STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNRIDGE OF HUNTSVILLE ASSISTED LIVING	4801 WHITESPORT CIRCLE HUNTSVILLE, AL 35801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments On July 24, 2024, an unannounced licensure survey and complaint investigation was conducted for this 58 bed Assisted Living Facility (ALF) with a census of 21. There were no complaints investigated during this survey. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities. The deficiencies cited pose a risk or potential risk of harm to the residents and require a plan of correction.	A 000		
A 301	420-5-4-.03 (1) (a) (b) (c) (d) Administration. The Assisted Living Facility Governing Authority. (a) An assisted living facility shall have an identified sole proprietorship, corporation, partnership, limited partnership, or other business entity that is its governing authority, or it shall have a designated individual or group of designated individuals who serve as its governing authority. A facility must give complete information to the Department identifying: 1. Each person who has an ownership interest of 10 percent or more of the governing authority. 2. Each person or entity who has an ownership interest of 10 percent or more in the real property or building used by the assisted living facility to offer its services.	A 301		

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A 301	Continued From page 1 3. Each officer and each director of the corporation if the governing authority is a corporation. 4. Each partner, including any limited partners, if the governing authority is a partnership. (b) The governing authority shall submit any changes to the information listed above to the Department within 15 days of the change. (c) Responsibility of Staff to Governing Authority. The administrator, medical staff, facility personnel, and all auxiliary organizations shall be directly or indirectly responsible to the governing authority. For the purposes of these rules, auxiliary organizations include but are not limited to licensed or certified outside providers, consultants, management companies that are not the facility license holder. (d) The governing authority is responsible for appointing and supervising the administrator who is responsible for overall management and the day-to-day operation of the facility. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the governing authority failed to ensure the facility operated in compliance with the SBOH rules for ALFs. The governing authority's lack of adequate oversight resulted in widespread deficient practices which placed all 21 residents of the facility at significant risk for harm due to	A 301		

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A 301	Continued From page 2 this failure to apply the SBOH rules for the day to day operations of the facility. Findings: At the time surveyors entered the specialty care assisted living facility (SCALF) on the same campus, on July 8, 2024, there was no administrator of record on file for the ALF facility at the Alabama Department of Public Health. Employee Identifier (EI)#1 was the Business Director at that time and reported to the surveyors that Sagora Senior Living had taken over management of the facility on May 15, 2024. EI#1 added that the previous administrator (EI#11) had left the facility on that same date. EI#1 became interim administrator of the facility on July 17, 2024, after surveyors completed the onsite survey of the SCALF. Prior to that time, EI#2 served as the executive director specialist for Sagora Senior Living but was not licensed as an assisted living administrator for the state of Alabama. EI#1 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 63 days when EI#1 became administrator. A new administrator was hired by Sagora and was scheduled to start the new position on July 29, 2024. The surveyors observed a general lack of management at the facility. There was no dietary manager and the emergency food supply had recently been replenished since surveyors exited the SCALF. During interviews with residents, the surveyors received numerous complaints regarding lack of variety in their foods, failure to provide alternate foods and improperly prepared foods. The kitchen was dirty and not properly	A 301		

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A 301	Continued From page 3 maintained. Water temperatures were inadequate to properly sanitize dishes even though this was previously cited during the SCALF survey. Dietary personnel verbalized and demonstrated a lack of leadership. A new dietary manager was hired during the onsite survey. Medication issues were identified during the onsite survey including residents not being allowed to identify their medications, a resident who was visually unable to identify medications and had no system in place for identification and medication doses omitted due to the medication not being available. During the SCALF survey, an Integrations Specialist with Sagora Senior Living was present at the facility and informed the surveyors that she (Integrations Specialist) had been sent to determine what the needs were at the facility since Sagora had assumed management of the facility in May 2024 and to assemble a team of Sagora personnel to come to the facility, including nurses and construction/maintenance to complete needed repairs. The Integrations Specialist also informed the surveyors that HRA was the previous management company at the facility and bills were not paid when Sagora took over management of the facility. EI#1 provided current payment records of bills to the surveyors. On July 24, 2024, EI#1 informed the surveyors that all bills were currently paid. The Integrations Specialist 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.	A 301		

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A 301	Continued From page 4 On July 24, 2024, EI#3, EI#4, EI#5 and EI#6 all agreed that the lack of management at the facility had likely contributed to the deficient practices identified by the surveyors. However, EI#4 verbalized Sagora's intent to correct the deficient practices that had been allowed under the previous management company and to achieve and maintain compliance with the SBOH rules for ALFs. EI#4 also stated that EI#6 had been contracted to provide consultation at the facility and to assist with ensuring that compliance with the Alabama rules for assisted living facilities was obtained and maintained. 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. 303 - The facility operated without a licensed administrator for greater than 45 days. 305 - The ADPH was not notified timely when a change in administrator occurred. 405 - Employees who had been at the facility greater than 90 days did not have current certification in cardiopulmonary resuscitation (CPR). 601 - Physician's orders were not followed for a resident's medication. 602 - A resident's medical examination was incomplete. 604 - Resident assessments were not completed as required. 611 - A resident's care plan was not current and did not contain appropriate interventions to address the care needs of the resident. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MAY 20, 2021. 614 - A visually impaired resident was unable to utilize the unit dose packaging system. A resident	A 301		

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A 301	Continued From page 5 was not given the opportunity to utilize the unit dose packaging system. 617 - A medication disposition form was incomplete. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MAY 20, 2021. 702 - Dishes were not properly sanitized. Leftover food was not properly stored, labeled and dated. There was no cover on the kitchen trash can. Thermometers were not maintained in all refrigerators. 703 - Alternate food selections were not provided per the alternate menu. The weekly menu was not followed in daily food preparation and food was not palatable. 804 - The food service area of the kitchenette was not clean. 1002 - Chemicals were unsecured. 1101 - The fire alarm and sprinkler systems were not inspected semiannually. 1203 - Fire extinguishers were not inspected annually. Carpet was frayed causing a trip hazard. 1206 - Two fire doors did not latch properly. Smoke barrier doors did not properly seal.	A 301		
A 303	420-5-4-.03 (2) (a) Administration. The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an	A 303		

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A 303	Continued From page 6 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. 5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age. 6. The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character. 7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week. 8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment and adequate care being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement. 9. The facility administrator is responsible for ensuring that required training is provided to all staff.	A 303		

