11/25/2024

Oaks on Parkwood SCALF

FACILITY ID# P3712

PLAN OF CORRECTION

A Response to the

Alabama Department of Public

Health Bureau of Health Provider

Standards Assisted Living

Facilities Unit's

Survey Report

On 10/24/2024

Administrator
Gwendolyn Smith

Submitted by
Don J. Bass
Executive Director

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3712	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS ON PARKWOOD SCALF	2651 LAUREL OAKS DRIVE BESSEMER, AL 35022

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A 000	Initial Comments On October 24, 2024, an unannounced licensure and complaint survey was conducted at this 51 bed Specialty Care Assisted Living Facility (SCALF) with a census of 30. Two complaints were investigated during this survey. LC20220928010 was investigated and was not substantiated. LC20230718004 was investigated and substantiated. One deficiency was cited as a result of the complaint investigations. 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 residents and require a plan of correction.	A 000	A 000 On October 24, 2024 an unannounced survey was conducted. This plan of correction in response to the statement of deficiencies demonstrates our good faith and desire to improve the quality of care and services rendered to our residents.	
A 303	420-5-20-.03 (2) (a) Administration. (2) The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the specialty care assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an	A 303	**Corrective Action for A303 continued on pg 2.**	03/24/2025

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

Doug J. Barnett — EXECUTIVE DIRECTOR — 11/15/24

Alabama Department of Public Health

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A 303	Continued From page 1 administrator shall meet all applicable statutory requirements. 4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days. 5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age. 6. The administrator and any individual authorized to act as a substitute shall be of 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 actually being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement. 9. The facility administrator is responsible for ensuring that required training is provided to all staff. 10. The administrator shall ensure that	A 303	**A 303 continued from page 1** A 303 Administration (2) Administrator EI#1 failed to perform duties to ensure the care and safety needs of all residents were met. Cited Tags :401, 602, 604, 611m 702,901, 1002, 1201. Refer to each individual tag for a description of corrective actions and monitoring to prevent further occurrence. Corrective Action 1. The Executive Director (ED)/designee will educate the administrator upon return from leave about the survey deficiencies, regulations,the POC, and regulatory compliance monitoring tools. 2. Create individual action plans for each of the cited deficiencies to assure that care and safety needs of all residents are met. Cited Tags ;401, 602, 604, 611, 702,901, 1002, 1201. Completed 11/15/2024. Please refer to each individual tag for a description of POC. Monitoring 1. Until the return of the Administrator the ED/ designee will review the daily process for the Administrator, in the morning meeting x 1 week, then 2xs a week x 2 weeks then random audits x 3 months. Education as needed to ensure compliance. 2. The monitoring sheets will be kept in the administrators office for review.	**03/24/2025** 03/24/2025

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A 303	Continued From page 2 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 observation, interview, and record review, the administrator, Employee Identifier (EI)#1, failed to properly perform her duties to ensure the care and safety needs of all residents were met. Findings: On July 18, 2023, a complaint was received in the ALF unit regarding staffing issues. The complainant reported there was only two caregivers to care for 30 residents. On October 21 - 24, 2024, surveyors with the ADPH conducted an onsite survey and complaint investigation and substantiated the complaint for	A 303		

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A 303	Continued From page 3 insufficient staffing. The administrator failed to ensure the facility was staffed with at least the minimum required staff at all times. Refer to deficiency 401 for additional information. The administrator failed to ensure two Annual Medical Examinations were provided to one resident. Refer to deficiency 602 for additional information. The administrator failed to ensure the Registered Nurse (RN) accurately assessed residents and identified significant weight loss for two residents. Refer to deficiency 604 for additional information. The administrator failed to ensure care plans were updated to address significant weight loss and use of a wheelchair. Refer to deficiency 611 for additional information. The administrator failed to ensure residents were not served sliced fruit from an opened metal can. Refer to deficiency 702 for additional information. The administrator failed to ensure a laundry dryer had proper mechanical ventilation. Refer to deficiency 901 for additional information. The administrator failed to ensure external use substances were secured at all times. Refer to deficiency 1002 for additional information. The administrator did not direct maintenance staff to ensure the exterior of the building was maintained and needed repairs were addressed. Refer to deficiency 1201 for additional information.	A 303		

