Department of Public Health, on June 8, 2024, documenting the alleged abuse incident and had conducted a facility investigation which resulted in termination of the employee on June 19, 2024. Following the facility investigation of the incident, staff training was completed by the facility on recognizing and reporting abuse. However, surveyors were able to substantiate that the facility failed to notify the resident's sponsor of the incident within 24 hours after the incident occurred. In addition, facility documentation of the incident contained discrepancies and the victim of the abuse was not assessed by a physician or certified registered nurse practitioner for several days after the injuries were documented.</p> <p>During the onsite surveys from July 8-11, 2024 and July 22-24, 2024, the surveyors interviewed multiple staff members. Two staff members reported to surveyors that abuse of residents continued to occur at the facility during the 3:00 PM-11:00 PM shift. The following allegations of abuse were reported to the surveyors.</p> <p>*Staff would prepare their own plates of food from the steam table once food was delivered from the kitchen for residents' evening meal. This was done prior to plating food for residents and serving residents which sometimes resulted in small portions for residents.</p> <p>*Suspicious bruising had been noted on residents.</p> <p>*An employee was observed about four months prior grabbing a resident by the arm and pulling the resident by the arm to force the resident to sit</p>	A 301		

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A 301	<p>Continued From page 4</p> <p>down.</p> <p>*Staff had been heard yelling at residents.</p> <p>*Residents were rushed at mealtime and plates were taken away from residents before the residents finished eating.</p> <p>*There was not always the required number of staff on the unit.</p> <p>*Residents who were incontinent were sometimes left wet or their beds were left wet and a towel placed over the wet area on the bed instead of changing the bed linens.</p> <p>*Residents' clothes were not changed when needed and baths were not always completed as directed on the residents' care plans.</p> <p>The allegations of abuse were reported to EI#2 on July 10, 2024 and a facility investigation was opened into the allegations which included suspension of an employee who was named in the allegations. The two staff members who reported the allegations of abuse to the surveyors stated that they had reported these allegations to EI#3, EI#4 and EI#5 previously without any follow-up from EI#3, EI#4 and EI#5. During separate interviews on July 11, 2024, EI#3, EI#4 and EI#5 all denied that they had previously been notified of these abuse allegations. The employee who was named in the allegations and suspended by the facility, pending investigation, was interviewed by the surveyors on July 11, 2024. The employee adamantly denied all allegations but did admit to eating food that was provided for residents after the residents were served their meals. The facility's investigation of this abuse allegation resulted in substantiation of some allegations and written counseling of the employee on July 15, 2024. On July 24, 2024, EI#3 informed the surveyors that the investigation did not reveal adequate evidence of abuse to substantiate termination of the employee.</p>	A 301		

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A 301	<p>Continued From page 5</p> <p>Interviews with residents and observations of residents during the onsite survey revealed the following information. One resident reported that he/she had seen staff hit a resident at night but was unable to provide staff or resident's names. One resident was heard by surveyors stating that he/she would rather die than to be in the facility. These statements were also documented in the resident's facility record.</p> <p>Although surveyors observed a monthly calendar of activities for the facility which listed multiple activities which were scheduled each day, residents appeared to be bored and were observed sitting in chairs or wheelchairs, frequently unattended. Some residents wandered aimlessly about the facility. A secure outside area was not properly maintained and was not safe for resident use. Staff reported the outside area had not been used in months and possibly as long as a year. Resources were available at the facility for activities but were not utilized. Resident assistants were assigned exercise activities to conduct with residents but reported that they (resident assistants) did not always have the time needed to provide activities. The few activities that were observed during the onsite survey were not individualized to meet the needs of each resident.</p> <p>During observation of breakfast, on the morning of July 9, 2024, surveyors noted that breakfast food items were not placed on the steam table to maintain proper temperatures. Food temperatures were checked at the request of the surveyors and were not adequate to prevent spoilage of food. Upon further investigation, surveyors discovered that the steam table had not functioned properly for months and possibly</p>	A 301		

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A 301	<p>Continued From page 6</p> <p>as long as one year. Although multiple staff members, including maintenance, nurses, dietary and resident assistants were aware of the steam table malfunction, repairs had not been completed to ensure food temperatures for residents were safe and appropriate.</p> <p>During a tour of the facility's kitchen, on July 10, 2024 at approximately 10:20 AM, EI#17, Regional Dietary Manager, informed the surveyor that he had just received a shipment of food that day. It was noted by the surveyor that the shelves in the pantry contained very little food. The facility's food supply had been allowed to dwindle to a very low level and there was no designated emergency food supply at the facility. There was currently no dietary manager at the facility.</p> <p>Observation of the facility's laundry room, on July 11, 2024, revealed the area was filthy. The floors were dirty, the lint traps were full of lint and there was a buildup of lint and trash in the entire area.</p> <p>The surveyors observed a general lack of management and leadership at the facility. During an interview, on July 11, 2024, EI#2 reported to the surveyors that she (EI#2) had been sent to determine what the needs were at the facility since Sagora had assumed management of the facility in May 2024. EI#2 added that HRA was the previous management company at the facility and bills were not paid when Sagora took over management of the facility. EI#3 provided current payment records of bills to the surveyors. On July 24, 2024, EI#3 informed the surveyors that all bills were currently paid. EI#2 stated to the surveyors that she (EI#2) was arranging a team of Sagora personnel to come to the facility to include nurses as well as construction/maintenance to complete needed</p>	A 301		

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A 301	<p>Continued From page 7</p> <p>repairs. EI#2 agreed with the surveyors that the lack of management had likely contributed to the deficient practices identified by the surveyors at the facility but verbalized Sagora's intent to correct the deficient practices that had been allowed under the previous management company. When surveyors returned to survey the assisted living facility, on July 24, 2024, they were informed that Sagora had contracted with a consultant to assist with ensuring that compliance with the Alabama rules for assisted living facilities was obtained and maintained.</p> <p>The following deficient practices were cited during the onsite survey due to a lack of management and oversight of the facility by the governing authority.</p> <p>303 - The facility had been without a licensed administrator for greater than 45 days. There was no administrative designee.</p> <p>305 - The ADPH was not notified of a change in administrator.</p> <p>401 - The facility was not staffed with at least the minimum staff allowed at all times.</p> <p>406 - Special needs training was not provided to staff. Current cardiopulmonary resuscitation (CPR) certification was not maintained for all employees. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 6, 2023.</p> <p>504 - The most recent state inspection report and plan of correction was not posted.</p> <p>508 - The facility failed to conduct an accurate investigation and failed to implement interventions timely when abuse of a resident by facility staff occurred. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.</p>	A 301		

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A 301	<p>Continued From page 8</p> <p>601 - Physician's orders were not followed for a resident's medications. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MAY 20, 2021.</p> <p>604 - Resident assessments were not completed as required. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MAY 20, 2021.</p> <p>611 - Residents' care plans were not current and did not contain appropriate interventions to address the residents' care needs. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON MAY 20, 2021 AND ON JULY 6, 2023.</p> <p>612 - An activity program was not provided which was designed to meet the individual needs of each resident.</p> <p>617 - Documentation of a resident's medication upon discharge from the facility was not documented. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MAY 20, 2021.</p> <p>702 - Leftover food was not properly labeled. The dishwasher did not maintain proper temperatures to sanitize dishes. Water temperatures were not recorded prior to dishwashing. Food was not maintained at a proper temperature to prevent spoilage.</p> <p>703 - Meal times and weekly menus were not posted. There was no emergency food to supply all residents for three days.</p> <p>901 - The lint traps in the dryers were full of lint creating a fire hazard.</p> <p>1002 - A sanitary and safe environment was not provided at all times.</p> <p>1101 - Fire drills were not conducted quarterly on each shift. The fire alarm and sprinkler systems were not inspected semiannually.</p> <p>1201 - The grounds and outdoor furnishings were not maintained in a safe and functional manner.</p>	A 301		

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A 301	Continued From page 9  1203 - Fire extinguishers were not inspected annually. The carpet was dirty and frayed. An electrical panel was not locked. 1206 - Safe egress through an outside courtyard gate was not provided.	A 301		
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	A 303		

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A 303	<p>Continued From page 10</p> <p>reputable and responsible character.</p> <p>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.</p> <p>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.</p> <p>9. The facility administrator is responsible for ensuring that required training is provided to all staff.</p> <p>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.</p> <p>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.</p> <p>12. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan.</p>	A 303		

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A 303	<p>Continued From page 11</p> <p>13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to operate with a properly licensed administrator for greater than 45 days. In addition, there was no individual with experience in the day-to-day operation of the facility, who was authorized in writing, to act for the administrator during absences.</p> <p>Findings:</p> <p>Surveyors entered the facility on July 8, 2024 and were greeted by EI#3 who introduced herself as the Business Director. When surveyors asked who the current administrator was, EI#3 stated that corporate staff had been coming from Sagora Senior Living. Shortly after surveyors entered the facility, EI#2 entered the facility and introduced herself as the Integrations Specialist with Sagora Senior Living, the facility's current management company. EI#3 informed surveyors that the last administrator (EI#18) left on May 15, 2024 when Sagora became the management company. EI#2 stated that, since May 15, 2024, Sagora had provided interim executive directors to manage the day to day operations of the facility with the most recent interim executive director being EI#1. However, EI#1 was not at the facility the week of the initial onsite survey and EI#2 had been sent to the facility instead. The surveyors asked EI#2 if any interim staff provided by Sagora had an Alabama assisted living administrator's license for SCALF. EI#2 stated she (EI#2) was</p>	A 303		

