

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D1601</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/10/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SERENITY SOUTH ENTERPRISE SENIOR LIVING I</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 WYNN ROAD</b> <b>ENTERPRISE, AL 36330</b>
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A 000	<p>Initial Comments</p> <p>On July 10, 2025 a complaint investigation was conducted for this 16 bed Assisted Living Facility with a census of 10.</p> <p>One complaint was investigated during this survey. Complaint Number 20250625009 was substantiated, with deficiencies cited as a result of the complaint investigation.</p> <p>Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities (ALF). The deficiencies cited pose a risk or potential risk of harm to the residents and require a plan of correction.</p>	A 000		
A 302	<p>420-5-4-.03 (1) (e) Administration.</p> <p>Policies.</p> <p>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 residents. 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:</p> <p>(i) Facility responsibility to protect all</p>	A 302		

Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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A 302	<p>Continued From page 1</p> <p>residents from abuse, neglect, and exploitation.</p> <p>(ii) How allegations of abuse, neglect, and exploitation will be handled by the facility.</p> <p>(iii) Resident confidentiality.</p> <p>(iv) Admission and continued stay criteria.</p> <p>(v) Discharge criteria and notification procedures for residents and sponsors.</p> <p>(vi) Facility responsibility when a resident's personal belongings are lost.</p> <p>(vii) What services the facility is capable and not capable of providing.</p> <p>(viii) Medication management.</p> <p>(ix) Infection control.</p> <p>(x) Meal service, timing, menus and food preparation, storage, and handling.</p> <p>(xi) Fire safety and emergency plan, fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness.</p> <p>(xii) Staffing and conduct of staff while on duty.</p> <p>(xiii) Oxygen administration and storage if used in the facility.</p> <p>(xiv) Dietary Policies. The dietitian, with the approval of the administrator, shall develop written policies and procedures for the</p>	A 302		

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A 302	<p>Continued From page 2</p> <p>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:</p> <p>(I) Sanitation of dishes, utensils, and service equipment, and sanitary food preparation and handling.</p> <p>(II) The attire and cleanliness of staff members who prepare, handle, or serve food.</p> <p>(III) A schedule of meals, which shall include between-meal nourishment or snacks, and fluids.</p> <p>(IV) Food substitutions or alternatives.</p> <p>(V) Method to ensure an adequate dietary plan is implemented for any resident with a therapeutic diet or special dietary needs.</p> <p>(VI) Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food.</p> <p>(VII) Provision of necessary services to any resident requiring adaptive devices to eat.</p> <p>(VIII) Procedure for the handling of potentially hazardous foods such as meat, milk, ice, and eggs.</p> <p>(IX) Storage of food.</p>	A 302		

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A 302	<p>Continued From page 3</p> <p>(X) Procedure for food service in the event of a disaster. Disaster menus shall be developed. The policy shall address how food will be obtained and maintained at safe temperatures if electricity is not available.</p> <p>This Rule is not met as evidenced by: Based on interview and document review, the facility failed to follow its own policies and procedures for management and operation of the facility.</p> <p>Findings:</p> <p>A facility policy titled, "INCIDENT OR ACCIDENT/UNUSUAL OCCURRENCE" revealed, "... POLICY: It is the policy of Serenity South Senior Living to report, investigate and document any incidents or accidents that involve a resident. An unusual occurrence is an incident that would not normally occur and which has the potential for or an actual adverse impact on a resident. The Executive Director will be notified immediately. As appropriate, an investigation will be conducted and appropriate interventions devised and implemented immediately. Refer to deficiencies 303 and 508 for additional information.</p> <p>A facility policy titled, "REPORTING ALLEGATIONS OF ABUSE/SUSPECTED ABUSE" revealed, "... POLICY: It is the policy of Serenity South Senior Living to ensure that each resident is free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, and misappropriation of a resident's property. Any allegations of abuse or suspected</p>	A 302		