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A 401	420-5-20-.04 (1) (2) Personnel. (1) A specialty care assisted living facility shall ensure adequate personnel are employed and on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. No specialty care assisted living facility shall have fewer staff on duty than specified in Table A below. Even if this minimum staffing ratio is met, the governing authority of a specialty care assisted living facility shall have additional staff on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. Facilities with resident bedroom wings separated from the remainder of the facility by a lockable door shall maintain dedicated staff to these areas adequate to meet all care and safety needs of the residents in these areas at all times. Table A Staff Number 7 AM - 3 PM 3 PM - 11 PM 11 PM - 7 AM 2 1 -16 Residents 1 - 16 Residents 1 - 16 Residents 3 17 - 24 Residents 17 - 36 Residents 17 - 48 Residents 4 25 - 32 Resident 37 - 48 Residents 49 - 64 Residents 5 33 - 40 Residents 49 - 60 Residents 65 - 80 Residents 6 41 - 48 Residents 61 - 72 Residents 81 - 96 Residents 7 49 - 56 Residents 73 - 84 Residents 97 - 112 Residents 8 57 - 64 Residents 85 - 96 Residents 113 - 128 Residents 9 65 - 72 Residents 97 - 108 Residents 129 - 144 Residents	A 401	A 401 Complaint survey inadequate staffing, per regulations. The cited staffing deficiency was immediately corrected and an action plan was submitted and accepted. Corrective Action 1. The ED/designee educated staff about regulations for staffing and posted staffing numbers-per regulations with the daily schedule/ 24 hour report. 2. The administrator/designee educated EI #9 about staffing regulations and reporting opportunities to administrator/designee. 3. The administrator/designee educated staff about chain of command, and who to contact if there are staffing opportunities. Monitoring 1.The ED/ designee will review the daily schedule during week days daily x 1 weeks then 2xs a week x 2 weeks then weekly x 1 week, then random audits x 3 months 2.ED/designee to review the monthly schedule before the end of each month x 1 month, then randomly for 3 months. 3.The monitoring sheets will be kept in the administrators office for review.	03/24/2025 10/24/2024 03/24/2025

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A 401	Continued From page 5	A 401		

10 73 - 80 Residents 109 - 120 Residents 145 - 160 Residents
11 81 - 88 Residents 120 - 132 Residents 161 - 176 Residents

1 Additional Staff For each 8 residents, or any fraction thereof, by which the census exceeds 88 For each 12 residents, or any fraction thereof, by which the census exceeds 132 For each 16 residents, or any fraction thereof, by which the census exceeds 176

(a) A specialty care assisted living facility shall be staffed at all times by at least one individual who has a current certification in cardiopulmonary resuscitation (CPR).

(b) A specialty care assisted living facility must be sufficiently staffed to ensure the safe evacuation of all residents in the event of a fire or emergency.

(2) Employee Schedule. A specialty care assisted living facility shall post a schedule of employees indicating names and days and hours scheduled to work. This schedule shall be retained in the facility for 6 months after use.

In the event of an unplanned staff shortage which would make it otherwise impossible to meet the staffing requirements imposed by these rules, a facility may employ a certified nurse aide who has not received the training specified in these rules. For the purposes of this subsection, a certified nurse aide is defined as an individual who has been deemed or determined to be competent by the Alabama Nurse Aide Registry

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A 401	Continued From page 6 maintained by the Alabama Department of Public Health. This individual may not work unless accompanied at all times by an individual who is appropriately trained in accordance with these rules. Such employment shall last only until the facility has employed staff trained in accordance with the above. In no event may the period during which such staff is employed in a facility exceed 120 consecutive hours. This Rule is not met as evidenced by: Based on observation, interview and document review, the facility was not staffed with at least the minimum required staff at all times. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: At the time of the onsite survey from October 21-24, 2024, the census of the facility was 31 residents with 30 residents currently in house. This census required no less than three staff members to be on duty from the hours of 11:00 PM-7:00 AM. On the early morning of October 22, 2024, staffing was observed for the 11:00 PM (October 21, 2024)-7:00 AM shift. EI#6, LPN (Licensed Practical Nurse), and EI#9, the staffing coordinator, were the only staff that were on duty during this observation. On the early morning of October 23, 2024, staffing was observed for the 11:00 PM (October	A 401		

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A 401	Continued From page 7	A 401		

22, 2024)-7:00 AM shift. EI#6 and EI#8, a resident care associate, were the only staff that were on duty. EI#6 and EI#8 reported another staff member had worked their shift but had left at 6:30 AM.