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A 303	<p>Continued From page 12</p> <p>unsure but would find out. Both EI#2 and EI#3 were unable to provide, in writing, an administrative designee and an Alabama assisted living administrator's license for Sagora staff who were assisting at the facility.</p> <p>On July 9, 2024, EI#2 provided to the surveyors a document which stated that the Executive Director Specialists with Sagora Senior Living would remain in place to oversee the operations of the facility until an administrator was hired. The document also stated that EI#1 could be contacted if urgent matters required immediate attention and that the Business Director, EI#3, would act as the direct point of contact for any concerns or queries. No Alabama-licensed administrator was named for the facility in the document.</p> <p>On July 10, 2024, EI#2 informed the surveyors that EI#3 would be the interim administrator at the facility. EI#3 provided a copy of her (EI#3's) Alabama assisted living administrator license which was category 1 (assisted living only) and did not license EI#3 to be administrator for a SCALF. At the end of the initial onsite survey, on July 11, 2024, EI#2 and EI#3 informed the surveyors that EI#3 had applied for an emergency category II (SCALF) administrator's license with the Board of Examiners. On July 17, 2024, EI#3 became the administrator of the facility.</p> <p>The facility had operated 63 days without a properly licensed administrator. This failure to provide a properly licensed administrator at the facility resulted in the following deficient practices which directly reflect the responsibilities of a licensed administrator.</p> <p>*The facility was not staffed with even the</p>	A 303		

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A 303	<p>Continued From page 13</p> <p>minimum allowed number of staff at all times. Refer to deficiency 401 for additional information. *Residents' care plans were not current and appropriate. Refer to deficiency 611 for additional information.</p> <p>*Previously cited deficient practices were not corrected and compliance with the SBOH rules for SCALFs was not maintained. These previously cited deficient practices included physician's orders not followed, resident assessments not completed, residents' care plans not current and appropriate, staffing inadequate and medication disposition not documented upon discharge of a resident. Refer to deficiencies 401, 604, 611 and 617 for additional information.</p> <p>On July 11, 2024, EI#2 agreed that the lack of a licensed administrator at the facility had likely contributed to these deficient practices identified by the surveyors.</p>	A 303		
A 305	<p>420-5-20-.03 (2) (c) Administration.</p> <p>(c) Department Notification.</p> <p>1. The licensee of a specialty care assisted living facility shall provide written notification of voluntary closure of the facility to the State Board of Health at least 30 days prior to the expected closure date.</p> <p>2. The State Board of Health shall be provided written notification not later than 15 days after any change in administrator.</p> <p>3. The State Board of Health shall be provided written notification not later than 15 days after any change in management company.</p>	A 305		

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A 305	<p>Continued From page 14</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the Alabama Department of Public Health timely when a change in administrator occurred.</p> <p>Findings:</p> <p>When surveyors entered the facility, on July 8, 2024, the administrator of record for the Alabama Department of Public Health was EI#18. EI#3, Business Director, informed the surveyors that EI#18 had not been employed at the facility since May 15, 2024, when Sagora Senior Living became the facility's management company. That same day, the surveyors asked EI#2 if the Department had been notified of this administrator change. EI#2 was unable to provide written notification from the facility to the Department when this change in administrator occurred.</p>	A 305		
A 401	<p>420-5-20-.04 (1) (2) Personnel.</p> <p>(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</p>	A 401		

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A 401	<p>Continued From page 15</p> <p>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.</p> <p style="text-align: center;">Table A</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">Staff Number</td> <td style="width:35%;">7 AM - 3 PM</td> <td style="width:35%;">3 PM - 11 PM</td> <td style="width:15%;"></td> </tr> <tr> <td>2</td> <td>1 -16 Residents</td> <td>1 - 16 Residents</td> <td></td> </tr> <tr> <td>3</td> <td>17 - 24 Residents</td> <td>17 - 36 Residents</td> <td></td> </tr> <tr> <td>4</td> <td>25 - 32 Resident</td> <td>37 - 48 Residents</td> <td></td> </tr> <tr> <td>5</td> <td>33 - 40 Residents</td> <td>49 - 60 Residents</td> <td></td> </tr> <tr> <td>6</td> <td>41 - 48 Residents</td> <td>61 - 72 Residents</td> <td></td> </tr> <tr> <td>7</td> <td>49 - 56 Residents</td> <td>73 - 84 Residents</td> <td></td> </tr> <tr> <td>8</td> <td>57 - 64 Residents</td> <td>85 - 96 Residents</td> <td></td> </tr> <tr> <td>9</td> <td>65 - 72 Residents</td> <td>97 - 108 Residents</td> <td></td> </tr> <tr> <td>10</td> <td>73 - 80 Residents</td> <td>109 - 120 Residents</td> <td></td> </tr> <tr> <td>11</td> <td>81 - 88 Residents</td> <td>120 - 132 Residents</td> <td></td> </tr> </table> <p>1 Additional Staff or any fraction thereof, by which the census exceeds 88</p> <p>For each 8 residents, For each 16 residents, or any fraction thereof, or any fraction thereof, by which the census exceeds 132</p> <p>For each 12 residents, or any fraction thereof, by which the census exceeds 176</p>	Staff Number	7 AM - 3 PM	3 PM - 11 PM		2	1 -16 Residents	1 - 16 Residents		3	17 - 24 Residents	17 - 36 Residents		4	25 - 32 Resident	37 - 48 Residents		5	33 - 40 Residents	49 - 60 Residents		6	41 - 48 Residents	61 - 72 Residents		7	49 - 56 Residents	73 - 84 Residents		8	57 - 64 Residents	85 - 96 Residents		9	65 - 72 Residents	97 - 108 Residents		10	73 - 80 Residents	109 - 120 Residents		11	81 - 88 Residents	120 - 132 Residents		A 401		
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A 401	<p>Continued From page 16</p> <p>(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).</p> <p>(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.</p> <p>(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.</p> <p>In the event of an unplanned staff shortage which would make it otherwise impossible to meet the staffing requirements imposed by these rules, a facility may employ a certified nurse aide who has not received the training specified in these rules. For the purposes of this subsection, a certified nurse aide is defined as an individual who has been deemed or determined to be competent by the Alabama Nurse Aide Registry maintained by the Alabama Department of Public Health. This individual may not work unless accompanied at all times by an individual who is appropriately trained in accordance with these rules. Such employment shall last only until the facility has employed staff trained in accordance with the above. In no event may the period during which such staff is employed in a facility exceed 120 consecutive hours.</p>	A 401		

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A 401	<p>Continued From page 17</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility was not staffed with at least the minimum required staff at all times.</p> <p>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 6, 2023.</p> <p>Findings:</p> <p>At the time of the initial onsite survey from July 8-11, 2024, the census of the facility was 17 residents with 14 residents currently in house. Review of employee schedules, on July 8, 2024, revealed one nurse and two resident assistants (RAs) were scheduled to work each shift from 7:00 AM-3:00 PM, 3:00 PM-11:00 PM and 11:00 PM-7:00 AM daily.</p> <p>During interviews, on July 8-11, 2024, three staff members (EI#9, EI#11 and EI#12) reported they had been left alone to work on the unit for small periods of time. On the morning of July 9, 2024, surveyors toured the unit and met residents. At approximately 7:20 AM, the surveyors were unable to locate any facility staff on the unit, only a private sitter who stated he/she (private sitter) thought all staff were upstairs in a meeting. At approximately 7:26 AM, EI#12 entered the facility and informed the surveyors that she (EI#12) had left the unit to open the front door to the building. EI#12 added that the other RA and nurses were upstairs in a meeting. EI#12 stated she (EI#12) was the only staff member on the unit at that time but added that she (EI#12) would get the work done and began assisting residents to the dining room. At approximately 7:35 AM, EI#9, Licensed Practical Nurse (LPN) was observed on the unit.</p>	A 401		

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A 401	Continued From page 18  On July 9, 2024, at approximately 8:10 AM, the surveyor discussed with EI#2 that no staff had been available on the unit earlier that morning. EI#2 stated that she (EI#2) had called staff upstairs for a mandatory meeting but added that she (EI#2) did not intend for everyone to leave the unit at the same time. EI#2 later informed the surveyors that a RA was present on the unit during the morning of July 9, 2024 but was in a resident's room, assisting the resident, and was not available to surveyors. EI#2 also acknowledged that one staff member on the unit did not meet the minimum staffing number of two staff at all times.	A 401		
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	A 406		

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A 406	<p>Continued From page 19</p> <p>American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire.</p> <p>5. Identifying and reporting abuse, neglect, and exploitation.</p> <p>6. Basic first aid.</p> <p>7. Advance directives.</p> <p>8. Protecting resident confidentiality.</p> <p>9. Resident fire and environmental safety.</p> <p>(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.</p> <p>(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</p>	A 406		