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A 302	<p>Continued From page 4</p> <p>abuse will be reported to the Executive Director and the Executive Director will report to the appropriate agencies. PROCEDURE: Serenity South Senior Living will investigate any suspected or reported alleged instance of resident abuse, ... and report such instances to the Division of Health Care Facilities in accordance with the rules and regulations of the Division of Health Care Facilities ..." Refer to deficiencies 303 and 508 for additional information.</p> <p>A facility policy titled, "ADMINISTRATOR (EXECUTIVE DIRECTOR)" revealed, "... POLICY: It is the policy of Serenity South Senior Living to an Administrator responsible to the governing authority/owners for the proper performance of his/her duties. ... PROCEDURE: 1. The Executive Director is responsible for the management and operation of the community. 5. ... the Executive Director will obey all applicable federal, state and local laws, ordinances and regulations. ..." Refer to deficiency 303 for additional information.</p>	A 302		
A 303	<p>420-5-4-.03 (2) (a) Administration.</p> <p>The Administrator.</p> <p>(a) Responsibility.</p> <p>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.</p> <p>2. Any individual employed as an administrator shall be properly licensed.</p>	A 303		

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A 303	<p>Continued From page 5</p> <p>3. Any individual employed as an administrator shall meet all applicable statutory requirements.</p> <p>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.</p> <p>5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age.</p> <p>6. The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character.</p> <p>7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week.</p> <p>8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment and adequate care being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement.</p> <p>9. The facility administrator is responsible for ensuring that required training is provided to all staff.</p> <p>10. The administrator shall ensure that residents who have health or safety needs</p>	A 303		

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A 303	<p>Continued From page 6</p> <p>beyond the capability of the facility will be safely transferred or discharged to an appropriate setting.</p> <p>11. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when needed.</p> <p>12. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan.</p> <p>13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, EI#1, the administrator, failed to adequately perform her duties to ensure the proper and safe management of the day to day operations of the facility. This failure placed all ten residents at risk for exploitation.</p> <p>Findings:</p> <p>On June 25, 2025, the ADPH received an anonymous complaint alleging a 30 count (card) supply of hydrocodone went missing and the administrator, Employee Identifier (EI)#1, said there would be no investigation. The complainant alleged no one had been interviewed about the missing narcotics and EI#1 had told staff the owner and consultant said there was no need to</p>	A 303		

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A 303	<p>Continued From page 7</p> <p>investigate.</p> <p>NOTE: On May 26, 2025, a card of 30 hydrocodone/APAP 10-325 mg (milligrams) tablets was missing. No investigation was conducted. The exploitation of a resident's narcotics was not reported to the ADPH.</p> <p>A review of a copy of Resident Identifier (RI)#1's "CONTROLLED DRUG RECEIPT RECORD/DISPOSITION FORM" revealed, "... Date Received 04/30/2025 ... (names RI#1) Drug Name/Strength HYDROCO (HYDROCODONE)/APAP TAB (TABLET) 10-325 MG ... Quantity Received 30 ..." A hand-written note written by EI#2, a former care assistant, dated May 26, 2025, revealed, "Meds (medications) counted by 1st and 2nd shift. 10pm shift med count missing hydro card full card(.) Contacted (names EI#1). She will look into it when she gets here. (Initialed by EI#2)" Refer to deficiency 504 for additional information for RI#1.</p> <p>Review of the information provided by EI#1 relating to the missing hydrocodone revealed three verbal warnings for EI#2, EI#3 and EI#4. EI#2's verbal warning indicated a violation of "... whole card (of hydrocodone) gone ... Corrective Actions needed ... Need to take more count time to count correctly ..." EI#3's verbal warning indicated a violation of "... missing card ... 30 count ... Specific Warning: let's find it. Always recount with when new person ..." EI#4's verbal warning indicated a violation of "... missing card of medicine for (name of RI#1) ... Specific Warning: Recount every time you change buildings, you're responsible ..." EI#1 documented she had called EI#9, the owner, EI#8, the consultant, Southern Care Hospice, EI#10, a care assistant/administrative designee</p>	A 303		

