STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P4911	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERHOUSE HERITAGE WOODS SCALF	3440 HILLCREAST ROAD MOBILE, AL 36695

(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 This is a 23 bed Specialty Care Assisted Living Facility (SCALF) with a census of 16 on August 11, 2022. There was one (1) complaint investigated during this unannounced licensure complaint survey. LC#20220419005 was substantiated. There were deficiencies written as a result of the complaint investigation. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practices resulted in the potential for harm to all residents and require a plan of correction.	A 000		
A 302	420-5-20-.03 (e) Administration. (e) Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). All residents shall be informed of new policies or changes in existing policies that may have bearing on the resident. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies shall cover the following: (i) Facility responsibility to protect all	A 302	The existing abuse policy and procedure updated to include definitions of exploitation and neglect with examples. Addendum #1 (Resident Abuse, Negelct, or Exploitation 2022) Staff will receive re-education and re-training on the updated Abuse Policy and Procedure by 9/12/2022. Mandatory Abuse re-training presented to staff by the local Ombudsman on 8/23/ 2022. Make up re-training provided by DHW or designee to be completed by 9/12/2022 Staff will receive ongoing monthly abuse re-training provided by DHW or designee for 3 months, then quarterly for 6 months, then annually, upon hire, and with any identified knowledge deficits. Monitoring for compliance will be performed monthly x3, then quarterly by Memory Care Director. Results will be reviewed at the monthly QA meeting by DHW and Administrator; any identified deficits will be addressed by the Memory Care Director immediately. Training and monitoring will be kept in Administrators office. Continued non-compliance will result in re-education, systems review, and or corrective disciplinary action up to and including termination.	9/12/2022 6/30/2023

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A 302	Continued From page 2 guidance of all personnel handling food as outlined by the most current Food and Drug Administration Food Code published by the U.S. Department of Health and Human Services. The facility shall develop and implement dietary policies and procedures to meet the needs of the residents in the facility. In addition to other matters deemed necessary by the facility, dietary policies shall address: (I) Sanitation of dishes, utensils, and service equipment, and sanitary food preparation and handling. (II) The attire and cleanliness of staff members who prepare, handle, or serve food. (III) A schedule of meals, which shall include between-meal nourishment or snacks, and fluids. (IV) Food substitutions or alternatives. (V) Method to ensure an adequate dietary plan is implemented for any resident with a therapeutic diet or special dietary needs. (VI) Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food. (VII) Provision of necessary services to any resident requiring adaptive devices to eat. (VIII) Procedure for the handling of potentially hazardous foods such as meat, milk, ice, and eggs. (IX) Storage of food.	A 302		

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A 406	Continued From page 4 (9) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. An RN shall identify staff training needs and shall provide or arrange for needed training. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that, prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on specialty care assisted living facilities. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire. 5. Identifying and reporting abuse, neglect, and exploitation. 6. Basic first aid. 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environmental safety.	A 406	The existing abuse policy and procedure updated to include definitions of exploitation and neglect with examples. Addendum #1 (Resident Abuse, Negelct, or Exploitation 2022) All staff will receive re-education and re-training on the updated Abuse Policy and Procedure and Chain of Command provided by the DHW or designee by 9/12/2022. Training documentation will be kept in the Administrator's office. Mandatory Abuse re-training presented to staff by the local Ombudsman on 8/23/ 2022. Make up re-training provided by DHW or designee to be completed by 9/12/2022 Staff will receive ongoing monthly abuse re-training provided by DHW or designee for 3 months, then quarterly for 6 months, then annually, upon hire, and with any identified knowledge deficits. Monitoring for compliance will be performed monthly x3, then quarterly by Memory Care Director. Results will be reviewed at the monthly QA meeting by DHW and Administrator; any identified deficits will be addressed by the Memory Care Director immediately. Training and monitoring will be kept in Administrators office. Continued non-compliance will result in re-education, systems review, and or corrective disciplinary action up to and including termination. The existing Grievance policy/ protocol updated to include formal process for internal review of resident, family, and staff concerns. Updated Grievance Policy to be mailed to resident responsible parties and distributed in person to residents by Administrator or designee by 9/12/2022. Future residents/responsible parties will receive updated Grievance Policy at contract signing Staff will receive Grievance policy re-training provided by Administrator or designee by 9/12/2022. Training will be kept in Administrators office. Addendum #2 (Grievance Policy and Pocedure, 2022)	9/12/2022 6/30/2023 9/12/2022