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A 303	Continued From page 7 10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting. 11. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when needed. 12. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan. 13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, administrator duties were not fulfilled due to failure of the facility to provide a properly licensed administrator as required. Findings: Surveyors entered the SCALF in the same building on July 8, 2024 and were greeted by EI#1 who introduced herself as the Business Director. When surveyors asked who the current administrator was, EI#1 stated that corporate staff had been coming from Sagora Senior Living to manage the ALF and SCALF. Surveyors were also informed by the Integrations Specialist with	A 303		

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A 303	Continued From page 8 Sagora Senior Living that the most recent interim executive director was EI#2. However, EI#2 did not have an Alabama assisted living administrator's license for ALF or SCALF. Surveyors were later provided with 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#2 could be contacted if urgent matters required immediate attention and that the Business Director 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. EI#1 did not become interim administrator of the facility until July 17, 2024. The previous administrator (EI#11) had left the facility on May 15, 2024. The facility had operated 63 days without a properly licensed administrator. On July 24, 2024, EI#4 informed the surveyors that a new administrator had been hired to replace EI#1 and would begin the role on July 29, 2024. 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. *Staff training in cardiopulmonary resuscitation was not completed as required. Refer to deficiency 405 for additional information. *Residents were not observed for changes in physical abilities and appropriate measures taken to ensure safety with medication assistance. Refer to deficiency 614 for additional information. *A resident's care plan was not current and appropriate. Refer to deficiency 611 for additional information. *Previously cited deficiencies were not corrected to ensure compliance with SBOH rules for ALFs.	A 303		

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A 303	Continued From page 9 These previously cited deficiencies included medication disposition documentation was incomplete and care plans were not current and appropriate. Refer to deficiencies 611 and 617 for additional information. On July 24, 2024, EI#3, EI#4, EI#5 and EI#6 all agreed that the lack of a licensed administrator at the facility had likely contributed to these deficient practices identified by the surveyors.	A 303		
A 305	420-5-4-.03 (2) (c) Administration. (c) Department Notification. 1. The licensee of an assisted living facility shall provide written notification of voluntary closure of the facility to the State Board of Health at least 30 days prior to the expected closure date. 2. The State Board of Health shall be provided written notification not later than 15 days after any change in administrator. 3. The State Board of Health shall be provided written notification not later than 15 days after any change in management company. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the Alabama Department of Public Health timely when a change in administrator occurred. Findings:	A 305		

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A 305	Continued From page 10 When surveyors entered the facility, on July 22, 2024, the administrator of record for the Alabama Department of Public Health was EI#1. However, EI#1 had recently become the administrator on July 17, 2024. EI#1 informed the surveyors that the previous administrator, EI#11, had not been employed at the facility since May 15, 2024, when Sagora Senior Living became the facility's management company. Records for the Alabama Department of Public Health ALF unit revealed that the Department had not been notified of an administrator change until July 17, 2024. EI#1 was unable to provide written notification from the facility to the Department when this change in administrator occurred.	A 305		
A 405	420-5-4-.04 (6) Personnel. (6) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained in the facility. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on assisted living facilities. 2. Facility policies and procedures. 3. Resident rights.	A 405		

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A 405	Continued From page 11 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire. 5. Identifying and reporting abuse, neglect, and exploitation. 6. Basic first aid. 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environment safety. 10. Special needs of the elderly, mentally ill, and mentally retarded. 11. Safety and nutritional needs of the elderly. 12. Identifying signs and symptoms of dementia. (b) Cardiopulmonary Resuscitation. An assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of an assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within 90 days of hire. An assisted living facility equipped with an automated external defibrillator (AED) shall be staffed at all times by at least one individual who	A 405		

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A 405	Continued From page 12	A 405		

has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or American Red Cross in CPR or AED utilization.

(c) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training.

(d) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above.

This Rule is not met as evidenced by:
Based on record reviews and interview, employees were not currently certified in CPR.

Findings:

Review of employee files, on July 23, 2024, revealed the following information.

EI#7 had been employed at the facility since February 13, 2024. EI#7 had previously been certified in CPR. However, EI#7's CPR certification had expired on July 11, 2024.

EI#12 had been employed at the facility since September 7, 2022. EI#12 was not currently certified in CPR.

During an interview on July 23, 2024, EI#1 stated

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A 405	Continued From page 13 that the CPR certification for these two employees had expired and added that a class for CPR recertification would be scheduled in the near future.	A 405		
A 601	420-5-4-.06 (1) Care of Residents. (1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician. (a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her choice. If the resident is unable to designate an attending physician, or does not wish to designate an attending physician, the facility shall assist the resident in identifying an attending physician who will serve the resident. A resident shall be permitted to change the designation of his or her attending physician at any time. Whenever a resident requires medical attention, an attempt shall first be made to contact the resident's attending physician, except in medical emergencies requiring activation of the local EMS system (911 or another emergency call). (b) Back-up Physician Support. Each assisted living facility shall have an agreement with one or more duly licensed physicians to serve in those instances when a resident's own attending physician cannot be reached, and to provide temporary medical attention to any resident whose attending physician is temporarily not available. A nurse practitioner or physician's assistant shall not serve as the back-up physician in an assisted living facility. (c) All physician orders shall be written in	A 601		

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A 601	Continued From page 14	A 601		

accordance with community standards. If verbal orders are used, they are to be used infrequently. A physician verbal order shall only be accepted by an RN or LPN employed by the facility and authorized to do so by facility policy and procedures and state law. All verbal orders shall be reduced to writing on the physicians' order sheet by a licensed facility nurse and shall be dated and signed by the nurse receiving the order. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, or another practitioner who is responsible for the care of the resident and authorized to write orders by facility policy. All verbal orders must be authenticated within such time period as provided by facility policy, but in no case shall exceed 30 days following entry of the order.

This Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to follow physician's orders for a resident's medication.

Findings:

RI#1 was admitted to the facility on July 6, 2021 with diagnoses which included dementia, recurrent major depression, anxiety, osteoporosis and hyperlipidemia.