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A 303	<p>Continued From page 8</p> <p>and Guardian Pharmacy.</p> <p>El#1 has been a licensed administrator since August 19, 2020. On the morning of July 9, 2025, El#1 said she did not notify the police and was waiting for the card of narcotics to show up. El#1 admitted she told staff she had reported the missing narcotics to the police in hopes whoever took the hydrocodone would return them. El#1 acknowledged it was her decision not to report or investigate the exploitation of RI#1's Hydrocodone.</p> <p>On the afternoon of July 9, 2025, El#5, a care associate, reported when RI#1's hydrocodone went missing, El#2, a former employee as of July 7, 2025, said the card may have fallen into her purse. El#5 said nothing was done after the narcotics went missing, no interviews and no investigation. El#5 said at the June 24, 2025, staff meeting El#1 said she had spoken to El#8, El#9 and the hospice group. El#1 said none of them were concerned about the missing narcotics and she was not going to worry about it either. El#5 said she had voiced to El#1 that the narcotic count was off before. El#5 said El#1 would call El#10 and El#1 would document whatever El#10 told her to.</p> <p>On the morning of July 10, 2025, El#6, a care assistant, was asked what was done after RI#1's hydrocodone went missing. El#6 said she was very upset because no interviews, no investigation, nothing, was done. El#6 said after the incident there was no training related to drug diversion.</p> <p>On the afternoon of July 10, 2025, El#1 said she trusted her staff. El#1 said when she assumed the narcotics would be returned, she was thinking</p>	A 303		

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A 303	<p>Continued From page 9</p> <p>on a personal level, not as an administrator. EI#1 said the only thing she did was issue verbal warnings. EI#1 said according to policy she was supposed to investigate and report the incident. When asked what was in place to identify and address drug diversion, EI#1 said she did not know what that meant. EI#1 said she did not know what type of abuse the theft of a resident's medication would be. When asked the types of abuse EI#1 did not recall exploitation. When asked why she did not notify the police of stolen narcotics, EI#1 said she was using her personal feelings. EI#1 said she did not report the exploitation of RI#1's hydrocodone because she was not doing any reports because she was giving them (the staff member that stole the narcotics) time to turn them in. EI#1 acknowledged she should have reported the incident to ADPH within 24 hours. EI#1 acknowledged it was her responsibility to ensure safekeeping of resident medications. EI#1 insisted she did not investigate the stolen narcotics because she was waiting for whoever took them to do the right thing and it was abuse.</p> <p>On the afternoon of July 10, 2025, EI#8 and EI#9 both deny knowledge that the exploitation of RI#1's hydrocodone had not been investigated or reported to ADPH.</p>	A 303		
A 504	<p>420-5-4-.05 (3) (d) Records and Reports.</p> <p>(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</p>	A 504		

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A 504	<p>Continued From page 10</p> <p>fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate.</p> <ol style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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.</li> <li>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.</li> <li>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.</li> <li>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</li> </ol>	A 504		

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A 504	<p>Continued From page 11</p> <p>authorizes the administrator of the facility to provide a safe place to keep funds on the premises, an individual account record for each resident shall be maintained by the administrator and an up-to-date record shall be maintained for all transactions.</p> <p>7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so.</p> <p>8. Every resident shall have the right to a reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals.</p> <p>9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident.</p> <p>10. Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to receive or reject medical care, dental care, or other health care services except those required to control communicable diseases.</p> <p>11. Every resident shall have the right to at least 30 days prior written notice of involuntary relocation or termination of residence from the facility unless the resident is a patient in a facility providing a higher level of care and no longer meets the eligibility and continued stay requirements in these rules, or for medical reasons the resident is considered by a physician</p>	A 504		

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NAME OF PROVIDER OR SUPPLIER  <b>SERENITY SOUTH ENTERPRISE SENIOR LIVING I</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 WYNN ROAD</b> <b>ENTERPRISE, AL 36330</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 504	<p>Continued From page 12</p> <p>to require an emergency relocation to a facility providing a more skilled level of care, or unless the resident engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record.</p> <p>12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person without restraint, interference, coercion, discrimination, or reprisal.</p> <p>13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file.</p> <p>14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the facility, provided that:</p> <p>(i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care.</p> <p>(ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless</p>	A 504		

