STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D2003	A. BUILDING: _____ B. WING _____	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH TERRACE OF ANDALUSIA 2	660 MOORE ROAD ANDALUSIA, AL 36420

(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 May 21, 2025, an unannounced licensure survey was conducted for this 16 bed Assisted Living Facility (ALF) with a census of 15. 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 require a plan of correction.	A 000		
A 405	420-5-4-.04 (6) Personnel. (6) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained in the facility. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on assisted living facilities. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR)	A 405		

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A 405	Continued From page 1 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 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	A 405		

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A 405	Continued From page 2 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 review and interview, facility staff were not trained in a special need of residents. Findings: On the morning of May 21, 2025, review of seven employee files revealed no training had been received for diabetes mellitus. Employee Identifier (EI)#1, the administrator, acknowledged the training had not been done.	A 405	A405 --Administrator and Director conducted one-on-one training education on Diabetes Mellitus that included policy and procedure with EI#1, EI#2, EI#3, EI#4, EI#5, EI#6, and EI#7 as well as all other employees during the period between 5/27/2025through 5/30/2025. --Administrator and Director reviewed all current employee files and conducted one-on-one training of policy and procedure on Diabetes Mellitus during the period between 5/27/2025 through 5/30/2025. --Administrator added the Diabetes Mellitus training to the new employment training policies and procedures on 5/21/2025. The Administrator added the Diabetes Mellitus training to the yearly employee in-service chart on 5/21/2025. --Administrator or Director will sign off on all employee training on hire as well as yearly in-service concerning the Diabetes Mellitus training. Documentation will be kept in each employee file as well as yearly training files. Files will be audited quarterly to ensure completion of education.	5/30/2025
A1101	420-5-4-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan	A1101		

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A1101	Continued From page 3 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. 2. Adequately protects against	A1101		

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A1101	Continued From page 4 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 5 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted at least once per month. Findings: On the afternoon of May 20, 2025, the fire drill log was noted to have three months with no fire drills conducted. EI#1 agreed the fire drills had not been conducted. THERESA HARRISON, REGISTERED NURSE	A1101	A1101 --Administrator and Director created a calendar on 5/21/2025 to conduct and sign off on monthly fire drills. --Administrator and Director reviewed the current system used to sign off on monthly fire drills and created a new calendar on 5/21/2025 to ensure that monthly fire drills will be completed, verified and checked off/signed off by the Administrator or Director each month. --The Administrator added and implemented a new calendar to the facility monthly reports for review and sign off by the Administrator or Director to ensure all fire drills are completed by the end of each month. --Administrator or Director will audit completion of fire drills monthly and maintain the monthly audit reports.	5/21/2025