Review of employee schedules, on October 22, 2024, revealed:
October 4-6, 2024, only two staff members were scheduled on the night shift (11:00 PM-7:00 AM) shift;
October 10, 2024, only two staff members were scheduled on the night shift;
October 15, 2024, only two staff members were scheduled on the night shift;
October 18-20, 2024, only two staff members were scheduled on the night shift;
October 22, 2024, only two staff members were scheduled on the night shift;
October 23-25, 2024, only one staff member was scheduled on the night shift;
October 26, 2024, only two staff members were scheduled on the night shift;
October 28, 2024, only two staff members were scheduled on the night shift;
October 30-31, 2024, only two staff members were scheduled on the night shift.

On the morning of October 23, 2024, EI#8 said she had worked most 11:00 PM-7:00 AM shifts with less than three staff members on duty.

On the morning of October 24, 2024, EI#9 said she was responsible for scheduling staff. EI#9 acknowledged the 11:00 PM-7:00 AM shifts that were not adequately staffed. EI#9 admitted there should be a minimum of three staff on duty for the night shifts.

On the morning of October 24, 2024, EI#3, the

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A 401	Continued From page 8 Director of Clinical Coordinators, acknowledged 11:00 PM-7:00 AM shifts for the month of October had not been fully staffed. ACTION PLAN On the morning of October 23, 2024, an action plan was requested to provide an appropriately staffed schedule. On the morning of October 24, 2024, a schedule was provided that was adequately staffed.	A 401		
A 602	420-5-20-.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 a specialty care assisted living facility, the resident or prospective resident shall be examined by a physician. For purposes of the initial physical examination, a physician currently licensed and 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. This examination is not required for a resident of a facility dually licensed as an assisted living facility and as a specialty care assisted living facility in those cases when the resident is transferred from the assisted living unit to the specialty care assisted living unit in the same 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	A 602	A 602 Medical Exam: annual exam for RI #2 could not be located by EI#3. Corrective actions 1. 100% Audit of all residents for original plan of care, and current annual medical exams, completed 11/11/2024. 2. Educated RN, physician, and staff about the regulations about Medical plans of care. Completed 11/12/2024 3. Educated RN about a system to monitor monthly care plans and create a calendar. Completed 11/12/2024 Monitoring: 1. Administrator/designee to review the medical plan of care monitoring tool daily x 1week, then 2 xs a week for 1 week then monthly x3 months. 2. Administrator/ designee to review with the RN the MPOC due for the month weekly x 4 weeks then monthly x3. 3. Educate as needed to ensure compliance 4. The monitoring sheets will be kept in the administrators office for review.	11/12/2024 03/24/2025

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A 602	Continued From page 9	A 602		03/24/2025

the resident's baseline weight and vital signs.

2. Medication presently prescribed (name, dosage, and strength of drug, frequency, 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 condition.

4. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration).

5. Changes in treatment.

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A 602	Continued From page 10	A 602		

(c) Change of Condition Physical Examinations. Changes in the resident's condition that require a physician examination and result in a change in diagnoses, condition, medications, or treatments shall be reported to the facility and 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. Changes in 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 record review and interview, two Annual Medical Examinations were not completed for one resident.

Findings:

RI#2 was admitted to the facility on January 22, 2021, with diagnoses which included age related macular degeneration, cerebral infarction, gastroesophageal reflux disease and pain. Review of RI#2's facility record revealed there