On the afternoon of July 22, 2024, during the surveyor's observation of medication assistance by EI#14, RI#1 had a physician's order for Deep Sea 0.65% nose spray twice daily at 8:00 AM and 4:00 PM. The nose spray was not available for administration at 4:00 PM and RI#1 missed the

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LYNRIDGE OF HUNTSVILLE ASSISTED LIVING	4801 WHITESPORT CIRCLE HUNTSVILLE, AL 35801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 601	Continued From page 15 4:00 PM dose. During an interview, on the afternoon of July 22, 2024, EI#14 stated that the nose spray for RI#1 had been ordered from the pharmacy but had not arrived. The surveyor requested the refill request fax to ascertain when the medication had been ordered but the facility was unable to provide any reorder documentation. EI#14 was asked by the surveyor what the process was for ordering missing medications. EI#14 stated "we fax a request to the pharmacy".	A 601		
A 602	420-5-4-.06 (2) (a) (b) (c) Care of Residents. (2) Medical Examination Record. (a) Initial Physical Examination. Not more than 30 days prior to admission of any resident to an assisted living facility, the resident or prospective resident shall be examined by a physician. For purposes of the initial physical examination only, a currently licensed physician in good standing with the Medical Licensure Commission of any state may complete this physical assessment. The physician shall report his or her findings in writing to the facility. In addition to any information otherwise required by the facility's policies and procedures, and in addition to any other information the physician recommends or believes is pertinent, the initial physical examination record shall contain the following: 1. All of the physician's diagnoses, and the resident's baseline weight and vital signs. 2. Medication presently prescribed (name, dosage, and strength of drug, frequency,	A 602		

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A 602	Continued From page 16 and route of administration). 3. A statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact. 4. Documentation of evaluation for tuberculosis within the previous 12 months. (b) Annual Physical Examination. In addition to the admission physical examination, each resident shall be examined annually by a physician, and findings from the annual physical examination shall be documented with a copy placed in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent, or recommended by the resident's attending physician, the annual physical examination shall contain the following: 1. The resident's weight and vital signs. 2. Changes in diagnoses. 3. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration). 4. Changes in treatment. (c) Change of Condition Physician Examinations. Changes in the resident's condition that require a physician examination and result in a change in diagnoses, medications, or treatments shall be reported to the facility and	A 602		

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A 602	Continued From page 17 documented in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent, or recommended by the resident's treating physician, this physical examination shall contain a listing of the following: 1. New diagnoses. 2. Changes in condition. 3. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration). 4. Changes in treatment. This Rule is not met as evidenced by: Based on interview and record review, a resident's Initial Physical Examination did not contain required information. Findings: RI#4 was admitted to the facility on March 22, 2024 with diagnoses which included dementia, type two diabetes mellitus, chronic kidney disease, hypertension, hyperlipidemia and hypothyroidism. Refer to deficiencies 604 and 614 for additional information on RI#4. On the morning of July 24, 2024, during record review, it was revealed that the baseline vital signs and weight were omitted on RI#4's Initial Physical Examination, dated March 22, 2024. On	A 602		

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A 602	Continued From page 18 the morning of July 24, 2024, EI#6 acknowledged the surveyor's findings.	A 602		
A 604	420-5-4-.06 (3) (a) (b) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility shall assess prospective residents for facility eligibility. This assessment shall document identified care needs and serve as a baseline for future assessments. (b) Monthly Assessments. The facility shall assess each resident monthly and more often when necessary to identify changes in resident's status. In addition to other items that may be required by the facility's own policies and procedures, the monthly assessment shall: 1. Assess the resident's ability to safely self-manage medications or safely self-administer medications with assistance. 2. Accurately weigh and record the weight of each resident. A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half or greater weight loss in a period of three months or less, or a ten percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician. 3. Document identified changes in	A 604		

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A 604	Continued From page 19 resident status. 4. Assess the appropriateness of each resident's plan of care. Any decline in resident status requires immediate implementation and documentation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on record reviews and interview, resident assessments were not completed as required. Findings: Review of resident records, on July 24, 2024, revealed the following information. RI#3 RI#3 was admitted to the facility on July 11, 2022 and had diagnoses which included asthma, low back pain, esophagitis, depression and anxiety. No weights were documented on RI#3's Monthly Assessments for the months of February 2024 and May, June, July, August, September, October, November and December 2023. EI#6 agreed the assessments were incomplete. RI#4 RI#4 had resided at the facility since March 22, 2024. Refer to deficiencies 602 and 614 for additional information on RI#4. On the morning of July 24, 2024, during record review, it was revealed that RI#4's Monthly	A 604		

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A 604	Continued From page 20 Assessments for January 2024 and February 2024 were omitted. On the morning of July 24, 2024, EI#6 acknowledged the surveyor's findings.	A 604		
A 611	420-5-4-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall be based on the initial medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be reviewed and updated based on the annual examination, and all other physician examinations, diagnoses, and recommendations of the resident's treating physician, and the resident's monthly assessments. The plan of care shall be developed and updated in cooperation with the resident and, if appropriate, the sponsor. All entries on the plan of care shall be accurately dated. 1. The plan shall at all times reflect the current condition of the resident and document the personal care and services required from the facility by the resident. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following:	A 611		

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A 611	Continued From page 21 2. A listing of the resident's individual needs or problems that require intervention by the facility. 3. A listing of interventions provided by the facility to address the resident's identified needs or problems. 4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider. 5. Activities of Daily Living. Residents of assisted living facilities shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident. (i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested. (ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips. (iii) Hair. Resident's hair shall be kept clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with	A 611		

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A 611	Continued From page 22 shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be provided assistance with personal safety. 6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on observation, record review and interview, a resident's care plan did not contain appropriate interventions to meet the care needs of the resident. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MAY 20, 2021. Findings: Review of resident records, on July 24, 2024, revealed the following information. RI#3 had resided at the facility since July 11, 2022. Refer to deficiency 604 for additional information on RI#3. On July 22, 2024, the surveyor observed RI#3's medications stored in his/her room. EI#7 informed the surveyors that RI#3 self-administered medications. A physician's order was present for RI#3 to self-administer medications. RI#3's Resident Service Plan, dated April 26, 2024, read "MEDICATION NEEDS-Licensed nurse or Med Tech to assist with all medications per MD orders". EI#6 agreed	A 611		

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A 611	Continued From page 23 the care plan was not accurate to direct staff in providing RI#3's care.	A 611		
A 614	420-5-4-.06 (5)(f)(g)(6)(7)(a)-(i) Care of Residents. (f) A resident may self-manage his or her medications. For the purposes of these rules, self-manage shall mean the resident is capable of maintaining possession and control of his or her medications, who does maintain possession and control of his or her medications, and self-administers his or her medications without creating an unreasonable risk to health and safety. (g) A resident that cannot self-manage his or her own medication without creating an unreasonable risk to health and safety may be assisted with self-administration of medication by any assisted living facility staff, including staff members who hold no professional licensure provided: 1. The resident can and does identify his or her name on the medication package and has a reasonable understanding of the unit dose packaging system in use by the facility such that the resident could protect himself or herself from medication errors when unit dose packages are brought to the resident by facility staff. The resident shall have the opportunity to demonstrate his or her ability to correctly utilize the unit dose package system at every opportunity for medication use. (6) Assistance with self-administration of medication includes the following practices: (a) Reminding a resident that it is time to	A 614		