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A 406	<p>Continued From page 20</p> <p>and evacuation plan and all other policies regarding safety, including policies for preventing elopements, responding to elopements, and fall prevention.</p> <p>(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.</p> <p>(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.</p> <p>(f) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above.</p>	A 406		

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A 406	<p>Continued From page 21</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide staff with appropriate special needs training. In addition, the facility failed to ensure all employees maintained current CPR certification.</p> <p>Findings:</p> <p>Special Needs Training</p> <p>On July 9, 2024, at approximately 8:05 AM, the surveyor observed medication administration provided to Resident Identifier (RI)#3 by EI#9. RI#3 was admitted to the facility on April 7, 2022 and had diagnoses which included diabetes mellitus type II, chronic kidney disease stage 3, dementia, hypothyroidism, Parkinson's disease, neuropathy, gastroesophageal reflux disease, hypertension and depression. During medication administration, EI#9 stated that RI#3 received a Dexcom continuous glucose monitoring system on July 3, 2024. EI#9 added that the Dexcom system patch was applied by facility nurses and would be changed every two weeks by the facility nurses. The surveyor asked EI#9 if she (EI#9) had a training class on the Dexcom system. EI#9 stated a class was going to be taught sometime in the future. Upon the surveyors' departure from the facility, on July 11, 2024, there had not been a class provided to the nursing staff on the Dexcom system.</p> <p>CPR Certification</p> <p>Review of employee files, on July 10, 2024, revealed EI#5 was certified in CPR but the certification would expire on July 11, 2024. When</p>	A 406		

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A 406	Continued From page 22  surveyors returned to the facility, on July 22, 2024, CPR recertification had not been completed for EI#5. EI#3 informed the surveyors that a CPR certification class would be scheduled in the near future and EI#5 would be included in the class.	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 the need for privacy.  4. Every resident shall have the right to	A 504		

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A 504	<p>Continued From page 23</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident.</p>	A 504		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>P4501</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/24/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LYNRIDGE OF HUNTSVILLE MEMORY CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4801 WHITESPORT CIRCLE HUNTSVILLE, AL 35801</b>
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A 504	<p>Continued From page 24</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file.</p>	A 504		

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A 504	<p>Continued From page 25</p> <p>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:</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>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.</p> <p>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.</p> <p>17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider Standards, the Local Ombudsman, the</p>	A 504		

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A 504	<p>Continued From page 26</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings.</p> <p>23. Every resident shall have the right to</p>	A 504		

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A 504	<p>Continued From page 27</p> <p>have free access to day rooms, dining, and other group living or common areas at reasonable hours.</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to post the most recent state inspection report and corrective action plan in a prominent location. In addition, the facility failed to maintain a safe and decent environment for residents, staff and visitors at all times.</p> <p>Findings: State Inspection Report</p> <p>During a tour of the facility, on July 8, 2024, no report of the facility's most recent state inspection and corrective action plan was located. EI#2 was also unable to locate the inspection report. On July 9, 2024, EI#3 provided a copy of the most recent inspection report to the surveyors who instructed EI#3 that the report should be posted in a prominent location of the facility.</p> <p>Safe and Decent Environment</p> <p>Multiple deficiencies were cited during the onsite survey which created an unsafe environment for</p>	A 504		

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A 504	<p>Continued From page 28</p> <p>residents, staff and visitors. These deficient practices included the following.</p> <p>*There had been no properly licensed administrator at the facility for greater than 45 days. (Deficiency 303)</p> <p>*Staffing was inadequate to meet the minimum requirements for a SCALF. (Deficiency 401)</p> <p>*Physician's orders were not followed for a resident's medication. (Deficiency 601)</p> <p>*Resident assessments were not completed as required and the residents' care plans were not updated with appropriate interventions to meet the residents' current care needs. (Deficiencies 604 and 611)</p> <p>*Proper procedure was not followed for dish sanitization and for maintaining proper food temperatures to ensure foods were served in a safe manner. (Deficiency 702)</p> <p>*Carpet was frayed, creating a trip hazard. (Deficiency 1203)</p> <p>*An electrical panel closet door was not locked. (Deficiency 1203)</p> <p>*The outdoor area was not safely maintained including lack of safe egress from the area through a gate which could not be unlocked from the inside. (Deficiency 1201)</p> <p>On July 11, 2024, EI#2 agreed with the surveyors' findings that the facility had not been maintained in a safe and decent manner.</p>	A 504		
A 508	<p>420-5-20-.05 (3) (h) Records and Reports.</p> <p>(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</p>	A 508		

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A 508	<p>Continued From page 29</p> <p>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.</p> <p>1. Incidents which require investigation are:</p> <p>(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.</p> <p>(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.</p> <p>(iii) The onset of wandering behavior by any resident who is not fully cognitively intact.</p> <p>(iv) Elopement by a resident.</p> <p>(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.</p> <p>(vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or</p>	A 508		

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A 508	<p>Continued From page 30</p> <p>residents as defined in these rules.</p> <p>(vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules.</p> <p>(viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or Staphylococcus aureus).</p> <p>(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.</p> <p>(x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident.</p> <p>(xi) An unplanned occurrence that results in media attention.</p> <p>(xii) A medication error, overdose, or over sedation.</p> <p>(xiii) Ingestion by a resident of a toxic substance that requires medical attention.</p> <p>(xiv) Any indication of malfunction of the sprinkler system, or fire alarm system.</p> <p>2. In addition to other items required by the facility's policies and procedures, the incident</p>	A 508		

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A 508	<p>Continued From page 31</p> <p>investigation shall contain the following:</p> <ul style="list-style-type: none"> <li>(i) Names of all residents involved.</li> <li>(ii) Names of all staff involved including person in charge at the time of the incident.</li> <li>(iii) When the administrator was notified (date and time).</li> <li>(iv) Circumstances under which the incident occurred.</li> <li>(v) When the incident occurred (date and time).</li> <li>(vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn).</li> <li>(vii) Immediate actions taken.</li> <li>(viii) The extent and description of injury, if any, to the affected resident or residents.</li> <li>(ix) Immediate treatment rendered.</li> <li>(x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified.</li> <li>(xi) Names, telephone numbers, and addresses of witnesses.</li> <li>(xii) Date and time relatives or sponsor were notified.</li> <li>(xiii) Out-of-facility treatment.</li> <li>(xiv) Follow-up care.</li> </ul>	A 508		

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A 508	<p>Continued From page 32</p> <p>(xv) Outcome resolution.</p> <p>(xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future.</p> <p>(xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation.</p> <p>(xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request.</p> <p>(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.</p> <p>(xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff.</p> <p>3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident:</p> <p>(i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention.</p> <p>(ii) Elopement by a resident.</p> <p>(iii) Suspected, alleged, confessed, witnessed, or actual abuse, neglect, or</p>	A 508		

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A 508	<p>Continued From page 33</p> <p>exploitation of a resident or residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file.</p> <p>(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.</p> <p>(v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident.</p> <p>(vi) An unplanned occurrence that results in media attention.</p> <p>(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.</p> <p>(viii) Ingestion by a resident of a toxic substance that requires medical attention.</p> <p>(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</p>	A 508		

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A 508	<p>Continued From page 34</p> <p>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.</p> <p>(x) Any indication of a malfunction of the sprinkler system, fire alarm system, or a door locking device.</p> <p>4. The report to the Department's Online Incident Reporting System shall include the following:</p> <p>(i) Facility name and direct phone number.</p> <p>(ii) Time and date of the report.</p> <p>(iii) Reporter's name.</p> <p>(iv) Name of resident(s), staff, or visitor(s) involved in the incident.</p> <p>(v) Names of staff on duty at the time of the incident.</p> <p>(vi) Date and time of the incident.</p> <p>(vii) A brief description of the incident.</p> <p>(viii) Any injury or injuries to resident(s).</p> <p>(ix) Action taken by the facility in response to the incident.</p> <p>(i) Vital Statistics Reports. A record shall be kept of all births, deaths, and stillbirths that occur within the specialty care assisted living</p>	A 508		