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A 602	Continued From page 11 were no Annual Physical Examinations for 2022 and 2023. EI#3 was unable to locate annual examinations for 2022 or 2023.	A 602		
A 604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility RN or care coordinator shall screen prospective residents for eligibility for admission into the specialty care assisted living facility. The screening shall include a clinical history, a mental status examination to include aphasia screening, a geriatric depression screen, a physical self-maintenance screen, and a behavior screen. Appendix A herein, contains the Physical Self Maintenance Scale (PSMS) form and the Behavior Screening form. These forms shall be completed to screen physical functioning and behaviors. The PSMS and Behavior Screen assessments shall be completed by the RN or care coordinator upon admission, annually, and when there is a change in the resident's status. The facility RN shall perform a comprehensive assessment of each prospective resident for facility eligibility. This assessment shall document identified care needs and serve as a baseline for the RN plan of care and future assessments. (b) Monthly Assessments. The RN shall assess each resident monthly and more often when necessary to identify changes in the resident's health status. The monthly assessment	A 604	A 604 Health Supervision: the RN failed to provide health supervision by inaccurately completing monthly assessments and failing to identify changes in resident health status for two residents. RI#1: Wt. loss of was not assessed and documented per regulations and measures were not initiated. RI#2 significant weight loss was not identified and the measures were not initiated per regulations. EI#5 was unclear about the process. Corrective Actions 1. The ED/designee conducted a 100% audit of weights obtained in October to assure loss was properly assessed and addressed per regulations. Completed 11/12/2024. 2. RN Reviewed and updated RI#1 & RI#2 weights Immediately and addressed per regulations. Completed 11/11/2024 3. ED/designee educated RN about A 604 Health supervision, and facility policy & procedures for obtaining, addressing, and planning any weight issues identified. Completed 11/12/2024 4. Educated staff about the facility process for obtaining weights and regulations for identification, assessing, and planning of any concerns. Completed 11/12/2024 Monitoring 1.The ED/designee to review the monthly weights with the RN prior to sending to the dietitian. Monthly x 1 then monthly x 3 months. 2.The Dietitian will review interventions 1x month for 1 months then monthly for 3 months. Dietitian will reeducate RN as needed. 3.The monitoring sheets will be kept in the administrators office for review.	11/12/2024 03/24/2025

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A 604	Continued From page 12	A 604		03/24/2025

shall include a review of monthly weights, falls, incidents, elopements, behavioral symptoms, medications, changes in resident status, and appropriateness of the resident's plan of care.

(c) Comprehensive Assessment. The facility RN shall perform a comprehensive assessment and communicate with the resident's attending physician and with the resident's sponsor or responsible family member when a decline in health status or behavior occurs, or if the resident develops any of the following problems:

1. Weight loss:

(i) Each month, the facility shall accurately weigh and record the weight of each resident.

(ii) A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half percent or greater weight loss in a period of 3 months or less, or a 10 percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician.

2. Falls (two or more falls within a 30 day period).

3. Elopement.

4. Any sign and symptom of adverse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3712	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS ON PARKWOOD SCALF	2651 LAUREL OAKS DRIVE BESSEMER, AL 35022

(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 604	Continued From page 13	A 604		

drug reaction, interaction or over sedation, or circumstances which contraindicate medications that have been prescribed for the resident.

5. Unmanageable, combative, or potentially harmful behavior(s).

6. Any accident with injury.

(d) Focused Assessments. The RN or LPN shall conduct focused assessments when necessary to identify changes in resident status.

(e) Any change in resident status requires immediate documentation and implementation of interventions or reassessment of existing interventions.

This Rule is not met as evidenced by:
Based on observation, interview and record review, the Registered Nurse (RN) failed to provide health supervision as evidenced by inaccurately completing monthly assessments and failing to identify changes in resident health status for two residents.

Findings:

RI#1
RI#1 was admitted to the facility on September 18, 2024, with diagnoses which included dementia with other behavioral disturbance, depression and anxiety. RI#1's admission weight was 89 pounds. RI#1's weight on October 3, 2024, was 83 pounds, equaling a 6.75% weight loss in 17 days. RI#1's weight on October 22, 2024, was 74.5 pounds equaling 16.3% weight

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3712	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS ON PARKWOOD SCALF	2651 LAUREL OAKS DRIVE BESSEMER, AL 35022

(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 604	Continued From page 14 loss in 36 days. RI#1's monthly assessment dated September 24, 2024, was missing the admission weight. "Dietician Review - If a Weight gain or Loss" was marked not applicable. This assessment was completed and signed by EI#5, the RN for the SCALF. EI#5 did not accurately assess RI#1, identify the significant weight loss, notify the physician and dietician and no measures were initiated to address the significant weight loss. RI#2 RI#2 was admitted to the facility on January 22, 2021, with diagnoses which included age related macular degeneration, cerebral infarction, gastroesophageal reflux disease and pain. RI#2's medical record revealed in October 2024, RI#2 had an 9.2% weight loss in 3 months and a 15.7% weight loss in 6 months. RI#2's monthly assessment dated October 3, 2024, was missing the admission weight. The "Dietician Review - If a Weight gain or Loss" was marked not applicable. This assessment was completed and signed by EI#5. EI#5 did not accurately assess RI#1, identify the significant weight loss, notify the physician and dietician and no measures were initiated to address the significant weight loss. On the afternoon of October 23,2024, EI#5 reported she had been the RN for the SCALF since May of 2023. EI#5 said she supervises the LPNs and resident care associates. EI#5 said she identifies changes in resident condition by what staff members document. EI#5's responsibilities include assessments for fall risks, formulating initial care plans and she care plans the weights. EI#5 said when she conducts monthly	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3712	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS ON PARKWOOD SCALF	2651 LAUREL OAKS DRIVE BESSEMER, AL 35022