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A 614	Continued From page 24 take a medication or medications, where such medications have been prescribed for a specific time of day, a specific number of times per day, specific intervals of time, or for a specific time in relation to mealtimes or other activities such as arising from bed or retiring to bed. (b) Physically assisting a resident by opening or helping to open a container holding medications. (c) Offering liquids to a resident to assist that resident in ingesting oral medications. (d) Physically bringing a container of medication to a resident. (7) Assistance with self-administration of medications shall under no circumstances include any of the following practices: (a) Medication administration as defined in these rules. (b) Determining the amount of medication to be given. If a medication is not available in unit dose packaging, unlicensed facility staff may measure the prescribed amount of medication only under the direction and control of the resident, provided that the resident is capable of determining the amount of medication to be given. (c) Giving a resident injections of any kind. (d) Telling or reminding a resident that it is time to take a PRN, or as needed medication.	A 614		

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A 614	Continued From page 25 (e) Placing medications in a feeding tube. (f) Giving enemas or suppositories. (g) Crushing or splitting medications, provided that a physician has ordered a specific medication to be crushed or split and the resident is capable of self-managing his or her own medication or the resident is capable of medication self-administration with assistance and would be capable of crushing or splitting his or her own medications but for limitations of mobility or dexterity, may be assisted with crushing or splitting medications by unlicensed staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. (h) Mixing medications with food or liquids, provided that a physician has ordered a medication to be mixed with food or liquid and the resident is capable of self-managing his or her own medications or the resident is capable of medication self-administration with assistance and would be capable of mixing his or her own medications with food or liquid but for limitations of mobility or dexterity, may be assisted with mixing medications with food or liquid by unlicensed staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe	A 614		

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A 614	Continued From page 26 practices by facility staff. (i) Assisting with self-administration of eye drops, eardrops, nose drops, inhalers, nebulizers, or topical medications, provided that a resident who is capable of self-managing his or her own medication or a resident who is capable of medication self-administration with assistance and who would be capable of self-administration of his or her own medications but for limitations of mobility or dexterity, may be assisted with eye drops, ear drops, nose drops, inhalers, nebulizers, or topical medications by unlicensed facility staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a resident who was visually impaired was able to utilize the unit dose packaging system and protect himself/herself from a medication error. In addition, a resident was not given the opportunity to utilize the unit dose packaging system at every opportunity for medication use. Findings: Visually Impaired Resident Review of resident records, on July 23, 2024, revealed the following information.	A 614		

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A 614	Continued From page 27 RI#2 was admitted to the facility on August 31, 2021 and had diagnoses which included atrial fibrillation, history of stroke, history of cancer of the vocal cords, weakness of the left hand and foot, gastroesophageal reflux disease, anxiety, macular degeneration, hypertension, high cholesterol, depression, anemia and hypertensive heart and chronic kidney disease. RI#2's vision was impaired and RI#2 was unable to read. During an interview, on July 23, 2024, RI#2 stated that he/she could only see images. On the morning of July 23, 2024, the surveyor observed medication assistance provided to RI#2 by EI#12, Medication Technician. When preparing medications for RI#2, EI#12 explained to the surveyor that tactile markers were applied to RI#2's medication packets each time medication was given and were applied by the staff member assisting with the medications, prior to taking the medications to RI#2. EI#12 applied a single plastic marker which had the appearance of an eyeball to RI#2's medication packets before taking the medications to RI#2. In RI#2's room, EI#12 presented the medication packets to RI#2 who felt the markers on the packets. RI#2 was asked how he/she identified evening medications and if there was a difference in the markers. RI#2 stated he/she was unable to tell the difference in the markers and trusted staff to provide him/her with the correct medications. The medications which were given to RI#2 were identified and marked with tactile identifiers by the Medication Technician prior to presenting the medications to RI#2 and, therefore, were not identified by RI#2. RI#2 was unable to distinguish the difference between morning and evening doses of medications. A note on the medication cart instructed staff to apply one star to RI#2's morning medications and two stars to RI#2's	A 614		

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A 614	Continued From page 28	A 614		

evening medications. No stars were available on the cart for use with RI#2's medications. RI#2 was unable to protect himself/herself from a medication error utilizing the current system.

During interviews on July 23 and 24, 2024, both EI#6 and EI#12 agreed the system currently in use for identification of RI#2's medications was not sufficient to protect RI#2 from a medication error. EI#6 stated a new method for RI#2 to identify medication would be implemented.

Resident Not Given the Opportunity to Utilize the Unit Dose Packaging System

RI#4 had resided at the facility since March 22, 2024. Refer to deficiencies 602 and 604 for additional information on RI#4.

On the afternoon of July 22, 2024, during the observation of medication assistance, the surveyor observed RI#4 was not directing his/her care. RI#4 was not given the opportunity to view the sliding scale for insulin administration and did not inform the medication technician of the proper dosage to administer. EI#14, Medication Technician, performed a fingerstick glucose check and obtained a result of 259 without the direction of RI#4. The Medication Administration Record sliding scale indicated the dosage of 4 units of Lispro was required. EI#14 informed RI#4 of the glucose reading 259 and stated, "you get 4 units of insulin". RI#4 did not have a sliding scale to refer to and did not state to EI#14 how many units to dial on the pen. RI#4 required dexterity assistance to dial the correct amount on the insulin pen. EI#14 administered the insulin dosage via insulin pen without direction from RI#4 and without allowing RI#4 to identify the medication and dosage. EI#4 was not licensed to

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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 614	Continued From page 29 administer medications or perform fingersticks. On the afternoon of July 22, 2024, EI#6 concurred that RI#4 should direct his/her own care and should also administer his/her own insulin or have the insulin administered by licensed staff under RI#4's direction.	A 614		
A 617	420-5-4-.06 (8) Care of Residents. (8) Disposal of Medications. 1. 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. Under no circumstances should expired, discontinued, or unused medications be stored or housed in the facility beyond 30 days. 2. 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. 3. When medications are destroyed on the premises of the assisted living facility, a record shall be made and retained for at least 3 years. This record shall include: the name of the assisted living facility, the method of disposal, the	A 617		

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A 617	Continued From page 30 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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to properly document destruction of a resident's medications after discharge of the resident from the facility. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MAY 20, 2021. Findings: Review of resident records, on July 23, 2024, revealed the following information. RI#8 was admitted to the facility on November 1, 2023 and had diagnoses which included hypertension, hypothyroidism, high cholesterol, degenerative joint disease and aortic stenosis. RI#8 was discharged from the facility to a skilled nursing facility on June 23, 2024. A Non-Narcotic Destruction Log was completed, on June 24, 2024, by EI#7. The form did not contain the prescription numbers of the medications which were destroyed. EI#6 agreed the form was incomplete.	A 617		
A 702	420-5-4-.07 (2) Food Service (2) Food Handling Procedures.	A 702		