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A 508	<p>Continued From page 35</p> <p>facility. By the fifth day of each month, the administrator shall make a report of such births, deaths, and stillbirths for the preceding month on such forms as the State Board of Health shall provide to the county health officer, or in counties without a county health officer, to the State Registrar. This report shall be in addition to the official birth, death, and stillbirth certificates. If there are no births, deaths, or stillbirths in any month, a report shall be made stating that fact to the county health officer.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to conduct a thorough and accurate investigation when abuse of a resident by a staff member occurred at the facility.</p> <p>THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.</p> <p>Findings:</p> <p>The Alabama Department of Public Health received a complaint which alleged a resident of the facility was abused by a facility staff member. The complaint also alleged the resident's sponsor was not notified of the alleged abuse until four days after the incident occurred. Surveyors were able to substantiate this complaint during the onsite survey and also found that the facility's investigation of this abuse incident was inaccurate and actions were not completed timely.</p> <p>Review of RI#9's facility record, on July 8, 2024,</p>	A 508		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 508	<p>Continued From page 36</p> <p>revealed the following information. RI#9 was admitted to the facility on November 13, 2023 and had diagnoses which included hypopituitarism, hyperlipidemia, dementia, degenerative joint disease and vitamin D deficiency. Refer to deficiencies 508 and 617 for additional information on RI#9. RI#9 had a history of altercations with other residents of the facility, elopement from the facility and resisting care. RI#9 was discharged from the facility on June 28, 2024 to the care of family.</p> <p>On the evening of June 7, 2024, at approximately 10:30 PM, a sitter who was present in the facility with another resident reported to EI#8, LPN with Shiftkey Staffing Agency, that she (the sitter) had witnessed verbal and physical abuse of RI#9 by EI#20. This allegation was substantiated by the facility during investigation of the incident and EI#20 was terminated.</p> <p>During an interview on July 9, 2024, at approximately 4:25 PM, EI#8 stated that she (EI#8) was the LPN on duty at the facility on June 7, 2024 when the alleged abuse incident occurred. EI#8 stated that she (EI#8) attempted to call RI#9's sponsor on the evening of June 7, 2024, but did not get an answer and did not leave a message. During an interview, on July 10, 2024, at approximately 10:35 AM, RI#9's sponsor stated that he/she attempted to call EI#4's phone number the following morning (June 8, 2024) when he/she (RI#9's sponsor) became aware of the missed call. However, EI#4 did not answer. EI#4 and EI#5 stated that EI#4 was on vacation at the time the incident occurred and both admitted that no follow-up telephone calls were made to RI#9's sponsor and the abuse was not reported to RI#9's sponsor until four days later. The abuse occurred on the evening of June 7,</p>	A 508		

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A 508	<p>Continued From page 37</p> <p>2024 and was not reported to RI#9's sponsor until the morning of June 11, 2024. A Comprehensive Assessment, completed by EI#4 on June 11, 2024, documented that RI#9's sponsor was notified of the alleged abuse incident on June 7, 2024 at 10:45 PM.</p> <p>EI#8 also informed the surveyors that she (EI#8) observed bruising on both of RI#9's arms and redness on RI#9's chest and face when she (EI#8) assessed RI#9 on the evening of June 7, 2024, following the incident. These injuries were documented on the Incident Report Form written by EI#8 on June 7, 2024. The Online Incident Report submitted to the ADPH by EI#5, on June 8, 2024, read "List any injuries to resident(s): no visible injuries noted". A comprehensive assessment of RI#9 was not performed by EI#4 until June 11, 2024. According to EI#4, bruising was not visible on RI#9's arms until June 11, 2024. The Comprehensive Assessment, completed by EI#4 on June 11, 2024, documented bruises and redness on RI#9's bilateral upper and lower arms. EI#5 also stated the police department was not notified of the alleged assault until June 11, 2024. Photographs were obtained from the police department which were taken during their investigation of the incident on June 11, 2024. The photographs showed black and greenish bruises to RI#9's upper and lower arms which did not appear to be new bruising. EI#8, EI#4 and EI#5 confirmed RI#9 was not sent out to be examined at the emergency department when the injuries were first discovered on June 7, 2024. RI#9 was not assessed by a physician or certified registered nurse practitioner (CRNP) until June 13, 2024 when the Physician's Response/Order read "Physical exam after incident report per facility...pt was examined to have bilateral upper</p>	A 508		

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A 508	<p>Continued From page 38</p> <p>arms and lower arms bruising (left) right, no open wound. Pt denied any pain and noted full range of motion. No sign of trauma or bruising was noted". On July 24, 2024, during the surveyors' second visit to the facility, EI#21 informed the surveyors that she (EI#21) came to the facility on June 11, 2024 and observed RI#9's arms following the alleged abuse. EI#21 stated both of RI#9's upper arms and forearms showed multiple areas of bruising indicative of abuse. EI#21 stated that she (EI#21) instructed EI#5 to contact the police that day. EI#21 also stated she (EI#21) thought RI#9 had been sent out to be checked at the emergency department on the evening that the abuse occurred.</p> <p>The documentation of RI#9's abuse at the facility contained conflicting information. RI#9's sponsor was not notified timely of the incident. RI#9 was not assessed timely by a physician or CRNP to determine any possible injuries as a result of the abuse. On July 11, 2024, EI#2 agreed with the surveyors' findings that the investigation of the abuse, sustained by RI#9 at the facility, was incomplete.</p>	A 508		
A 601	<p>420-5-20-.06 (1) Care of Residents.</p> <p>(1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician.</p> <p>(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</p>	A 601		

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A 601	<p>Continued From page 39</p> <p>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).</p> <p>(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 practitioner or physician's assistant shall not serve as the back-up physician in a specialty care assisted living facility.</p> <p>(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</p>	A 601		

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A 601	<p>Continued From page 40</p> <p>order.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow the physician's orders for a resident's medication.</p> <p>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MAY 20, 2021.</p> <p>Findings:</p> <p>RI#5 was admitted to the facility on June 6, 2022, with diagnoses which included dementia, vitamin D deficiency, gastroesophageal reflux disease, hypertension, pain, and sleep apnea. On July 9, 2024, at approximately 8:05 AM, the surveyor observed medication administration by EI#9. RI#5 was not given medication due to EI#9 advised the surveyor that the medication had not arrived from the pharmacy. The surveyor interviewed EI#4 about the prescribed medication, and she (EI#4) advised that the Diflucan regimen had been completed as ordered by RI#5's physician. Upon record review, RI#5 had a physician's order, dated July 3, 2024, for Diflucan 150 milligrams by mouth (PO) every (q) 72 hours times 3 doses. The surveyor requested the medication administration record (MAR) for RI#5. Per the MAR documentation, RI#5's Diflucan was administered on July 6, 2024, but not on July 9, 2024. EI#9 advised the surveyor that, on July 9, 2024, the Diflucan had not been received from the pharmacy. Upon further investigation by the surveyors, the Diflucan was received at the facility on July 4, 2024, at 2:35 AM. The first dose of Diflucan was not administered until July 6, 2024, and the second dose was not administered at all.</p>	A 601		

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A 601	Continued From page 41	A 601		
A 604	<p>During the exit interview on July 11, 2024, EI#2 agreed with the surveyors' findings.</p> <p>420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents.</p> <p>(3) Health Supervision.</p> <p>(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.</p> <p>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.</p> <p>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.</p> <p>(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</p>	A 604		

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A 604	<p>Continued From page 42</p> <p>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.</p> <p>(c) Comprehensive Assessment. The facility RN shall perform a comprehensive assessment and communicate with the resident's attending physician and with the resident's sponsor or responsible family member when a decline in health status or behavior occurs, or if the resident develops any of the following problems:</p> <ol style="list-style-type: none"> <li>1. Weight loss:               <ol style="list-style-type: none"> <li>(i) Each month, the facility shall accurately weigh and record the weight of each resident.</li> <li>(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.</li> </ol> </li> <li>2. Falls (two or more falls within a 30 day period).</li> <li>3. Elopement.</li> <li>4. Any sign and symptom of adverse</li> </ol>	A 604		

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A 604	<p>Continued From page 43</p> <p>drug reaction, interaction or over sedation, or circumstances which contraindicate medications that have been prescribed for the resident.</p> <p>5. Unmanageable, combative, or potentially harmful behavior(s).</p> <p>6. Any accident with injury.</p> <p>(d) Focused Assessments. The RN or LPN shall conduct focused assessments when necessary to identify changes in resident status.</p> <p>(e) Any change in resident status requires immediate documentation and implementation of interventions or reassessment of existing interventions.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, resident assessments were not completed as required.</p> <p>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MAY 20, 2021.</p> <p>Findings:</p> <p>Review of resident records, on July 10 and 11, 2024, revealed the following information.</p> <p>RI#2</p> <p>RI#2 was admitted to the facility on May 24, 2024 with diagnoses which included severe vascular dementia with behavioral disturbance, chronic obstructive pulmonary disease with hypoxia, pain, hypertension, insomnia, hypothyroidism and atrial</p>	A 604		

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A 604	<p>Continued From page 44</p> <p>fibrillation. RI#2 was currently in a psychiatric facility at the time of the initial onsite survey. Resident Service Notes for RI#2, dated June 25, 2024, documented RI#2 expressed a desire to "not be living any more. I just want to die! I'm going to find a way to die". RI#2 was sent to a psychiatric facility on July 1, 2024 due to suicidal ideation. When RI#2 initially threatened suicide, on June 25, 2024, no comprehensive assessment, PSMS and behavior screening were completed. RI#2 was not properly assessed by the facility registered nurse to determine the need for possible psychiatric placement.</p> <p>RI#3</p> <p>RI#3 had resided at the facility since April 7, 2022. Refer to deficiency 406 for additional information on RI#3. No monthly assessments of RI#3 were documented in February and March 2024. In addition, no monthly weight was documented for RI#3 in March 2024.</p> <p>RI#5</p> <p>RI#5 had resided at the facility since June 6, 2024. Refer to deficiency 601 for additional information on RI#5. No monthly weight was documented for RI#5 in March 2024.</p> <p>RI#9</p> <p>RI#9 was admitted to the facility on November 13, 2023. Refer to deficiencies 508 and 617 for additional information on RI#9. On June 7, 2024, an allegation of abuse to RI#9 by a staff member of the facility was received by the nurse on duty (EI#8) for the 3:00 PM-11:00 PM shift at the facility. EI#8, LPN, performed a focused assessment of RI#9 on June 7, 2024 after the</p>	A 604		