(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 604	Continued From page 15	A 604		

assessments, she checks the resident's vital signs, skin and changes. EI#5 added she knew the residents. EI#5 was asked what percentage of weight had RI#1 lost on October 3, 2024. EI#5 could not answer and admitted she did not know how to calculate the percentages. EI#5 said she was told they would put the weights in and if anything was significant, the dietician would notify them. EI#5 added she did not know how the dietician would know the weights had been put in. EI#5 said on October 3, 2024, when she signed RI#1's monthly assessment, RI#1 weighed 83 pounds. EI#5 said she did not document RI#1's admission weight, did not know why and she just did not chart it. EI#5 admitted RI#1 had lost 6 pounds and she had indicated no weight loss on the assessment and that was inaccurate. EI#5 was asked what she should have done and she said notified the dietician. EI#5 acknowledged RI#1 has lost 14.5 pounds from September 18, 2024, through October 22, 2024. EI#5 said she did not know what percentages indicate significant weight loss and could not accurately answer assessment questions regarding weight loss. EI#5 said she had noticed RI#2 was now taking longer to eat and was walking slower but did not mention any weight loss concern. EI#5 did not know RI#2 was using a wheelchair but said she should have been aware. EI#5 said she had documented no weight loss for RI#2 and that was inaccurate. EI#5 said the physician, dietician and family were not notified and she had done nothing to address the significant weight losses for RI#1 and RI#2.

On the morning of October 24, 2024, EI#3 said the weight loss for RI#1 and RI#2 were not accurately assessed or addressed.

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3712	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS ON PARKWOOD SCALF	2651 LAUREL OAKS DRIVE BESSEMER, AL 35022

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A 611	Continued From page 16	A 611		
A 611	420-5-20-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. The RN shall develop written plans of care for each resident prior to or at the time of admission. The plans of care shall be based on resident's assessments, diagnoses, and recommendations of the resident's physician. The plan of care shall be developed in cooperation with the resident, if appropriate, and the sponsor. The RN shall identify resident care problem areas and formulate written interventions to address those problems. The RN shall evaluate the implementation of the interventions and the resident's response to the interventions and modify the plan of care as necessary. 1. The plan shall at all times reflect the current condition of the resident. All entries on the plan of care shall be accurately dated. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following: 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	A 611	**A 611 Care of the residents.** The facility failed to ensure the care plans were updated to address significant weight loss and use of a wheelchair. Corrective Actions 1. RN to update Care plans for RI#1 & RI#2 for weight loss and RI#2 need for a wheelchair for mobility. Completed 11/12/2024. 2. Administrator/designee to educate the RN about the regulations for updating care plans with changes in condition and significant change. 3. 100% audit of weights obtained for October and documentation of significant changes per regulations. 4. Dietitian educated RN to assure understanding of the dietitian protocol and review changes in condition that would require RN assessments and care planning. Monitoring 1. ED/designee to review the 24 hour report for changes in condition and completion of updated care plan week days x 2 weeks then 3xs week x 1 week then 1 x week x 1 week then random audits for 3 months. 2. The monitoring sheets will be kept in the administrators office for review	03/24/2025 03/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3712	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS ON PARKWOOD SCALF	2651 LAUREL OAKS DRIVE BESSEMER, AL 35022

(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 611	Continued From page 17	A 611		

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 a specialty care assisted living facility shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident.