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A 702	Continued From page 31 (a) Dish and Utensils Washing, Disinfection, and Storage. 1. Wash water shall be changed with sufficient frequency to avoid gross contamination, and final rinse water shall be kept clean and clear. 2. Hand washed repeated service and multi-service utensils and dishes, after washing and rinsing, shall be sanitized by either of the following methods: (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 (ii) A cold water sanitizer. A sanitizing solution shall be used in accordance with manufacturer's 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 30 seconds in 12.5 ppm of iodine or the amount of time set 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. 3. Dishes and utensils shall be allowed to air dry.	A 702		

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A 702	Continued From page 32 4. After washing, rinsing, sanitizing, and air-drying, all repeated use service ware (utensils 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. 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. (b) Ice. Crushed or chipped ice shall be protected from splash, drip, and hand contamination during storage and service. The ice scoop may be stored in 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. (c) Protection of Food from Contamination. 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 back flow, and any other contamination. Sugar, syrup, and condiment receptacles shall be provided with lids and shall be kept covered when not in use. 2. Medications, biologicals, poisons, detergents, and cleaning supplies shall not be kept in the refrigerator or in other areas used for storage of food.	A 702		

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3. Food shall not be stored on the floor. All food and food ingredients stored on shelving must be placed on shelving that is at least six inches above the floor.

4. Refrigerators shall maintain a maximum temperature of 41 degrees Fahrenheit. Freezers shall be maintained at a maximum temperature of 0 degrees Fahrenheit. Thermometers shall remain in refrigerators and freezers at all times.

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 3 days from the date it was prepared.

6. All food products shall be used by the manufacturer's indicated date or discarded.

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 to ensure that food is not contaminated in transport and that foods that are transported are held and served at the appropriate temperatures at all times.

8. Hot food shall be maintained at a minimum of 135 degrees Fahrenheit and cold foods at a maximum 41 degrees Fahrenheit.

9. Frozen food items (raw and cooked) shall be thawed under refrigeration or under

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running water prior to preparation. Frozen food 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).

10. Laundry shall not be brought through the food preparation or service area.

(d) Storage and Service of Milk and Ice Cream.

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.

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.

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.

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A 702	Continued From page 35 (e) Kitchen Garbage and Trash Handling. 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. 2. After being emptied, all garbage cans and trash cans shall be washed and dried before reuse. (f) Employees' Cleanliness. 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. 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. 3. Street clothing not worn by the employee shall be stored in lockers, dressing rooms, or closets designated for staff use. (g) Live Fowl or Animals. Live fowl or animals shall not be allowed in the food service	A 702		

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A 702	Continued From page 36 area. (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. (i) Dining in Kitchen. Dining in the kitchen shall not be permitted in congregate assisted living facilities. (j) Paper for Food Wrapping. Only new paper, foil, or plastic wrap shall be used for wrapping of foods. (k) Laundering of clothing shall not be permitted in food preparation or service areas. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to properly sanitize dishes and document results of dish sanitization and failed to properly store, label and date food items. In addition, food areas were not kept clean, trash was not properly discarded and thermometers were not maintained in all refrigerators for monitoring of temperatures. Findings: Dish Sanitization On the afternoon of July 22, 2024, the surveyor observed the kitchen dishwasher and observed a maximum temperature of 158 degrees Fahrenheit. No documentation was available when requested from EI#6 at time of the observation to validate that the manufacturer had	A 702		

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A 702	Continued From page 37	A 702		

sanitation temperature other than the required 171 degrees Fahrenheit.

Record review of Dishmachine Temperature Records, on the afternoon of July 22, 2024, revealed wash temperature of 138 degrees Fahrenheit and rinse temperature of 140 degrees Fahrenheit for the breakfast meal that day. Multiple omissions of temperatures on multiple dates were noted.

This same deficient practice of improper dishwasher temperatures was cited during the survey of the SCALF facility in the same building two weeks prior. Both the ALF and SCALF facilities shared the same main kitchen for food preparation. Surveyors were informed during the SCALF survey that the three compartment sinks would be used to sanitize dishes until the dishwasher was repaired.

Food Not Properly Stored, Labeled and Dated

On the afternoon of July 22, 2024, surveyors observed the small refrigerator in the kitchenette area of the facility. Stored in the refrigerator were pitchers of tomato juice and orange juice which were uncovered and contained no dates or labeling. On that same afternoon, EI#10 concurred with the surveyors' findings that the items were not properly stored and labeled.

On the morning of July 23, 2024, the surveyor observed the walk in refrigerator in the main kitchen. Inside the refrigerator was what appeared to be a bag of cheese, unlabeled and not dated. EI#10 stated that the item should have been labeled and dated with a do not use beyond date. EI#10 stated that he (EI#10) was in the process of training kitchen staff who were

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A 702	Continued From page 38 responsible for storing food. On the afternoon of July 22, 2024, during a tour of the kitchenette area, surveyors observed that the three canisters containing breakfast cereals each contained scoops which were stored in the cereal potentially causing food contamination by contact while handling the food scoops. EI#10 was notified of the observation. No Thermometers in Refrigerators During a tour of the facility and all resident rooms on the afternoon of July 22, 2024, the surveyor and EI#3 observed that numerous refrigerators in resident rooms did not contain thermometers for monitoring temperatures. EI#3 stated the refrigerators were provided by the facility but was unsure who was responsible for monitoring temperatures. No documents were available which recorded monitoring of refrigerator temperatures other than a single sheet posted on the small refrigerator in the kitchenette which only contained three temperatures for the month of July. On July 24, 2024, EI#6 informed the surveyors that thermometers had been obtained for all refrigerators and were being placed in the refrigerators. Trash Storage On the afternoon of July 22, 2024, the surveyor observed trash on the floors of the kitchen and trash receptacles in the kitchen without tight-fitting lids. During an interview on the morning of July 24, 2024, EI#3 acknowledged the observations.	A 702		