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A 604	Continued From page 45  incident was reported. A comprehensive assessment, PSMS and behavior screening were not completed for RI#9 until June 11, 2024, four days later. EI#4, RN, reported to the surveyors that she (EI#4) was off when the alleged abuse incident occurred.  On July 11, 2024, EI#4 agreed with the surveyors' findings.	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	A 611		

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A 611	<p>Continued From page 46</p> <p>to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following:</p> <p>2. A listing of the resident's individual needs or problems that require intervention by the facility.</p> <p>3. A listing of interventions provided by the facility to address the resident's identified needs or problems.</p> <p>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.</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(iii) Hair. Residents' hair shall be kept clean, neat, and well groomed.</p> <p>(iv) Manicure. Fingernails and toenails</p>	A 611		

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A 611	<p>Continued From page 47</p> <p>shall be kept clean and trimmed.</p> <p>(v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed.</p> <p>(vi) Personal Safety. Residents shall be provided assistance with personal safety.</p> <p>6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, residents' facility care plans did not address the residents' current care needs with appropriate interventions.</p> <p>THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON MAY 20, 2021 AND ON JULY 6, 2023.</p> <p>Findings:</p> <p>Review of resident records, on July 10 and 11, 2024, revealed the following information.</p> <p>RI#1</p> <p>RI#1 was admitted to the facility on August 9, 2019 and had diagnoses which included early dementia, hyperlipidemia, renal insufficiency, vitamin B12 deficiency, vitamin D deficiency and headaches. RI#1 frequently wandered throughout the facility and would stop to speak to anyone</p>	A 611		

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A 611	<p>Continued From page 48</p> <p>passing by. During interviews throughout the survey, staff reported that RI#1 would resist care assistance by staff. On July 10, 2024, at approximately 8:25 AM, the surveyors observed RI#1 wandering in the facility and also noted that RI#1 was wearing the same clothing that RI#1 had worn on July 8 and July 9, 2024. When questioned about RI#1's clothing, EI#12 took RI#1 to his/her room and attempted to change the clothing. RI#1 resisted both physically and verbally and left his/her room. EI#12 reported to EI#2 that she (EI#12) had been unable to change RI#1's clothing. EI#2 instructed EI#12 to try again later or to have a different caregiver attempt the clothing change. RI#1's resistance to care was not addressed on RI#1's facility care plan with appropriate interventions for staff to follow to ensure that RI#1 received safe and proper personal care and hygiene.</p> <p>RI#2</p> <p>RI#2 had resided at the facility since May 24, 2024. Refer to deficiency 604 for additional information on RI#2. On June 25, 2024, RI#2 verbalized intent to commit suicide as well as a plan. RI#2 was not sent to a psychiatric facility until RI#2's suicidal ideations continued on July 1, 2024. RI#2's facility care plan had not been updated on June 25, 2024 with appropriate interventions to address RI#2's suicidal threats and to keep RI#2 safe.</p> <p>On July 11, 2024, EI#4 agreed with the surveyors that these residents' care plans had not been kept current and appropriate.</p>	A 611		
A 612	420-5-20-.06 (4) (c) (d) (e) (f) Care of Residents.	A 612		

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A 612	<p>Continued From page 49</p> <p>(c) Activity Program. There shall be an activity program designed to meet the individual needs of each resident. The facility shall maintain supplies and equipment as necessary to implement the activity programs. Every day the facility shall provide activities appropriate to residents with dementia. Residents who have wandering behaviors shall have a documented activity program to manage this behavior.</p> <p>(d) Pets residing at the facility or used in activity programs shall be in good health and shall have current vaccinations as required by law. Vaccination certificates, or copies of vaccination certificates, shall be kept on file at the facility to demonstrate compliance with this requirement.</p> <p>(e) Mail, Telegrams, and Other Communications.</p> <p>1. Incoming mail, telegrams, and other written communications addressed to the resident shall be delivered to the resident unopened. Outgoing mail shall be promptly delivered to regular postal channels upon receipt from the resident. Residents shall be permitted to receive telephone calls at the facility in complete privacy.</p> <p>2. Personnel of the facility shall assist residents with communications, such as writing letters or assisting with writing letters, or reading mail out loud if requested to do so.</p> <p>(f) Appointments. Residents shall be assisted in making and keeping appointments.</p>	A 612		

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A 612	<p>Continued From page 50</p> <p>This Rule is not met as evidenced by: Based on observations and interview, the facility failed to provide an activity program designed to meet the individual needs of each resident.</p> <p>Findings:</p> <p>During a tour of the facility, on July 8, 2024, surveyors observed a monthly calendar of activities for the facility which showed multiple activities were scheduled each day. However, the surveyors observed very few activities listed on the calendar which were actually carried out on a daily basis during the onsite survey. Although there were designated staff to perform activities, EI#12, Resident Assistant, was observed leading residents in an exercise activity on the morning of July 10, 2024, which decreased the amount of time that EI#12 had to perform her (EI#12's) duties as a Resident Assistant. During interviews, RAs reported to the surveyors that they (RAs) were instructed to perform activities although two staff members were employed by the facility to assist residents with activities. Residents were frequently observed walking aimlessly around the facility or sitting alone in wheelchairs in the common areas. Although a secure outside area was provided for the residents, staff reported that the residents had not been outside for several months. A raised garden bed was available in the secure outside area as well as multiple chairs and a hummingbird feeder but these areas were not clean and properly maintained. The walkways and furniture in the outside area were covered with leaves and pinestraw, the raised garden bed was not in use and bags of garden soil were</p>	A 612		

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A 612	Continued From page 51  propped against the garden bed. The hummingbird feeder was empty. Although some activities were provided to residents, resources were not utilized to provide adequate, appropriate activities to prevent wandering and boredom for the residents. On July 11, 2024, EI#2 agreed with the surveyors' findings.	A 612		
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,	A 617		

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A 617	<p>Continued From page 52</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of the disposition of a resident's medications when the resident was discharged from the facility.</p> <p>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MAY 20, 2021.</p> <p>Findings:</p> <p>RI#9 resided at the facility from November 13, 2023 until June 28, 2024. Refer to deficiencies 508 and 604 for additional information on RI#9. Review of RI#9's facility record, on July 8, 2024, revealed there was no documentation of the disposition of RI#9's medications upon RI#9's discharge from the facility. EI#9 stated that RI#9's medications were released to RI#9's family and a medication disposition form had been completed. However, the facility was unable to locate a medication disposition form for RI#9.</p>	A 617		
A 702	<p>420-5-20-.07 (2) Food Service.</p> <p>(2) Food Handling Procedures.</p> <p>(a) Dish and Utensils Washing, Disinfection, and Storage.</p>	A 702		

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A 702	<p>Continued From page 53</p> <ol style="list-style-type: none"> <li>1. Wash water shall be changed with sufficient frequency to avoid gross contamination, and final rinse water shall be kept clean and clear.</li> <li>2. Hand washed repeated service and multi-service utensils and dishes, after washing and rinsing, shall be sanitized by either of the following methods:               <ol style="list-style-type: none"> <li>(i) Utensils and dishes shall be completely immersed for a period of not less than 30 seconds in water that is at least 171 degrees Fahrenheit (pouring scalding water over utensils and dishes does not meet this requirement); or</li> <li>(ii) A cold water sanitizer: A sanitizing solution shall be used in accordance with the manufacturers' instructions. Utensils and dishes shall be completely immersed for a period of not less than 10 seconds in a clean solution containing not less than 50 ppm, and not more than 200 ppm, of available chlorine bleach or its equivalent or 30 seconds 12.5 ppm of iodine or the amount of time specified by the manufacturer in a 200 ppm quaternary ammonium solution. Water temperature must be at least 75 degrees Fahrenheit. Water temperatures and chemical concentrations shall be monitored and documented prior to dishwashing. A record of each test shall be maintained for at least three months.</li> </ol> </li> <li>3. Dishes and utensils shall be allowed to air dry.</li> <li>4. After washing, rinsing, sanitizing, and air-drying, all repeated use service ware (utensils</li> </ol>	A 702		