(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. Residents' 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3712	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS ON PARKWOOD SCALF	2651 LAUREL OAKS DRIVE BESSEMER, AL 35022

(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 611	Continued From page 18 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 record review and interview, the facility failed to ensure care plans were updated to address significant weight loss and use of a wheelchair. Findings: RI#1 experienced a significant weight loss on October 3, 2024, of 6.75% in 17 days. On October 22, 2024, RI#1 had a significant weight loss of 16.3% in 36 days. RI#1's care plan did not address the significant weight loss. RI#2 experienced a significant weight loss on October 3, 2024, of 9.2% in 3 months and a 15.7% weight loss in 6 months. RI#2 was using a wheelchair for ambulation. RI#2's care plan did not address the significant weight loss or use of a wheelchair. On the afternoon of October 23,2024, EI#5 reported she had not addressed RI#1's significant weight loss in their care plan. EI#5 also reported she had not addressed RI#2's significant weight loss or use of a wheelchair in their care plan.	A 611		
A 702	420-5-20-.07 (2) Food Service. (2) Food Handling Procedures. (a) Dish and Utensils Washing,	A 702		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3712	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS ON PARKWOOD SCALF	2651 LAUREL OAKS DRIVE BESSEMER, AL 35022

(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 702	Continued From page 19 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 the manufacturers' instructions. Utensils and dishes shall be completely immersed for a period of not less than 10 seconds in a clean solution containing not less than 50 ppm, and not more than 200 ppm, of available chlorine bleach or its equivalent or 30 seconds 12.5 ppm of iodine or the amount of time specified by the manufacturer in a 200 ppm quaternary ammonium solution. Water temperature must be at least 75 degrees Fahrenheit. Water temperatures and chemical concentrations shall be monitored and documented prior to dishwashing. A record of each test shall be maintained for at least three months. 3. Dishes and utensils shall be allowed to air dry. 4. After washing, rinsing, sanitizing, and	A 702	**A 702 FOOD SERVICE** The facility failed to ensure residents were not served sliced fruit from an opened manufacture's 104 ounce metal can. Corrective Action 1. Dietitian to educate staff about the food service regulations for food preparation. Monitor 1. The administrator/designee will observe food preparation randomly during meals 3xs week for a week, then weekly x 2 weeks, then x 1 week x 1 week, then random meal preparation audits x 3 months. 2. The monitoring sheets will be kept in the administrators office for review.	03/24/2025 11/15/2024 03/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3712	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS ON PARKWOOD SCALF	2651 LAUREL OAKS DRIVE BESSEMER, AL 35022

(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 702	Continued From page 20 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 shall be stored in a holder inside the ice bin in a manner to prevent ice from coming into contact with the handle, or it may be stored in an airtight container outside the ice bin. (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 backflow, 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 nor in other areas used for storage of food. 3. Food shall not be stored on the floor.	A 702		

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	P3712	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS ON PARKWOOD SCALF	2651 LAUREL OAKS DRIVE BESSEMER, AL 35022

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A 702	Continued From page 21 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 maintain 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 three days from the date is 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 so that food is not contaminated in transport and foods that are transported are held and served at the appropriate temperature at all times. 8. Hot food shall be maintained at a minimum temperature of 135 degrees Fahrenheit and cold foods at a maximum temperature of 41 degrees Fahrenheit. 9. Frozen food items (raw and cooked) shall be thawed under refrigeration or under	A 702		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3712	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS ON PARKWOOD SCALF	2651 LAUREL OAKS DRIVE BESSEMER, AL 35022

(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 702	Continued From page 22 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.	A 702		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3712	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 702	Continued From page 23 (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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3712	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS ON PARKWOOD SCALF	2651 LAUREL OAKS DRIVE BESSEMER, AL 35022

(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 702	Continued From page 24 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 observation and interview, the facility failed to ensure residents were not served sliced fruit from an opened manufacturers' 104 ounce metal can. Findings: An observation was made on the evening of October 22,2024, of EI#12, a kitchen staff member, serving pear slices directly from an opened metal can. EI#12 was asked what she dipped the pear slices from when she served the residents. EI#12 answered a can. EI#12 said she has served food directly from cans before. On the morning of October 24, 2024, EI#3 said fruit should not have been served directly out of an opened can.	A 702		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3712	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS ON PARKWOOD SCALF	2651 LAUREL OAKS DRIVE BESSEMER, AL 35022