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A 703	Continued From page 39	A 703		
A 703	420-5-4-.07 (3) Food Service. (3) Dietary Service. (a) Number of Meals. No fewer than three meals shall be provided each 24 hours. Food service shall be provided in a resident's room during temporary illness if necessary. The diet shall be well-balanced, palatable, properly prepared, and sufficient in quantity and quality to meet the nutritional needs of the residents in accordance with Dietary Reference Intakes of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The food must be adapted in type and preparation to the habits, preferences, and physical abilities of the residents. (b) Timing of Meals. A time schedule for serving meals to residents and personnel shall be established. Meals shall be served approximately five hours apart with no more than 14 hours between the evening meal and breakfast. The time schedule of meals shall be posted with the menu. The facility shall make evening snacks available after service of the evening meal. The facility shall provide fluids throughout the day and shall make between-meal nourishment (snacks) available. (c) Menu. The menu shall be planned and written at least 1 week in advance. The current week's menu shall be posted in the food service area and shall be kept on file for the following 2 weeks. For any resident with a physician's order for a therapeutic diet, the facility shall have a copy of the diet and the facility shall document the adjustment of its menu to accommodate the resident's needs.	A 703		

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A 703	Continued From page 40 (d) Alternate food selections or substitutes shall be made available to all residents. (e) A facility shall not obtain food from charitable organizations. A facility shall not avoid serving a meal by sending or transporting residents to missions, soup kitchens, or other charitable facilities for meals. (f) The amount of food on hand shall be sufficient to serve three meals per day to all residents for 3 days. Non-perishable food and potable water shall be maintained in the facility in sufficient quantity to serve three meals per day to all residents for 3 days. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide alternate food selections per the posted alternate menu. In addition, food served to residents did not always match the weekly menu and was not always palatable. Findings: During an interview on the afternoon of July 22, 2024, RI#7 revealed that the facility did not provide alternate menu selections as posted. RI#7 stated that he/she asked the cook (EI#13) for an alternate selection and was told "we don't have an alternate menu". During an interview on the afternoon of July 23, 2024, EI#13 stated "I did not know we had an alternative menu, but alternatives are always available as long as we	A 703		

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have the items asked for in house". EI#13 stated that the resident needs to let the staff know what selection they want so it can be prepared ahead of time. EI#13 added "we do not have a good process right now of communicating the residents' wishes to the kitchen".

One resident reported to the surveyors that weekly menus were not normally posted and if a menu was posted, staff did not follow the menu in preparing meals. The resident also stated that sometimes the menu was not presented to the residents until 15 minutes before the food was served.

Multiple residents reported to the surveyors that, if a weekly menu was posted, the foods which the residents were served did not always match the foods listed on the menu. Surveyors confirmed this through observation of meals during the onsite survey. Residents also reported that they (residents) were served the same food for several meals and their diets lacked variety. Surveyors were also able to substantiate this during observation of meals. The residents were served broccoli and potatoes with cheese at least three times consecutively for the lunch and dinner meals. On the evening of July 22, 2024, a resident presented the surveyors with a piece of barbecued chicken which the resident stated was tough. The surveyor attempted to cut the chicken with a knife and the chicken was tough and difficult to cut.

During an interview, on July 24, 2024, EI#4 informed the surveyors that this was not how Sagora typically prepares and serves food to residents. EI#4 agreed that a lack of consistent management in the kitchen likely contributed to the recent food issues and added that a new

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A 703	Continued From page 42 dietary manager had been hired and would assume the new position in August 2024.	A 703		
A 804	420-5-4-.08 (4) Physical Facilities. (4) Food Service Facilities. (a) Floors. Floors in food service areas shall be of such construction as to be easily cleaned, sound, smooth, non-absorbent, without cracks or crevices, and shall be provided with approved and conveniently located facilities for the disposal of floor wash water. (b) Walls and Ceilings. Walls and ceilings of food service areas shall be of tight and substantial construction, and smoothly finished. The walls and ceilings shall be without horizontal ledges and shall be washable up to the highest level reached by splash and spray. Roofs and walls shall be maintained free of leaks. All openings to the exterior shall be provided with doors or windows which prevent the entrance of rain or dust during inclement weather. (c) Screens or Outside Openings. Openings to the outside shall be effectively screened, or suitable provisions made equal to screening (such as fly fans). Screen doors shall be equipped with self-closing devices. (d) Lighting. The kitchen, dishwashing area and the dining room shall have adequate light. (e) Ventilation. Vent/exhaust hoods, vented to the outdoors, shall be provided over cooking surfaces to aid in removing cooking odors. Existing recirculating vent hoods in Family	A 804		

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A 804	Continued From page 43	A 804		

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

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

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

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

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A 804	Continued From page 44 (i) Equipment and Utensil Construction. Equipment and utensils, except single service utensils, shall be so constructed as to be easily cleaned and shall be kept in good repair. No cadmium plated, lead, or readily corrodible utensils or equipment shall be used. (j) Separation of Kitchen from Resident Rooms and Sleeping Quarters. Any room used for sleeping quarters shall be separated from the food service area by a solid wall with no direct openings. Sleeping accommodations shall not be permitted within the food service area. (k) Clean Rooms. Floors, walls, and ceilings of rooms in the food service area shall be clean and free of an accumulation of rubbish, dust, grease, dirt, etc. (l) Clean Equipment. Equipment in the food service area shall be clean and free of dust, grease, dirt, etc. (m) Clean Counters, Tables, Tablecloths, and Napkins. Tables and counters, which are used for food service, shall be kept clean. Tablecloths and cloth napkins shall be laundered after each use. (n) Location and Space Requirements. Food service facilities shall be located in a specifically designated area and shall include the following rooms and space: kitchen, dishwashing, food storage, and dining room. (o) Equipment. Minimum equipment in the kitchen shall include the following: 1. Range. In a Family or Group assisted	A 804		

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A 804	Continued From page 45 living facility, a residential use range is permitted. A Congregate assisted living facility shall have a heavy-duty range suitable for institutional use with double oven, or equivalent. 2. Refrigerator. A Family or Group assisted living facility may use a residential refrigerator. A Congregate assisted living facility shall have a heavy duty refrigerator suitable for institutional use. 3. Fire extinguisher. A five-pound type BC for residential hoods, and K type for commercial hoods. 4. Dishwashing. The dishwashing equipment for Family and Group assisted living facilities shall be either residential type using cold water sanitizers or commercial type with a booster water heater. Dishwashing equipment for all Congregate assisted living facilities shall be commercial type using a booster water heater or an automatic dispensing sanitizing chemical system. 5. A three-compartment sink with a booster heater or chemical sanitizing system for the third compartment shall be provided in Congregate assisted living facilities. 6. Garbage cans with cover. (p) Food Storage. A well-ventilated, cool food storage room, pantry, or cabinets shall be provided. Adequate shelving, bins, suitable cans, and raised platforms shall be provided and kept clean. Perishable food shall be stored at least six inches above the floor. The storeroom shall be of	A 804		