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A 504	<p>Continued From page 13</p> <p>the service is to be performed without compensation; and</p> <p>(iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time without recourse.</p> <p>15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges.</p> <p>16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities.</p> <p>17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll-free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll-free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area.</p> <p>18. All state inspection reports and any resulting corrective action plan from the past 24 months shall be posted in a prominent location. If there has been no inspection in the past 24 months, then the results of the most recent inspection and any resulting corrective action plan shall be posted.</p>	A 504		

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A 504	<p>Continued From page 14</p> <p>19. Every resident shall have the right to 30 days prior written notice to both resident and sponsor of any increase of fees or charges.</p> <p>20. Every resident shall have the right to 30 days prior written notice of any involuntary change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents.</p> <p>21. Every resident shall have the right to wear his or her own clothes, to keep and use his or her own personal possessions including toilet articles except for personal possessions too large to be stored in the resident's room.</p> <p>22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings.</p> <p>23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours and to freely come and go from the home.</p> <p>24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to prevent a resident from exploitation.</p>	A 504		

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A 504	<p>Continued From page 15</p> <p>Findings:</p> <p>On June 25, 2025, the ADPH received an anonymous complaint alleging a 30 count (card) supply of hydrocodone went missing and the administrator said there would be no investigation. The complainant alleged no one had been interviewed about the missing narcotics and EI#1 had told staff the owner and consultant said no need to investigate.</p> <p>NOTE: On May 26, 2025, a card of 30 hydrocodone/APAP 10-325 mg (milligrams) tablets was missing.</p> <p>Resident Identifier (RI)#1 was admitted to the facility on May 8, 2024, with diagnoses to include diabetes mellitus, obstructive sleep apnea, morbid obesity and nerve damage pain. RI#1's prescribed medications included hydrocodone/APAP 10-325 mg one tablet by mouth every 4 (four) hours as needed for pain. RI#1's prescribed medications included hydrocodone/APAP 10-325 mg one tablet by mouth every 4 (four) hours as needed for pain. A review of a copy of a "CONTROLLED DRUG RECEIPT RECORD/DISPOSITION FORM" revealed, "... Date Received 04/30/2025 ... (names RI#1) Drug Name/Strength HYDROCO (HYDROCODONE)/APAP TAB (TABLET) 10-325 MG ... Quantity Received 30 ..." A hand-written note written by EI#2, a care assistant, dated May 26, 2025, revealed, "Meds (medications) counted by 1st and 2nd shift. 10pm shift med count missing hydro card full card(.) Contacted (names EI#1). She will look into it when she gets here. (Initialed by EI#2)"</p> <p>Review of the information provided by EI#1</p>	A 504		

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A 504	<p>Continued From page 16</p> <p>relating to the missing hydrocodone revealed three verbal warnings for EI#2, EI#3 and EI#4. EI#2's verbal warning indicated a violation of "... whole card (of hydrocodone) gone ... Corrective Actions needed ... Need to take more count time to count correctly ..." EI#3's verbal warning indicated a violation of "... missing card ... 30 count ... Specific Warning: let's find it. Always recount with when new person ..." EI#4's verbal warning indicated a violation of "... missing card of medicine for (name of RI#1) ... Specific Warning: Recount every time you change buildings, you're responsible ..." EI#1 documented she had called EI#9, the owner, EI#8, the consultant, Southern Care Hospice, EI#10, a care assistant/administrative designee and Guardian Pharmacy. This documentation indicates RI#1's narcotics were stolen.</p> <p>On the afternoon of July 9, 2025, EI#5, a care associate, reported when RI#1's hydrocodone went missing, EI#2, a former employee as of July 7, 2025, said the card may have fallen in her purse.</p> <p>On the afternoon of July 10, 2025, EI#1 said she did not know what type of abuse the theft of a resident's medication would be. When asked the types of abuse EI#1 did not recall exploitation. EI#1 admitted the stolen narcotics was abuse.</p>	A 504		
A 508	<p>420.5.4-.05 (3) (h) Records and Reports.</p> <p>(h) Incident Investigation. When an incident, as defined below, occurs in an assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and</p>	A 508		