A 406	Continued From page 5 (b) Prior to providing any resident care, all staff shall complete The Dementia Education and Training Act (DETA) Care Series Training developed by the Alabama Department of Mental Health or equivalent training approved by the State Health Officer. All licensed staff shall complete DETA Brain Series Training, The Pharmacological Management of Dementia, and the Dementia Assessment Series provided by the DETA Program or equivalent training approved by the State Health Officer prior to resident contact. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained. (c) All staff who have resident contact shall be able to demonstrate diversional methods and redirection. All staff shall be able to demonstrate an understanding of the implications of caring for residents with agnosia, amnesia, aphasia, and apraxia. All staff shall be able to demonstrate an understanding of the facility's fire and evacuation plan and all other policies regarding safety, including policies for preventing elopements, responding to elopements, and fall prevention. (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	A 406		

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A 406	Continued From page 7 EI#4, EI#5, EI#6, EI#7, EI#8, and EI#9. Six (6) of six (6) employees were unable to describe an example of resident exploitation. On August 09, 2022, four (4) of the six employees told the surveyor that they had reported EI#6 for verbal abuse of the residents. On August 09, 2022, the surveyor reviewed the facility's policy and procedures for abuse. The policy only mentioned the words exploitation and neglect in the title and the policy summary. There was no definition or example of exploitation or neglect listed in the policy or procedure. The Abuse policy and procedure only contained definitions for mental abuse, physical abuse, sexual abuse, and verbal abuse. On August 10, 2022, EI#1 and EI#2 both told the surveyor that there had been no abuse reported to either of them. Therefore, there had been no investigation of the abuse or neglect suffered by RI#5. EI#3 was not available during the survey, and apparently had not reported the abuse or neglect to EI#1 or EI#2 for follow-up as required in the abuse policy and procedures.	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	A 504	1.Keys to SCALF courtyard door given to each staff member on duty. Keys are to be passed on from shift to shift and signed in/out by nurse and care managers. Staff assigned to SCALF will keep key on their person at all times while on duty. An emergency spare key placed in Fire Box(1) and behind bookcase(1) next to courtyard exit door. Re-training for handling SCALF courtyard door keys completed with all scheduled staff, others to be re-trained prior to their next scheduled shift or by 8/17/22. Re-training to be provided by the Memory Care Director or designee. Training documentation to be kept in the Administrators office. Key Possession Audits for compliance to be performed by Memory Care Director or designee three times week for 3 months, then weekly for three months, then monthly for 6 months. Key possession verified and documented on monthly fire drill documentation. Audit and fire drill documentation will be kept in Administrators office. On 8/26/2022 Magnet lock and key pad repaired on designed fire exit to courtyard. On 9/6/2022 fire alarm system activated verifying magnet lock released and door unlocked automatically upon activation of fire alarm. Keyed lock removed from	9/5/2022 8/30/2023 9/5/2022 9/12/2022

A 504	Continued From page 8 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 unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time. 5. Every resident shall have freedom to participate in and benefit from social, religious, and community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. 6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the premises, an individual account record for each	A 504		

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A 504	Continued From page 10 is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record. 12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person without restraint, interference, coercion, discrimination, or reprisal. 13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file. 14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the facility, provided that: (i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care. (ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation.	A 504		

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A 504	Continued From page 12 20. Every resident shall have the right to 30 days prior written notice of any involuntary change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. 21. Every resident shall have the right to wear his or her own clothes, and to keep and use his or her own personal possessions, including toilet articles, except for personal possessions too large to be stored in the resident's room. 22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings. 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe environment from fire and disease for all 16 residents living in the facility. This deficient practice placed all 16 residents at risk for	A 504		