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A 702	<p>Continued From page 54</p> <p>and dishes) shall be stored in a clean, dry place that is protected from pests, dust, splash, and other contaminants. Utensils shall be handled in such a way as to prevent contamination from hands and clothing.</p> <p>5. The results from the use of dishwashing machines shall be equivalent to those obtained from the method outlined above, as documented in material provided from the manufacturer and kept on file at the facility.</p> <p>(b) Ice. Crushed or chipped ice shall be protected from splash, drip, and hand contamination during storage and service. The ice scoop shall be stored in a holder inside the ice bin in a manner to prevent ice from coming into contact with the handle, or it may be stored in an airtight container outside the ice bin.</p> <p>(c) Protection of Food from Contamination.</p> <p>1. Food and food ingredients shall be stored, handled, and served so as to be protected from pests, dust, rodents, droplet infection, unsanitary handling, overhead leakage, sewage backflow, and any other contamination. Sugar, syrup, and condiment receptacles shall be provided with lids and shall be kept covered when not in use.</p> <p>2. Medications, biologicals, poisons, detergents, and cleaning supplies shall not be kept in the refrigerator nor in other areas used for storage of food.</p> <p>3. Food shall not be stored on the floor. All food and food ingredients stored on shelving</p>	A 702		

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A 702	<p>Continued From page 55</p> <p>must be placed on shelving that is at least six inches above the floor.</p> <p>4. Refrigerators shall maintain a maximum temperature of 41 degrees Fahrenheit. Freezers shall maintain at a maximum temperature of 0 degrees Fahrenheit. Thermometers shall remain in refrigerators and freezers at all times.</p> <p>5. All leftover foods shall be labeled and dated with a "use by date," so that it may be consumed or discarded by that date, which is no more than three days from the date is was prepared.</p> <p>6. All food products shall be used by the manufacturer's indicated date or discarded.</p> <p>7. Food shall be prepared either in the licensed facility or another location even when that location is not part of the licensed facility. All food preparation areas used by the facility shall be subject to the same inspections as though part of the licensed facility. The licensed facility is responsible to ensure adequate equipment and measures are used so that food is not contaminated in transport and foods that are transported are held and served at the appropriate temperature at all times.</p> <p>8. Hot food shall be maintained at a minimum temperature of 135 degrees Fahrenheit and cold foods at a maximum temperature of 41 degrees Fahrenheit.</p> <p>9. Frozen food items (raw and cooked) shall be thawed under refrigeration or under running water prior to preparation. Frozen food</p>	A 702		

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A 702	<p>Continued From page 56</p> <p>may also be thawed as part of the cooking process when indicated by package directions. Raw meats shall be stored below and away from vegetables, fruits, and other foods to prevent contamination (meat juices dripping on other foods).</p> <p>10. Laundry shall not be brought through the food preparation or service area.</p> <p>(d) Storage and Service of Milk and Ice Cream.</p> <p>1. Milk and fluid milk products shall be served only from the original containers in which they were received from the distributor. This shall not apply to cream for coffee, cereals, and milk for milk drinks which may be dispensed from a readily cleanable container approved for such use.</p> <p>2. Milk and fluid milk products shall be stored in such a manner that bottles or containers from which the milk or milk product is to be poured or drunk will not become contaminated from drip or contact with foods. Milk shall be maintained and stored at a maximum temperature of 41 degrees Fahrenheit and shall not be served at a temperature warmer than 45 degrees Fahrenheit unless specifically requested to be served at a warmer temperature by a resident.</p> <p>3. Contaminating substances shall not be stored with or over open containers of ice cream. Ice cream dippers, spatulas, and other serving utensils shall be cleaned between uses.</p> <p>(e) Kitchen Garbage and Trash</p>	A 702		

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A 702	<p>Continued From page 57</p> <p>Handling.</p> <p>1. Kitchen garbage and trash shall be placed in suitable containers with tight-fitting lids and properly stored pending removal. Kitchen garbage and trash shall not be allowed to accumulate in the kitchen and shall be removed from the premises at frequent intervals.</p> <p>2. After being emptied, all garbage cans and trash cans shall be washed and dried before reuse.</p> <p>(f) Employees' Cleanliness.</p> <p>1. Employees engaged in the handling, preparation, and serving of food shall wear clean clothing at all times. Employees shall wear hair restraints, for example, hairnets, headbands, caps, or other adequate means to prevent contamination of food from hair. Employees whose duties include contact with residents shall change clothing or wear a clean covering over clothing before handling, preparing, or serving food.</p> <p>2. Employees handling food shall wash their hands thoroughly before starting work each day, immediately after contact with any soiled matter, and before returning to work after each visit to the rest room.</p> <p>3. Street clothing not worn by the employee shall be stored in lockers, dressing rooms, or closets designated for staff use.</p> <p>(g) Live Fowl or Animals. Live fowl or animals shall not be allowed in the food service area.</p>	A 702		

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A 702	<p>Continued From page 58</p> <p>(h) Smoking and Spitting. Smoking, other use of tobacco products, and spitting within the food service area shall be prohibited for all staff, residents, and visitors.</p> <p>(i) Dining in Kitchen. Dining in the kitchen shall not be permitted in Congregate assisted living facilities.</p> <p>(j) Paper for Food Wrapping. Only new paper, foil, or plastic wrap shall be used for wrapping of foods.</p> <p>(k) Laundering of clothing shall not be permitted in food preparation or service areas.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to properly label leftover food and properly sanitize dishes. In addition, the facility did not monitor and record water temperatures for the dishwasher and food was not maintained at the required temperature to prevent spoilage.</p> <p>Findings: Leftover Food Not Properly Labeled</p> <p>On July 10, 2024, at approximately 10:20 AM, the surveyor performed a kitchen tour. Along with EI#17, the surveyor observed the following food labeled using the 'prepared date' instead of the 'use by date'. EI#17 agreed with the surveyor's findings.</p> <p>Ground turkey labeled 7/9/2024 Fruit salad labeled 7/9/2024</p>	A 702		

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A 702	<p>Continued From page 59</p> <p>Salad labeled 7/9/2024 Cauliflower soup labeled 7/9/2024</p> <p>Dishwasher Temperatures/Dishes Not Properly Sanitized</p> <p>On July 10, 2024, at approximately 10:30 AM, the surveyor observed that the temperature log for the dishwasher was missing. The temperature for the dishwasher during the rinse cycle only reached 119 degrees. The surveyor observed numerous rinse cycles and the temperature never increased over 119 degrees. During an interview, EI#17 agreed with the surveyor. EI#17 set up the three compartment sinks for sanitization of dishes until the dishwasher could be repaired.</p> <p>Food Temperatures</p> <p>During observation of breakfast, on the morning of July 9, 2024, at approximately 7:25 AM, the surveyors observed 10 residents sitting in the dining room waiting for breakfast to be served. At 7:40 AM, breakfast food was brought to the dining room and placed on or near the steam table. Surveyors asked when the food had been checked for temperature and EI#19 stated the food was checked for temperature in the kitchen (on the second floor) before bringing it to the SCALF (on the first floor). EI#19 added that the food temperatures were not checked again once the food was delivered to the SCALF. Surveyors observed that the steam table did not have steam coming from the table. Surveyors asked if the steam table was working and EI#14 stated that only one out of the three compartments worked. The breakfast items were placed in the two compartments that were not working along with the one that did work. EI#14 started plating the food at 7:51 AM and surveyors requested for the</p>	A 702		

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A 702	Continued From page 60  food to be checked for proper temperature to prevent spoilage of food. At 8:00 AM, EI#19 checked the temperature on the food which revealed eggs 110 degrees Fahrenheit and oatmeal 134.2 degrees Fahrenheit. EI#2 had arrived in the SCALF while food was being checked for proper temperature. EI#19 also stated that the only steam table compartment that did work was not turned on by the third shift so it could be warming. EI#2 instructed staff to take food back to the kitchen and warm it up. At approximately 8:30 AM, the food was brought back to the SCALF and served to the residents with proper temperatures to prevent spoilage of food. Upon further investigation, surveyors discovered that the steam table had not functioned properly for months and possibly as long as one year. Although numerous staff members, including maintenance, nurses, dietary and resident assistants were aware of the steam table malfunction, repairs had not been completed to ensure food temperatures for residents were safe and appropriate.	A 702		
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	A 703		

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NAME OF PROVIDER OR SUPPLIER  <b>LYNRIDGE OF HUNTSVILLE MEMORY CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4801 WHITESPORT CIRCLE HUNTSVILLE, AL 35801</b>
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A 703	<p>Continued From page 61</p> <p>Sciences. The food must be adapted in type and preparation to the habits, preferences, and physical abilities of the residents.</p> <p>(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.</p> <p>(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.</p> <p>(d) Alternate food selections or substitutes shall be made available to all residents.</p> <p>(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.</p> <p>(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</p>	A 703		

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A 703	<p>Continued From page 62</p> <p>potable water shall be maintained in the facility in sufficient quantity to serve three meals per day to all residents for 3 days.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to post meal times and weekly menus. In addition, the facility did not have sufficient food for all residents for three meals a day for 3 days.</p> <p>Findings:</p> <p>Meal Times and Menu</p> <p>On July 9, 2024, at approximately 7:10 AM, the surveyors observed there were not any meal times or weekly menus posted. The surveyors interviewed EI#17 about the missing meal times and menus. EI#17 was from Sagora Senior Living due to the previous dietary manager had resigned. EI#17 advised the surveyor that he (EI#17) would make sure that it was corrected.</p> <p>Emergency Food</p> <p>On July 10, 2024, at approximately 10:20 AM, the surveyor and EI#17 observed there was not any emergency food for all residents for three days. During an interview, EI#17 advised the surveyor that he (EI#17) was in the process of ordering food. EI#17 agreed with the surveyor's findings that emergency food was inadequate.</p>	A 703		
A 901	420-5-20-.09 (1) (2) Laundry.  (1) General.	A 901		