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A 508	<p>Continued From page 17</p> <p>implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review.</p> <p>1. Incidents which require investigation are:</p> <p>(i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as bruising, pain, or injury that is not consistent with actions necessary in providing day to day care to a resident or for which medical treatment was sought.</p> <p>(ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid, including but not limited to: a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office.</p> <p>(iii) The onset of wandering behavior by any resident who is not fully cognitively intact.</p> <p>(iv) Elopement by a resident.</p> <p>(v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules.</p> <p>(vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules.</p>	A 508		

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A 508	<p>Continued From page 18</p> <p>(vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules.</p> <p>(viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I of Alabama Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or Staphylococcus aureus).</p> <p>(ix) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility.</p> <p>(x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident.</p> <p>(xi) An unplanned occurrence that results in media attention.</p> <p>(xii) A medication error, overdose, or over sedation.</p> <p>(xiii) Ingestion by a resident of a toxic substance that requires medical attention.</p> <p>(xiv) Any indication of malfunction of the sprinkler system, or fire alarm system.</p> <p>2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following:</p>	A 508		

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A 508	<p>Continued From page 19</p> <ul style="list-style-type: none"> <li>(i) Names of all residents involved.</li> <li>(ii) Names of all staff involved including person in charge at the time of the incident.</li> <li>(iii) When the administrator was notified (date and time).</li> <li>(iv) Circumstances under which the incident occurred.</li> <li>(v) When the incident occurred (date and time).</li> <li>(vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn).</li> <li>(vii) Immediate actions taken.</li> <li>(viii) The extent and description of injury, if any, to the affected resident or residents.</li> <li>(ix) Immediate treatment rendered.</li> <li>(x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified.</li> <li>(xi) Names, telephone numbers, and addresses of witnesses.</li> <li>(xii) Date and time relatives or sponsor were notified.</li> <li>(xiii) Out-of-facility treatment.</li> <li>(xiv) Follow-up care.</li> </ul>	A 508		

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A 508	<p>Continued From page 20</p> <p>(xv) Outcome resolution.</p> <p>(xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future.</p> <p>(xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation.</p> <p>(xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request.</p> <p>(xix) The entire investigative file and documentation of all corrective action taken shall be retained for a period of not less than 3 years after the resident is discharged or dies.</p> <p>(xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff.</p> <p>3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident:</p> <p>(i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention as defined in these rules.</p> <p>(ii) Elopement by a resident.</p> <p>(iii) Suspected, alleged, confessed, or witnessed abuse, neglect, or exploitation of a resident or residents by staff, visitors, or other</p>	A 508		

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A 508	<p>Continued From page 21</p> <p>residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file.</p> <p>(iv) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility.</p> <p>(v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident.</p> <p>(vi) An unplanned occurrence that results in media attention.</p> <p>(vii) Any medication error, overdose, or over sedation. The incident shall be immediately reported to the attending physician, facility medical director, or back-up physician.</p> <p>(viii) Ingestion by a resident of a toxic substance that requires medical attention.</p> <p>(ix) Notifiable diseases and health conditions listed in Appendix I of the Alabama Administrative Code Sec. 420-4-1-.04. shall be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1-.04. The facility shall</p>	A 508		

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A 508	<p>Continued From page 22</p> <p>maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than 3 years.</p> <p>(x) Any indication of malfunction of the sprinkler system, or fire alarm system.</p> <p>4. The report to the Department's Online Incident Reporting System shall include the following:</p> <p>(i) Facility name and direct phone number.</p> <p>(ii) Time and date of the report.</p> <p>(iii) Reporter's name.</p> <p>(iv) Name of resident(s), staff, or visitor(s) involved in the incident.</p> <p>(v) Names of staff on duty at the time of the incident.</p> <p>(vi) Date and time of the incident.</p> <p>(vii) A brief description of the incident.</p> <p>(viii) Any injury or injuries to resident(s).</p> <p>(ix) Action taken by the facility in response to the incident.</p>	A 508		