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A 504	Continued From page 14 PPE (personal protective equipment) containers setup in the hall outside of two different rooms. One room was shared by RI#1 and RI#2, the second room was shared by RI#3 and RI#4. The surveyor observed EI#5 walking down the hall without a mask on his/her face. EI#5 observed the surveyor in the dining room and EI#5 immediately applied an N 95 mask. EI#2 told the surveyor that EI#5 should have been wearing a mask at all times. Later that same day EI#4 was observed to enter the room shared by RI#1 and RI#2 without using any PPE. EI#4 placed a Styrofoam tray on the table in RI#2's sitting area, knocked on RI#2's bedroom door and spoke to RI#2 through a closed door. Then EI#4 removed the food tray from RI#2's room telling the surveyor that RI#2 had eaten breakfast and RI#2's sponsor had brought RI#2 some food from outside the facility. EI#4 put the food tray on top of the serving cart and continued down the hall delivering food trays to the remaining residents. EI#2 agreed that RI#2's food tray should have been left in the room. When EI#4 got to the room shared by RI#3 and RI#4, EI#4 donned a gown and delivered the food trays for the two residents. EI#4 came out of the room removed the gown and carried the gown through the dining room with the gown waving in the air to the trash can located next to the laundry room, where the gown was thrown away. RI#6 was sitting at a table in the dining room without a mask eating his/her lunch, as EI#4 walked past RI#6 with the gown waving in the air. According to the Covid precautions documentation on the door, EI#4 should have put the gown in the trash can next to RI#3 and RI#4's room.	A 504		

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			Meal service procedure updated to include second employee verification that residents receive each meal. Audits for compliance to be performed by Memory Care Director or designee during alternating meal times; three times a week for 3 months, then weekly for three months, then monthly for 6 months. Audit documentation will be kept in Administrators office. Continued non-compliance will result in re-education, systems review, and or corrective disciplinary action up to and including termination.	

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A 609	Continued From page 17	A 609		

RI#5's room.
On May 23, 2022 - no dinner received by RI#5.
On July 24, 2022 - RI#5 was not notified of breakfast.
RI#5 went on to tell the surveyor that if RI#5 was given a food plate/tray by EI#6 that RI#5 only ate the food that was still packaged, because RI#5 had seen EI#6 eat off of plates and trays of other residents and EI#6 served the remaining food to the resident.

RI#5 told the surveyor on at least three occasions that he/she would probably have "repercussions" for talking with the surveyor. RI#5 felt that EI#6 had retaliated against RI#5 in the past because of RI#5's reports to administration against EI#6 which resulted in RI#5 not getting a meal or not being told when the meal was being served. EI#6 told RI#5 in the dining room, in front of other residents, in a nasty manner that EI#6 knew RI#5 had reported EI#6 for not giving RI#5 his/her food.

On August 09, 2022, EI#7 told the surveyor that a co-worker had previously reported EI#6 for talking disrespectfully to the residents on the memory care unit this year. EI#7 told the surveyor that he/she had first spoke with EI#6 then sent EI#6 a video on how to interact with other people, and how body language can be misinterpreteted. EI#7 told the surveyor that EI#7 didn't feel that EI#6 was receptive to EI#7's comments, so EI#7 reported EI#6 to EI#3.

On August 09, 2022, EI#8 told the surveyor that EI#6 was on the phone with EI#8 when EI#8 heard EI#6 call an unknown resident "stinky butt". EI#8 reported EI#6 to EI#3.