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A 804	Continued From page 46 such construction as to prevent the invasion of rodents and insects, the seepage of dust and water, leakage, or any other source of contamination. (q) Dining Room. A resident dining room, or rooms, shall be provided which is large enough to seat not less than 100 percent of the bed capacity. (r) Water Heating Equipment. Equipment for heating an ample supply of water, under pressure, for all washing purposes shall be provided. Hot water shall be piped to all hand-washing facilities, and to each compartment of all dishwashing and laundry sinks. Water heaters shall be automatic type. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to keep the food service area in the kitchenette clean. Findings: On the afternoon of July 22, 2024, during a facility tour of the dining and kitchenette area on the second floor, it was revealed that the floor of the area was very sticky with unknown substance. Debris was observed on the floor by the surveyor. EI#10 and EI#3 were notified of the observation.	A 804		
A1002	420-5-4-.10 (2) Sanitation and Housekeeping. (2) Housekeeping and Physical Plant Maintenance. The facility must provide a safe,	A1002		

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A1002	Continued From page 47 functional, sanitary, decent, and comfortable environment for residents, staff, and the public. (a) Equipment and Supplies. The home shall maintain an adequate quantity of housekeeping and maintenance equipment and supplies. (b) Bathtubs and Lavatories. Bathtubs and lavatories shall be kept clean and in proper working order, and shall not be used for laundering. (c) Resident Bedrooms. Resident bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance. (d) General Storage. 1. Broken beds, extra mattresses, mop buckets, and dust rags shall not be kept in hallways, closets, corners, or occupied resident rooms. Such items must be stored neatly and orderly in designated storage rooms. 2. The use of attics for storage of combustible materials shall be prohibited unless protected by an automatic sprinkler system and then only in small quantities so as not to create a hazardous condition. 3. Basements used for storage shall meet acceptable standards for storage and shall be designed and constructed in a manner that protects against fire hazards. 4. Flammable materials such as gasoline, motor fuels, lighter fluid, turpentine,	A1002		

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A1002	Continued From page 48 acetone, and oil-based paint shall not be stored in the facility. Unless prohibited by a facility's own policies, however, a cognitively intact resident who uses lighter fluid to fill a personal cigarette lighter, or one who uses flammable materials such as paint or glue in connection with a personal hobby, may store small quantities of those materials in a safe and secure manner within his or her own room. 5. Poisonous or External Use Substances. Facility cleaning supplies and poisons shall be attended at all times or shall be kept in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to keep cleaning supplies in a secure area. Findings: On the afternoon of July 22, 2024, during a tour of the dining and kitchenette area on the second floor, it was observed that cleaning solutions were in an unsecured cabinet in the kitchenette serving area of the dining room, resulting in potential unauthorized access. EI#3 and EI#10 were notified of the finding.	A1002		
A1101	420-5-4-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple	A1101		

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A1101	Continued From page 49	A1101		

smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place.

(b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift of Group and Congregate facilities. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the currently adopted Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years.

(c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs.

(d) Roller latches are prohibited on doors separating corridors from adjacent spaces.

(e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that:

1. Minimizes leaks and spills.

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A1101	Continued From page 50 2. Adequately protects against inappropriate access. 3. Complies with the requirements of the currently adopted Life Safety Code. (f) Fire Alarm and Sprinkler System. 1. Fire Alarm System. Where fire alarm systems are required, a corridor smoke detection system shall be installed on each floor, including areas open to the exit access corridor, to comply with NFPA 72, connected to the facility's fire alarm system. In lieu of corridor smoke detection, smoke detectors connected to the building fire alarm system may be installed in each resident's room, open areas, and at smoke doors (except that corridor smoke detection shall not be deleted when its use is dictated by other requirements). 2. Fire alarm and sprinkler system outages of more than 4 hours require evacuation of the facility or the establishment of a continuous fire watch. The fire watch procedure must be coordinated with the Department and the local Fire Marshal. Outages and fire watch documentation shall be reported to the Department within 12 hours or no later than the next duty day, and shall be corrected expeditiously. 3. The fire alarm system and the sprinkler system shall be inspected by licensed, trained, and qualified personnel at least semiannually for compliance with the respective codes. Inspection and testing reports shall be maintained in the facility for a period of at least 3 years.	A1101		

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A1101	Continued From page 51 This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire alarm and sprinkler system were inspected as required. Findings: On the afternoon of July 23, 2024, review of fire alarm and sprinkler inspections revealed that the last semi-annual fire alarm and sprinkler inspection was on July 28, 2023. During an interview on the afternoon of July 23, 2024, EI#9 stated that the facility did not currently have a fire alarm and sprinkler system inspection company on contract but was in the process of finalizing a contract. EI#9 agreed the systems had not been inspected as required.	A1101		
A1203	420-5-4-.12 (5) Physical Environment. (5) General Building Requirements - Family, Group, and Congregate. (a) Structural Soundness and Repair. The building shall be structurally sound, free from leaks and excessive moisture, in good repair, and painted with sufficient frequency to be reasonably attractive inside and out. The interior and exterior of the building shall be kept clean and orderly. (b) Temperature to be Maintained. The facility shall maintain a comfortable temperature. A comfortable range is between 71-81 degrees Fahrenheit. (c) Lighting. Each resident's room shall	A1203		

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have artificial light adequate for reading and other uses as needed. All entrances, hallways, stairways, inclines, ramps, cellars, attics, storerooms, kitchens, laundries, and service units shall have sufficient artificial lighting to prevent accidents and promote efficiency of service. Night lights shall be provided in all hallways, stairways, and bathrooms.

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

(e) Emergency Lighting.

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

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

(f) Floors.