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A 508	<p>Continued From page 23</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report and investigate exploitation of a resident.</p> <p>Findings:</p> <p>NOTE: On May 26, 2025, a card of 30 hydrocodone/APAP 10-325 mg (milligrams) was missing. No investigation was conducted. The exploitation of a resident's narcotics was not reported to the ADPH.</p> <p>RI#1 was admitted to the facility on July 14, 2023, with diagnoses to include nerve damage, diabetes mellitus, atrial fibrillation, morbid obesity and coronary heart disease. RI#1's prescribed medications included hydrocodone/APAP 10-325 mg one tablet by mouth every 4 (four) hours as needed for pain. A review of a copy of a "CONTROLLED DRUG RECEIPT RECORD/DISPOSITION FORM" revealed, "... Date Received 04/30/2025 ... (names RI#1) Drug Name/Strength HYDROCO (HYDROCODONE)/APAP TAB (TABLET) 10-325 MG ... Quantity Received 30 ..." A hand-written note written by EI#2, a care assistant, dated May 26, 2025, revealed, "Meds (medications) counted by 1st and 2nd shift. 10pm shift med count missing hydro card full card(.) Contacted (names EI#1). She will look into it when she gets here. (Initialed by EI#2)"</p> <p>Review of the information provided by EI#1 relating to the missing hydrocodone revealed three verbal warnings for EI#2, EI#3 and EI#4. EI#2's verbal warning indicated a violation of "... whole card (of hydrocodone) gone ... Corrective Actions needed ... Need to take more count time</p>	A 508		

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NAME OF PROVIDER OR SUPPLIER  <b>SERENITY SOUTH ENTERPRISE SENIOR LIVING I</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 WYNN ROAD</b> <b>ENTERPRISE, AL 36330</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 508	<p>Continued From page 24</p> <p>to count correctly ..." EI#3's verbal warning indicated a violation of "... missing card ... 30 count ... Specific Warning: let's find it. Always recount with when new person ..." EI#4's verbal warning indicated a violation of "... missing card of medicine for (name of RI#1) ... Specific Warning: Recount every time you change buildings, you're responsible ..." EI#1 documented she had called EI#9, the owner, EI#8, the consultant, Southern Care Hospice, EI#10, a care assistant/administrative designee and Guardian Pharmacy.</p> <p>EI#1 has been a licensed administrator since August 19, 2020. On the morning of July 9, 2025, EI#1 said she did not notify the police and was waiting for the card of narcotics to show up. EI#1 admitted she told staff she had reported the missing narcotics to the police in hopes whoever took the hydrocodone would return them. EI#1 acknowledged it was her decision not to report or investigate the exploitation of RI#1's Hydrocodone.</p> <p>On the afternoon of July 9, 2025, EI#5, a care associate, reported nothing was done after the narcotics went missing, no interviews and no investigation. EI#5 said at the June 24, 2025, staff meeting EI#1 said she had spoken to EI#8, EI#9 and the hospice group. EI#1 said none of them were concerned about the missing narcotics and she was not going to worry about it either.</p> <p>On the morning of July 10, 2025, EI#6, said she was very upset because no interviews, no investigation, nothing was done. EI#6 said after the incident there was no training related to drug diversion.</p> <p>On the afternoon of July 10, 2025, EI#1 said the</p>	A 508		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D1601</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/10/2025</b>
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A 508	<p>Continued From page 25</p> <p>only thing she did was the verbal warnings. EI#1 said according to policy she was supposed to investigate and report the incident. EI#1 said she did not report the exploitation of RI#1's hydrocodone because she was not doing any reports because she was giving them (the staff member that stole the narcotics) time to turn them in. EI#1 acknowledges she should have reported the incident to ADPH within 24 hours. EI#1 insists she did not investigate the stolen narcotics because she was waiting for whoever took them to do the right thing and it was abuse.</p> <p>On the afternoon of July 10, 2025, EI#9 said he told EI#1 to get with EI#8 and do what she was supposed to do. EI#9 said he would never tell EI#1 not to investigate and it should have been investigated. EI#9 said he and EI#8 were concerned.</p> <p>THERESA HARRISON, REGISTERED NURSE</p>	A 508		