On August 10, 2022, the surveyor reviewed

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A1203	Continued From page 19	A1203		
A1203	420-5-20-.12 (5) Physical Environment. (5) General Building Requirements - Group and Congregate. (a) Structural Soundness and Repair. The building shall be structurally sound, free from leaks and excessive moisture, in good repair, and painted with sufficient frequency to be reasonably attractive inside and out. The interior and exterior of the building shall be kept clean and orderly. (b) Temperature to be Maintained. The facility shall maintain a comfortable temperature. A comfortable range is between 71-81 degrees Fahrenheit. (c) Lighting. Each resident's room shall have artificial light adequate for reading and other uses as needed. All entrances, hallways, stairways, inclines, ramps, cellars, attics, storerooms, kitchens, laundries, and service units shall have sufficient artificial lighting to prevent accidents and promote efficiency of service. Night lights shall be provided in all hallways, stairways, and bathrooms. (d) Screens. All screen doors and operable windows shall be equipped with tight-fitting, full-length 16 mesh screens. Screen doors shall be equipped with self-closing devices. (e) Emergency Lighting. 1. All specialty care assisted living facilities shall provide an emergency artificial lighting system to adequately illuminate halls, corridors, and stairwells in case of electrical power failure. As a minimum, dry cell	A1203	Keys to SCALF courtyard door given to each staff member on duty. Keys are to be passed on from shift to shift and signed in/out by nurse and care managers. Staff assigned to SCALF will keep key on their person at all times while on duty. An emergency spare key placed in Fire Box(1) and behind bookcase(1) next to courtyard exit door. Re-training for handling SCALF courtyard door keys completed with all scheduled staff, others to be re-trained prior to their next scheduled shift or by 8/17/22. Re-training to be provided by the Memory Care Director or designee. Training documentation to be kept in the Administrators office. Key Possession Audits for compliance to be performed by Memory Care Director or designee three times week for 3 months, then weekly for three months, then monthly for 6 months. Key possession verified and documented on monthly fire drill documentation. Audit and fire drill documentation will be kept in Administrators office. Continued non-compliance will result in re-education, systems review, and or corrective disciplinary action up to and including termination. On 8/26/2022 Magnet lock and key pad repaired on designed fire exit to courtyard. On 9/6/2022 fire alarm system activated verifying magnet lock released and door unlocked automatically upon activation of fire alarm. Keyed lock removed from door. Staff re-trained on keypad functionality and door code. Door code placed in area visible to staff. Magnetic lock functionality to be inspected monthly and documented on monthly fire drill. Documentation to be kept in Administrators office. Continued non-compliance will result in re-education, systems review, and or corrective disciplinary action up to and including termination.	9/5/2022 8/30/2023 9/6/2022

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A1203	Continued From page 21 halls or corridors, the handrails shall be mounted at 30 - 36 inches above the floor and returned to the wall at each end. (k) Stairways. Stairways shall be well lighted, kept in good repair, and have handrails. Open space under stairs shall not be used for storage purposes. All walls and doors under stairs shall meet the same fire rating as the stairwell. (l) Doors. 1. In each new specialty care assisted living facility, doors of resident bathrooms connected to resident bedroom shall swing into the bedroom. 2. Bedroom and bathroom doors may be equipped with hardware that will permit a resident to lock himself within the room, provided a master key is readily accessible for the staff at a central location. 3. Resident bedroom and other exit access doors in specialty care assisted living facility shall be at least three feet wide. 4. Exterior egress doors except the main entry/exit door, may be equipped with a delayed egress locking system installed in accordance with NFPA 101. Other exterior egress doors may be arranged to prevent free and unhindered egress from specialty care assisted living facilities, in accordance with the Special Requirements portion of this section. 5. Exit doors swinging outward shall	A1203		

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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
A1203	Continued From page 23 standard. (p) Manufactured homes/mobile homes are not permitted. (q) Fireplaces and inserts shall be inspected and cleaned annually, and shall comply with the currently adopted building code. Openings shall be protected with screens or doors. (r) Exit marking. In all facilities, a sign bearing the word "EXIT" in plain legible block letters shall be placed at each exit. Additional signs shall be placed in corridors and passageways wherever necessary to indicate the direction of exit. Letters of signs shall be at least four inches high. All exit and directional signs shall be kept clearly legible by continuous internal electric illumination and have battery back-up or emergency power. (s) Heating, Lighting, and other Service Equipment. 1. Central or individual room gas heating systems shall be of the enclosed flame type equipped with automatic flame shut-off control and shall be vented directly to the outside. Heating units of any type shall be located to avoid direct contact with any combustible material and shall be maintained in accordance with manufacturer's recommendation. 2. Open flame and portable heaters are prohibited in specialty care assisted living facilities. This does not apply to a fire place with gas logs protected as noted elsewhere in these rules.	A1203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P4911	A. BUILDING: _____ B. WING _____	08/11/2022

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A1203	Continued From page 25 On August 10, 2022, EI#1 and EI#2 told the surveyor that the designated EXIT door would not open upon activation of the fire alarm, as the magnetic lock had malfunctioned and been disabled due to the lack of availability of replacement parts. The magnetic lock had been replaced with a keyed lock, so that the EXIT door to the courtyard was locked at all times. The surveyor requested and received an immediate plan of action to address this resident safety issue. TONYA AVENATTI, REGISTERED NURSE	A1203		