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

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

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A1203	Continued From page 53 throughout the facility. (g) Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface and shall be kept clean and in good repair. (h) Windows. Operable windows shall be so constructed and maintained so that they fit snugly, and are capable of being opened and closed easily. (i) Ceiling Height. Each room occupied by residents shall have a ceiling height of eight feet or more. Existing facilities with ceiling heights less than eight feet shall be acceptable when the height complies with the codes. (j) Handrails. If handrails are installed in halls or corridors, the handrails shall be mounted at 30-36 inches above the floor and returned to the wall at each end. (k) Stairways. Stairways shall be well lighted, kept in good repair, and have handrails. Open space under stairs shall not be used for storage purpose. All walls and doors under stairs shall meet the same fire rating as the stairwell. (l) Doors. 1. In each new assisted living facility, doors of resident bathrooms connected to resident bedrooms shall swing into the bedroom. 2. Bedroom and bathroom doors may be equipped with hardware that will permit a resident to lock himself within the room, provided a master key is readily accessible for the staff at	A1203		

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A1203	Continued From page 54 a central location. 3. Resident bedroom and other exit access doors in each assisted living facility shall be at least three feet wide. Bedroom doors in Family assisted living facilities shall not be less than 32 inches wide. 4. Exterior egress doors except the main entry/exit door, may be equipped with a delayed egress locking system installed in accordance with NFPA 101. Other special locking arrangements are permitted only in specialty care assisted living facilities. 5. Exit doors swinging outward shall swing out over a landing having a minimum length and width equal to the door's width at the same level as the floor level, except existing doors shall not have more than a four inch step down. Exit doors of Family facilities may swing inward. (m) Ventilation. The building shall be well-ventilated at all times to prevent accumulation of objectionable odors. Kitchens, laundries, service rooms, toilets, and bathrooms shall be ventilated by windows, gravity vents, or mechanical means as necessary to prevent offensive odors from entering other parts of the facility. (n) Fire Extinguishers. Fire extinguishers shall be provided for each hall, kitchen, and laundry, of type and capacity appropriate to the need. 1. Each fire extinguisher shall receive an annual inspection with maintenance, and	A1203		

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recharging when necessary, by a fire equipment servicing representative. An annual servicing tag shall be attached to the extinguisher reflecting the name of the servicing company, representative, day, month, and year of maintenance.

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

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

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

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

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

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LYNRIDGE OF HUNTSVILLE ASSISTED LIVING	4801 WHITESPORT CIRCLE HUNTSVILLE, AL 35801

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A1203	Continued From page 56 (s) Heating, Lighting, and other Service Equipment. 1. Central or individual room gas heating systems shall be of the enclosed flame type equipped with automatic flame shut-off control and shall be vented directly to the outside. Heating units of any type shall be located to avoid direct contact with any combustible material and shall be maintained in accordance with manufacturer's recommendation. 2. Open flame and portable heaters are prohibited in assisted living facilities. This does not apply to a fire place with gas logs protected as noted elsewhere in these rules. 3. Lighting shall be restricted to electricity. Electric wiring, motors, and other electrical equipment in all assisted living facilities shall be in accordance with local electrical codes and the NFPA National Electrical Code. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide annual fire extinguisher inspections. In addition, the carpet was frayed in areas, causing a trip hazard. Findings: Fire Extinguishers During a tour of the facility on the afternoon of July 22, 2024, the surveyors observed the last annual inspection date on multiple fire extinguishers was April 2023. When interviewed, on July 23, 2024, EI#9, Maintenance Director,	A1203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D4527	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNRIDGE OF HUNTSVILLE ASSISTED LIVING	4801 WHITESPORT CIRCLE HUNTSVILLE, AL 35801

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A1203	Continued From page 57 advised the surveyors that the facility was in the process of changing to a new company to provide fire extinguisher inspections and agreed the annual fire extinguisher inspections had not been completed. Carpet During a tour of the facility on the afternoon of July 22, 2024, the surveyors observed the transition point of the entry from the hallway to the dining area had frayed and uneven carpet potentially presenting a trip hazard to residents, visitors and staff. Several other areas of frayed carpet throughout the hallways and doorways were also noted during a tour of the facility that same afternoon. This fraying of the carpet caused a trip hazard to residents, visitors and staff. EI#3 and EI#6 agreed with the surveyors' findings.	A1203		
A1206	420-5-4-.12 (8) Physical Environment. (8) Building Requirements - Congregate Assisted Living Facility. (a) General. Congregate assisted living facilities licensed, constructed, or renovated under the currently adopted codes shall comply with the building code and the requirements for limited care facilities in the "New Health Care Occupancies" Chapter of the Life Safety Code (excluding NFPA 101A, Alternative Approaches to Life Safety). Facilities, or portions of facilities, built under previously adopted editions of the codes shall comply with the currently adopted Life Safety Code Chapter for Existing Residential Board and Care Occupancies, Impractical Evacuation Capability, thereby requiring compliance with the requirements for limited care	A1206		

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A1206	Continued From page 58 facilities in the "Existing Health Care Occupancies" Chapter for the Life Safety Code (excluding NFPA 101A Alternative Approaches to Life Safety). (b) Exit doors. Panic hardware shall be installed on all exit doors. (c) Corridors and Passageways. Corridors and passageways shall be unobstructed and shall not lead through any room or space used for a purpose that may obstruct free passage. (d) In new construction, the temperature of hot water accessible to residents shall be automatically regulated by tempering valves and a circulating pump system, unless the water heater is dedicated to resident use. (e) Utility rooms shall be provided for each floor of Congregate assisted living facilities. The following equipment shall be provided: 1. Paper towel holder with an adequate supply of paper towels. 2. Wall cabinet or shelves. 3. Table or counter. 4. Soap dispenser with soap. 5. Sink - counter top, wall or floor mounted. 6. Space and facilities for cleaning equipment and supplies.	A1206		

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A1206	Continued From page 59	A1206		

This Rule is not met as evidenced by:
Based on observation and interview, the facility failed to provide smoke compartment barrier integrity as the fire doors did not latch properly. This would be potential harm to the residents in the event of a fire. In addition, two smoke barrier doors did not seal properly upon activation of the fire alarm system to prevent smoke from passing through the barrier.

Findings:

Fire Doors Not Latched Properly

On the afternoon of July 22, 2024, the surveyor observed two fire doors which did not latch correctly, allowing the door to stay in open position, thus causing a breech in the smoke barrier integrity. The fire door on the third floor adjacent to fire alarm pull station 420 and the fire door on the second floor adjacent to fire alarm pull station 214, did not close appropriately and would not latch correctly.

On the afternoon of July 22, 2024, EI#3 was notified of the observation that the fire doors did not close and secure the fire smoke barrier. EI#3 concurred that the doors did not secure properly and stated she (EI#3) would have the maintenance supervisor (EI#9) take care of it. The surveyors rechecked both doors later during the onsite survey and both doors functioned properly.

Smoke Barrier Doors Not Properly Sealed

On the afternoon of July 23, 2024, the fire alarm

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A1206	Continued From page 60 system was activated by EI#9 at the request of the surveyors. Upon activation of the fire alarm system, the two smoke barrier doors leading to the elevator area closed but a gap remained in the area where the two doors came together which would allow smoke to pass through the barrier in the event of a fire. EI#9 agreed the doors did not create an adequate smoke barrier. CONNIE CHERRY, REGISTERED NURSE GREGORY ZEITLIN, REGISTERED NURSE	A1206		