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A 901	<p>Continued From page 63</p> <p>(a) Direction and Supervision. Responsibility for laundry services shall be assigned to an employee.</p> <p>(b) Linen. Linens shall be handled, stored, processed, and transported in a manner consistent with generally accepted infection control practices.</p> <p>(2) Location and Space Requirements.</p> <p>(a) Each specialty care assisted living facility shall have laundering facilities unless commercial laundries are used. An on-site laundry shall be located in a specifically designated area, and there shall be adequate rooms and spaces for sorting, processing, and storage of soiled material. Laundry rooms shall not open directly into resident rooms or food service areas. Domestic washers and dryers which are for the exclusive use of residents may be provided in resident areas, provided they are installed in such a manner that they do not cause a sanitation problem or offensive odors.</p> <p>(b) Each specialty care assisted living facility shall have a system in place to keep clean linen and dirty linen separated and to prevent the re-use of dirty linen before it is cleaned. Dirty linens and clothing shall not be stored, even temporarily, in the area set aside for clean linen.</p> <p>(c) Ventilation of Laundry. Provisions shall be made for proper mechanical ventilation of the laundry, if located within the specialty care assisted living facility. Provisions shall also be made to prevent the re-circulation of air in commercial equipment laundries into heating and air conditioning systems outside the laundry area.</p>	A 901		

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A 901	<p>Continued From page 64</p> <p>(d) Lint Traps. Adequate, effective, and clean lint traps shall be used in all dryers.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain clean dryer lint traps.</p> <p>Findings:</p> <p>On July 11, 2024, at approximately 12:00 PM, the surveyors conducted a tour of the facility's laundry room with EI#2 and EI#6. The facility had two commercial dryers which had a large amount of lint in the traps creating a fire hazard. One of the lint trap doors was difficult to open/close and was in the need of repairs. EI#2 and EI#6 agreed with the surveyors' findings.</p>	A 901		
A1002	<p>420-5-20-.10 (2) Sanitation and Housekeeping.</p> <p>(2) Housekeeping and Physical Plant Maintenance. The facility must provide a safe, functional, decent, sanitary, and comfortable environment for residents, staff, and the public.</p> <p>(a) Equipment and Supplies. The home shall maintain an adequate quantity of housekeeping and maintenance equipment and supplies.</p> <p>(b) Bathtubs and Lavatories. Bathtubs and lavatories shall be kept clean and in proper working order, and shall not be used for laundering.</p>	A1002		

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A1002	<p>Continued From page 65</p> <p>(c) Resident Bedrooms. Resident bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance.</p> <p>(d) General Storage.</p> <p>1. Broken beds, extra mattresses, mop buckets, and dust rags shall not be kept in hallways, closets, corners, or occupied resident rooms. Such items must be stored neatly and orderly in designated storage rooms.</p> <p>2. The use of attics for storage of combustible materials shall be prohibited unless protected by an automatic sprinkler system and then only in small quantities so as not to create a hazardous condition.</p> <p>3. Basements used for storage shall meet acceptable standards for storage and shall be designed and constructed in a manner that protects against fire hazards.</p> <p>4. Flammable materials such as gasoline, motor fuels, lighter fluid, turpentine, acetone, and oil based paint shall not be stored in the facility. Unless prohibited by a facility's own policies, however, a cognitively intact resident who uses lighter fluid to fill a personal cigarette lighter, or one who uses flammable materials such as paint or glue in connection with a personal hobby, may store small quantities of those materials in a safe and secure manner within his or her own room.</p> <p>5. Poisonous or External Use Substances. Facility cleaning supplies and</p>	A1002		

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A1002	<p>Continued From page 66</p> <p>poisons shall be attended at all times or shall be kept in a secure area.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a sanitary and decent environment for staff, residents, and the public.</p> <p>Findings:</p> <p>On July 11, 2024, at approximately 12:00 PM, the surveyors conducted a tour of the facility's laundry room with EI#2 and EI#6. The surveyors observed the laundry room floor was covered with black sticky substances. The commercial washing machines drained into some type of holding container which had unknown substances hanging out of the container. The sink in the laundry room was covered in some type of black/brown/yellow substance. The small closet had dirt, grime and trash on the floor and old mops. EI#2 and EI#6 agreed with the surveyors' findings that the laundry room was not maintained in a sanitary and decent condition.</p>	A1002		
A1101	<p>420-5-20-.11 (1) Fire and Safety</p> <p>(1) General.</p> <p>(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.</p>	A1101		

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A1101	<p>Continued From page 67</p> <p>(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.</p> <p>(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.</p> <p>(d) Roller latches are prohibited on doors separating corridors from adjacent spaces.</p> <p>(e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that:</p> <ol style="list-style-type: none"> <li>1. Minimizes leaks and spills.</li> <li>2. Adequately protects against inappropriate access.</li> <li>3. Complies with the requirements of the currently adopted Life Safety Code.</li> </ol>	A1101		

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A1101	<p>Continued From page 68</p> <p>(f) Fire Alarm and Sprinkler System.</p> <p>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).</p> <p>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.</p> <p>3. The fire alarm system and the sprinkler system shall be inspected by licensed, trained, and qualified personnel at least semiannually for compliance with the respective codes. Inspection and Testing reports shall be maintained in the facility for a period of at least 3 years.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to conduct fire drills on each shift every quarter. In addition, fire alarm and sprinkler</p>	A1101		

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A1101	<p>Continued From page 69</p> <p>inspections were not performed semiannually as required.</p> <p>Findings:</p> <p>Fire Drills</p> <p>On July 9, 2024, during a review of the fire drill records, the surveyor noted that the facility failed to conduct fire drills on each shift quarterly. During an interview on July 10, 2024, EI#6 agreed with surveyors that the fire drills were not conducted on each shift every quarter.</p> <p>Fire Alarm and Sprinkler System Inspections</p> <p>On July 9, 2024, the surveyor reviewed fire alarm and sprinkler system inspections provided by EI#6. No inspections had been performed for the year 2024. The most recent fire alarm system inspection was documented on April 13, 2023 and the most recent sprinkler system inspection was documented on April 11, 2023. EI#6 stated that they were changing companies to conduct the inspections and admitted that the inspections were not done timely.</p>	A1101		
A1201	<p>420-5-20-.12 (1) Physical Environment.</p> <p>(1) Buildings and Grounds.</p> <p>(a) The specialty care assisted living facility including site and grounds must be constructed, arranged, and maintained to ensure the safety of the residents and building occupants.</p> <p>(b) Building Classification.</p>	A1201		

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A1201	<p>Continued From page 70</p> <ol style="list-style-type: none"> <li>1. Group specialty care assisted living facilities shall be planned to serve the residents to be admitted and shall comply with Section (1), (2), (3), (5), (6), and (8) of AAC Rule 420-5-20.12.</li> <li>2. Congregate specialty care assisted living facilities shall be planned to serve the residents to be admitted and shall comply with Sections (1), (2), (3), (7), and (8) of AAC Rule 420-5-20-.12.</li> <li>3. Renovation within the exterior walls of a specialty care assisted living facility shall in no case be of such nature as to lower the character of the structure below the applicable building requirements for the classification of license held by the specialty care assisted living facility.</li> <li>4. Dually licensed facilities.               <ol style="list-style-type: none"> <li>(i) For the purposes of meeting physical facility and building code requirements, a building housing both a regular assisted living facility and a specialty care assisted living facility shall be classified as a Group or Congregate facility in accordance with the combined licensed bed capacities of both facilities. For the purposes of meeting resident care and administrative requirements, the specialty care assisted living facility and the regular assisted living facility shall be separately considered, and each shall be classified as a Congregate facility or a Group facility in accordance with the licensed bed capacity of each, and the determination shall not be based on their combined bed capacity.</li> <li>(ii) When a facility has a portion of a building licensed for specialty care residents,</li> </ol> </li> </ol>	A1201		

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A1201	<p>Continued From page 71</p> <p>instead of the entire facility, the sleeping, bathing, dining, and activity areas shall be in a distinct and separate unit within the building, licensed for specialty care assisted living. Administrative, kitchen, and service areas may be shared between the two licensed portions.</p> <p>(c) Location. Each specialty care assisted living facility established or constructed shall be located so that it is free from undue noises, smoke, dust, or foul odors. New assisted living facilities shall be located at least 1,000 feet from railroads, freight yards, or disposal plants. This distance can be reduced to 500 feet when facility is separated by a boarded fence at least 6 feet high. This rule shall not prevent enlargement or expansion of existing assisted living facilities.</p> <p>(d) Local Restrictions. The location and construction of a specialty care assisted living facility shall comply with local zoning, building, and fire ordinances. Evidence to this effect, signed by local fire, building, or zoning officials, may be required as a condition of licensure. If a facility is to be located in an area that does not have any zoning, building, or fire authority review, a letter stating such shall be obtained from the local county commission through official board action or from the office of the probate judge.</p> <p>(e) Specialty Care assisted living facilities shall be located on publicly maintained streets or roads, and connected with driveways which shall be kept passable at all times.</p> <p>(f) Occupancy. No part of a specialty care assisted living facility may be rented, leased, or used for any commercial purpose not reasonably necessary for the residents of the</p>	A1201		