(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 901	Continued From page 25	A 901	A 901 Laundry The facility failed to provide proper mechanical ventiation of laundry dryer.	
A 901	420-5-20-.09 (1) (2) Laundry. (1) General. (a) Direction and Supervision. Responsibility for laundry services shall be assigned to an employee. (b) Linen. Linens shall be handled, stored, processed, and transported in a manner consistent with generally accepted infection control practices. (2) Location and Space Requirements. (a) Each specialty care assisted living facility shall have laundering facilities unless commercial laundries are used. An on-site laundry shall be located in a specifically designated area, and there shall be adequate rooms and spaces for sorting, processing, and storage of soiled material. Laundry rooms shall not open directly into resident rooms or food service areas. Domestic washers and dryers which are for the exclusive use of residents may be provided in resident areas, provided they are installed in such a manner that they do not cause a sanitation problem or offensive odors. (b) Each specialty care assisted living facility shall have a system in place to keep clean linen and dirty linen separated and to prevent the re-use of dirty linen before it is cleaned. Dirty linens and clothing shall not be stored, even temporarily, in the area set aside for clean linen. (c) Ventilation of Laundry. Provisions shall be made for proper mechanical ventilation of the laundry, if located within the specialty care	A 901	Corrective action 1. EI#10 immediately cleaned the dryer vent to allow air flow. Administrator/designee educated staff about the removal of lint from the dryer vents. 2. Administrator/designee to assigned/ schedule staff to check and remove lint if needed. Monitoring 1. Administrator/designee to check vents 3xs week x 2 weeks, then 2xs week x1 weeks, then random audits x 3 months 2. The monitoring sheets will be kept in the administrators office for review.	10/24/2024 03/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3712	A. BUILDING: _____ B. WING _____	10/24/2024

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OAKS ON PARKWOOD SCALF	2651 LAUREL OAKS DRIVE BESSEMER, AL 35022

(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 901	Continued From page 26 assisted living facility. Provisions shall also be made to prevent the re-circulation of air in commercial equipment laundries into heating and air conditioning systems outside the laundry area. (d) Lint Traps. Adequate, effective, and clean lint traps shall be used in all dryers. This Rule is not met as evidenced by: Based on observation, and interview the facility failed to provide proper mechanical ventilation of a laundry dryer. Findings: During a tour of the facility on the afternoon of October 24, 2024, the surveyor observed the laundry dryer exhaust was clogged with lint occluding the dryer exhaust presenting a potential fire hazard. During an interview, on the afternoon of October 24, 2024, EI#10 concurred with the surveyor's observation. EI#10 cleaned the dryer exhaust vent to allow some exhaust flow, but was unable to clean the internal run of exhaust ventilation piping.	A 901		
A1002	420-5-20-.10 (2) Sanitation and Housekeeping. (2) Housekeeping and Physical Plant Maintenance. The facility must provide a safe, functional, decent, sanitary, and comfortable environment for residents, staff, and the public. (a) Equipment and Supplies. The home shall maintain an adequate quantity of	A1002		

continued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1002	Continued From page 27 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, 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	A1002	A1002 continued from page 27 **A1002** Sanitation and Housekeeping The facility failed to ensure external use substances were secure at all times. 1. Administrator/designee educated staff about the regulations for locking all chemicals and facility procedures and the location for chemicals. Completed 11/12/2024. 2. Administrator/designee inspected all areas for substances and assured cabinets and locks were intact. 10/24/2024 Monitoring 1. Administrator/ designee to do compliance rounds 5x's x 1 week, then 3xs a week x 1 week then 1x week x 1 week then random audits x 3 months. 2. The monitoring sheets will be kept in the administrators office for review.	12/24/2024 **03/24/2025**

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A1002	Continued From page 28 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 ensure external use substances were secured at all times. Findings: On the morning of October 21, 2024, an observation was made by the surveyor and EI#3 of the unlocked shower room. Shampoos, conditioners, body washes and medicated powder were observed on two over-bed tables. These products are for external use. On the morning of October 24, 2024, EI#3 said chemical products should be kept secured from resident access.	A1002		
A1201	420-5-20-.12 (1) Physical Environment. (1) Buildings and Grounds. (a) The specialty care assisted living facility including site and grounds must be constructed, arranged, and maintained to ensure the safety of the residents and building occupants.	A1201		

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A1201	Continued From page 29 (b) Building Classification. 1. Group specialty care assisted living facilities shall be planned to serve the residents to be admitted and shall comply with Section (1), (2), (3), (5), (6), and (8) of AAC Rule 420-5-20.12. 2. Congregate specialty care assisted living facilities shall be planned to serve the residents to be admitted and shall comply with Sections (1), (2), (3), (7), and (8) of AAC Rule 420-5-20-.12. 3. Renovation within the exterior walls of a specialty care assisted living facility shall in no case be of such nature as to lower the character of the structure below the applicable building requirements for the classification of license held by the specialty care assisted living facility. 4. Dually licensed facilities. (i) For the purposes of meeting physical facility and building code requirements, a building housing both a regular assisted living facility and a specialty care assisted living facility shall be classified as a Group or Congregate facility in accordance with the combined licensed bed capacities of both facilities. For the purposes of meeting resident care and administrative requirements, the specialty care assisted living facility and the regular assisted living facility shall be separately considered, and each shall be classified as a Congregate facility or a Group facility in accordance with the licensed bed capacity of each, and the determination shall not be based on their combined bed capacity.	A1201	Continued from page 29 **A 1201** **Physical Environment** The facility failed to ensure the exterior of the building was maintained and needed repairs were addressed. Corrective Action 1. Dry wall in shower room repaired and painted after survey exit completed 10/26/2024 2. Building was pressure washed and cleaned on November 8th,9th,&10th. Monitoring 1. Administrator/designee to round with the maintenance director 3xs week x 2 weeks, then 1x week for 2 weeks, then random audits for 3 months. 2. The monitoring sheets will be kept in the administrators office for review.	03/24/2025

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A1201	Continued From page 30	A1201		

(ii) When a facility has a portion of a building licensed for specialty care residents, instead of the entire facility, the sleeping, bathing, dining, and activity areas shall be in a distinct and separate unit within the building, licensed for specialty care assisted living. Administrative, kitchen, and service areas may be shared between the two licensed portions.

(c) Location. Each specialty care assisted living facility established or constructed shall be located so that it is free from undue noises, smoke, dust, or foul odors. New assisted living facilities shall be located at least 1,000 feet from railroads, freight yards, or disposal plants. This distance can be reduced to 500 feet when facility is separated by a boarded fence at least 6 feet high. This rule shall not prevent enlargement or expansion of existing assisted living facilities.

(d) Local Restrictions. The location and construction of a specialty care assisted living facility shall comply with local zoning, building, and fire ordinances. Evidence to this effect, signed by local fire, building, or zoning officials, may be required as a condition of licensure. If a facility is to be located in an area that does not have any zoning, building, or fire authority review, a letter stating such shall be obtained from the local county commission through official board action or from the office of the probate judge.

(e) Specialty Care assisted living facilities shall be located on publicly maintained streets or roads, and connected with driveways which shall be kept passable at all times.

(f) Occupancy. No part of a specialty

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A1201	Continued From page 31	A1201		

care assisted living facility may be rented, leased, or used for any commercial purpose not reasonably necessary for the residents of the facility. Only residents of the facility shall be permitted to utilize these services. The Department shall approve all plans for occupancy.

(g) Basements. The basement shall be considered as a story if it meets criteria established by the codes for a story.

(h) The specialty care assisted living facility must maintain adequate furnishings, fixtures, supplies, and equipment for its services.

(i) Facilities, supplies, and equipment must be maintained in safe operating condition.

(j) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.

This Rule is not met as evidenced by:
Based on observation and interview, the facility failed to ensure the exterior of the building was maintained and needed repairs were addressed.

Findings:

In the early morning of October 22, 2024, EI#11, a maintenance technician, reported to this building with a list of things from the maintenance director to repair. EI#11 had a list of 19 areas or rooms that had need for repairs. Some of the areas had multiple repair needs. EI#11 reported he was aware of some of the issues. When asked why those repairs had not been made, he

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A1201	Continued From page 32 answered they were short staffed. EI#11 worked at another building on this campus. On the morning of October 22, 2024, the following observations were made with EI#3. In the shower room there was missing sheetrock and crumbled sheetrock observed on the adjacent floor. The vinyl siding and stucco exterior on two sides of the building and in the enclosed courtyard were observed with a heavy black build-up. The front and street end of the building that were visible to visitors were clean. EI#3 said the sides of the building with black build-up needed pressure washing. On the morning of October 24, 2024, EI#10, the maintenance director, admitted he was made aware of the building concerns on October 21, 2024, and agreed with the deficient practice identified. EI#10 was asked why the exterior of the building with heavy build-up of a black substance on sides, out of view of visitors, had not been cleaned. EI#10 said it was going to be cleaned next week. On the morning of October 24, 2024, EI#3 agreed with the surveyor regarding the needed repairs and cleaning. THERESA HARRISON, REGISTERED NURSE GREGORY ZEITLIN, REGISTERED NURSE	A1201		