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A1201	<p>Continued From page 72</p> <p>facility. Only residents of the facility shall be permitted to utilize these services. The Department shall approve all plans for occupancy.</p> <p>(g) Basements. The basement shall be considered as a story if it meets criteria established by the codes for a story.</p> <p>(h) The specialty care assisted living facility must maintain adequate furnishings, fixtures, supplies, and equipment for its services.</p> <p>(i) Facilities, supplies, and equipment must be maintained in safe operating condition.</p> <p>(j) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.</p> <p>This Rule is not met as evidenced by: Based on observations and interview, the facility failed to maintain the grounds and outdoor furnishings in the courtyard.</p> <p>Findings:</p> <p>On July 10, 2024, at approximately 8:15 AM, the surveyors along with EI#2 and EI#6 performed a tour of the outdoor courtyard. The surveyors observed a broken chair in the courtyard. The sidewalks and chairs were covered with leaves and pinestraw. A walkway that lead to a gate contained concrete pavers which were not level and most of the pavers were loose. The pavers created a trip hazard and the potential for harm to all 17 residents. During an interview the same day, EI#2 and EI#6 agreed with the surveyors'</p>	A1201		

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NAME OF PROVIDER OR SUPPLIER  <b>LYNRIDGE OF HUNTSVILLE MEMORY CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4801 WHITESPORT CIRCLE HUNTSVILLE, AL 35801</b>
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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
A1201	Continued From page 73 findings.	A1201		
A1203	<p>420-5-20-.12 (5) Physical Environment.</p> <p>(5) General Building Requirements - Group and Congregate.</p> <p>(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.</p> <p>(b) Temperature to be Maintained. The facility shall maintain a comfortable temperature. A comfortable range is between 71-81 degrees Fahrenheit.</p> <p>(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.</p> <p>(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.</p> <p>(e) Emergency Lighting.</p> <p>1. All specialty care assisted living facilities shall provide an emergency artificial lighting system to adequately illuminate halls,</p>	A1203		

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A1203	<p>Continued From page 74</p> <p>corridors, and stairwells in case of electrical power failure. As a minimum, dry cell battery-operated lighting shall be provided to light such spaces.</p> <p>2. Emergency lighting must provide illumination in accordance with the currently adopted Life Safety Code for at least 90 minutes.</p> <p>(f) Floors.</p> <p>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.</p> <p>2. Any differences in floor levels shall not prevent a resident from navigating safely throughout the facility.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p>	A1203		

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A1203	<p>Continued From page 75</p> <p>(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.</p> <p>(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.</p> <p>(l) Doors.</p> <p>1. In each new specialty care assisted living facility, doors of resident bathrooms connected to resident bedroom shall swing into the bedroom.</p> <p>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.</p> <p>3. Resident bedroom and other exit access doors in specialty care assisted living facility shall be at least three feet wide.</p> <p>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.</p>	A1203		

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A1203	<p>Continued From page 76</p> <p>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.</p> <p>(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.</p> <p>(n) Fire Extinguishers. Fire extinguishers shall be provided for each hall, kitchen, and laundry, of type and capacity appropriate to the need.</p> <p>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.</p> <p>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.</p> <p>(o) Call System. A central electric or electronic call system shall be conveniently provided for each resident, usable in bedrooms</p>	A1203		

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A1203	<p>Continued From page 77</p> <p>and bathrooms. The call system shall be certified to meet the applicable Underwriters Laboratories standard.</p> <p>(p) Manufactured homes/mobile homes are not permitted.</p> <p>(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.</p> <p>(r) Exit marking. In all facilities, a sign bearing the word "EXIT" in plain legible block letters shall be placed at each exit. Additional signs shall be placed in corridors and passageways wherever necessary to indicate the direction of exit. Letters of signs shall be at least four inches high. All exit and directional signs shall be kept clearly legible by continuous internal electric illumination and have battery back-up or emergency power.</p> <p>(s) Heating, Lighting, and other Service Equipment.</p> <p>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.</p> <p>2. Open flame and portable heaters are prohibited in specialty care assisted living facilities. This does not apply to a fire place with</p>	A1203		

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A1203	<p>Continued From page 78</p> <p>gas logs protected as noted elsewhere in these rules.</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide annual fire extinguisher inspections. In addition, the carpet was dirty and frayed, the ceiling was in the need of repair and an electrical panel door was open.</p> <p>Findings:</p> <p>Fire Extinguishers</p> <p>On July 8, 2024, at approximately 3:39 PM, during a facility tour, the surveyors observed the last inspection date on the fire extinguishers was April 2023. Upon record review, on July 9, 2024, the fire extinguisher annual inspections had not been completed. When interviewed, on July 9, 2024, EI#6 advised the surveyors that the facility was in the process of changing to Global Fire and that the annual fire extinguisher inspections had not been done.</p> <p>Carpet</p> <p>On July 8, 2024, at approximately 3:43 PM, during a facility tour, the surveyors observed the carpet was dirty and and frayed. The surveyors observed several resident doorways were</p>	A1203		

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A1203	<p>Continued From page 79</p> <p>missing the transition strip from carpet to vinyl which caused the carpet to fray, creating an unveled surface and trip hazard. During an interview with EI#2 and EI#6 that same afternoon, both agreed with the surveyors' findings.</p> <p>Electrical Panel Closet Door</p> <p>On July 8, 2024, at approximately 3:45 PM, during a facility tour, the surveyors observed two doors labeled "electrical room". The surveyors observed the doors were not locked and opened freely and the closet housed two large electrical panels. Access to these electrical panels could have caused harm to all 17 residents. During an interview with EI#2 and EI#6 that same afternoon, both agreed with the surveyors' findings.</p> <p>Ceiling</p> <p>On July 8, 2024, at approximately 3:50 PM, during a facility tour, the surveyors observed resident room 19 with what appeared to be mold on the ceiling. Resident room 12 appeared to have had some type of water leak and the ceiling was in the need of repairs. During an interview with EI#2 and EI#6 that same afternoon, both agreed with the surveyors' findings.</p>	A1203		
A1206	<p>420-5-20-.12 (8) Physical Environment</p> <p>(8) Additional Requirements for Specialty Care Assisted Living Facilities.</p> <p>(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</p>	A1206		

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A1206	<p>Continued From page 80</p> <p>indicated below.</p> <p>(b) Additional Smoke Detection. Smoke detectors (electrical or system type) shall be provided in the sleeping rooms and any bedroom suite sitting areas, which house dementia residents. These detectors shall initiate at least a local alarm or supervisory signal, through the fire alarm system or call system.</p> <p>(c) Windows in specialty care facilities may have devices which prevent opening of the window.</p> <p>(d) Areas to Wander and Secure Perimeter.</p> <p>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.</p> <p>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.</p> <p>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</p>	A1206		

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A1206	<p>Continued From page 81</p> <p>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.</p> <p>4. If the facility's emergency plan uses the fenced or walled outdoor spaces merely as areas that are immediately passed through and exited, not as refuge areas for containment of residents, there is no size or area requirement for the fenced or walled spaces.</p> <p>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.</p> <p>(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.</p> <p>1. Delayed-egress locks must comply with the requirements for "Special Locking Arrangements" found in NFPA 101 Life Safety Code.</p> <p>2. Electrically locked doors shall comply with the following:</p> <p>(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</p>	A1206		

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A1206	<p>Continued From page 82</p> <p>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.</p> <p>(ii) A key, code, or card release switch shall be provided inside the facility at each locked door, which shall override the locking system to allow exiting from the compartment or building.</p> <p>(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.</p> <p>(iv) Locks shall release automatically upon loss of electric power controlling the lock.</p> <p>(v) The facility shall provide the residents sponsors with adequate information about the facility's door locking arrangements.</p> <p>(vi) The facility shall assure, at least monthly, that locked or delayed-egress exit doors function properly, in accordance with required fire safety provisions.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide safe egress from an exterior courtyard gate.</p> <p>Findings:</p> <p>On July 10, 2024, at approximately 8:15 AM, the surveyors along with EI#2 and EI#6 toured the</p>	A1206		

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A1206	<p>Continued From page 83</p> <p>exterior perimeter. While touring the exterior courtyard there was one gate which could not be opened. During an interview, EI#6, Maintenance Director, stated the gate could be opened from the outside, but the keypad had been ordered to repair the gate so that it could be opened from the inside. The gate was closed from the outside using a mounted brace so that the gate could not be opened from the inside. On July 10, 2024, EI#6 stated that a new keypad had arrived, and the gate was scheduled to be repaired on July 11, 2024.</p> <p>On July 12, 2024, EI#6 emailed the surveyor with verification that the courtyard exterior gate had been repaired.</p> <p>CONNIE CHERRY, REGISTERED NURSE TROY BLACK, REGISTERED NURSE</p>	A1206		