STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P4102	A. BUILDING: _____ B. WING _____	C 04/15/2025

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SUMMER VILLAGE MAGNOLIA PLACE	1553 PROFESSIONAL PARKWAY AUBURN, AL 36830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments On April 15, 2025, an unannounced licensure and complaint survey was conducted for this 42 bed Specialty Care Assisted Living Facility (SCALF) with a census of 20. There were five (5) complaints investigated during this survey. LC#20250102017, LC#20220629012 and LC#20211213002 were substantiated. LC#20211004010 and LC#20210503012 were unsubstantiated. 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 significant harm for all residents and require a plan of correction.	A 000		
A 301	420-5-20-.03 (1) (a) (b) (c) (d) Administration. (1) The Specialty Care Assisted Living Facility Governing Authority. (a) A specialty care assisted living facility shall have an identified sole proprietorship, corporation, partnership, limited partnership, or other business entity that is its governing authority, or it shall have a designated individual or group of designated individuals who serve as its governing authority. A facility must give complete information to the Department identifying: 1. Each person who has an ownership interest of 10 percent or more of the governing authority.	A 301		

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A 301	Continued From page 1 2. Each person or entity who has an ownership interest of 10 percent or more in the real property or building used by the specialty care assisted living facility to offer its services. 3. Each officer and each director of the corporation if the governing authority is a corporation. 4. Each partner, including any limited partners, if the governing authority is a partnership. (b) The governing authority shall submit any changes to the information listed above to the Department within 15 days of the change. (c) Responsibility of Staff to Governing Authority. The administrator, medical staff, facility personnel, and all auxiliary organizations shall be directly or indirectly responsible to the governing authority. For the purposes of these rules, auxiliary organizations include but are not limited to licensed or certified outside providers, consultants, management companies that are not the facility license holder. (d) The governing authority is responsible for appointing and supervising the administrator who is responsible for overall management and the day-to-day operation of the facility. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days. This Rule is not met as evidenced by: Based on observation, interview and record	A 301		

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A 301	Continued From page 2	A 301		

review, the governing authority failed to adequately oversee the administrator to ensure the facility operated in compliance with the SBOH rules for SCALFs. This failure resulted admission of ineligible residents, retention of ineligible residents, inadequate staffing, poorly managed staff who failed to treat residents with dignity and respect, the inability to meet residents' care and safety needs, lack of adequate health supervision, poorly developed resident care plans that were not current and did not address resident problem areas with appropriate care actions, improper medication management resulting in a significant medication error and potential resident harm, hindered egress and an unsafe environment.

THIS DEFICIENCY WAS CITED AS A RESULT OF COMPLAINT INVESTIGATIONS.

Findings:

The Alabama Department of Public Health received three complaints which were substantiated during the onsite survey. One complaint alleged a resident's sponsor was not notified of an increased dose of Haloperidol and the resident overdosed. Another complaint alleged the facility was understaffed, residents' code status was not documented in charts or in the computer record, residents needed a higher level of care, monthly weights were not obtained, and the administrator was not a licensed administrator. The third complaint from DHR (Alabama Department of Human Resources) alleged the facility had reported to them that a resident had been kicked but the facility did not report the abuse to the ADPH.

On the afternoon of April 15, 2025, Employee

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A 301	Continued From page 3 Identifier (EI)#1, the Administrator, was asked what oversight the governing body provided to ensure timely discharge of ineligible residents. EI#1 said when a resident is no longer eligible and in need of discharge, staff email EI#4, the Vice President of Operations (VPO). EI#4 involves the facility's legal team to ensure accuracy of the resident's eligibility status. EI#1 said EI#4 makes the final decision as to whether or not a resident is discharged. When asked if EI#4 was a licensed administrator at the facility, EI#1 answered no. On the afternoon of April 15, 2025, EI#3, the Executive Director, was asked what oversight he provided to EI#1, the Administrator. EI#3 said they discuss matters and collaborate to support the administrator. EI#3 said during retention meetings they review (a resident) and he(EI#3) gives his opinion. EI#3 did not name any oversight for the day to day operations. Review of EI#3's Job Summary revealed, "... The Executive Director has the ultimate authority over and management responsibility for all functional areas of the ... community and ensures compliance with all current industry standards and guidelines. ..." On the afternoon of April 15, 2025, EI#11, the Corporate Attorney, who was included on emails regarding an ineligible resident, was asked what oversight she provided to EI#1 regarding admission and retention of residents. EI#11 said it was a case by case review and she had attorney-client privileges. On the afternoon of April 15, 2025, EI#4, was asked what oversight she had provided EI#1. EI#4 said they collaborate with EI#1 in the decision making. EI#4 said if a resident is outside of acuity, they (facility staff) notify them	A 301		

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A 301	Continued From page 4	A 301		

(management and their legal department) for a review. EI#4 said she and the legal department collaborate with EI#1 and the legal department issues the discharge notice. EI#4 said they (management) can make any decision as part of the chain of command. When asked if EI#1 had the authority to discharge a resident, EI#4 said no, they collaborate with her (EI#1).

On the afternoon of April 15, 2025, EI#5, the Chief Operating Officer, was asked about the oversight he provided to EI#1. EI#5 said EI#3 and EI#4 are the two people who support EI#1. EI#5 said when there is a potential admission or discharge, EI#3 and EI#4 give guidance or permission. EI#5 said the cooperation is the oversight. EI#5 said the legal department creates the discharge notices. When asked why the discharge for Resident Identifier (RI)#4 was not done in a timely manner, EI#5 said it was in a timely manner (see tag 621). EI#5 said EI#1 cannot discharge a resident without guidance from EI#4. Note: The facility retained RI#4 seven and a half months after RI#4 was identified as needing a higher level of care.

The following deficient practices were cited during the onsite survey as a result of the governing authority's failure to provide appropriate oversight.

302 - The facility failed to establish and implement its own policies and procedures.

303 - The administrator failed to properly manage the day to day operations of the facility and failed to ensure previously cited deficiencies were corrected and compliance with SBOH rules for a SCALF was maintained.

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A 301	Continued From page 5 306 - The facility failed to ensure an acting administrator was licensed. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 401 - The facility was not staffed at all times with at least the minimum staff required. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 402 - Newly employed personnel were not properly screened prior to hire and resident contact. 406 - The facility failed to ensure staff completed all required training. 501 - The facility failed to ensure records were maintained and readily available. 504 - The facility failed to ensure residents were treated with dignity and were free from chemical restraint. 508 - The facility failed to complete investigations of reported incidents and failed to report abuse to ADPH. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON FEBRUARY 1, 2018, (formerly tag 516) AND OCTOBER 4, 2022. 601- The facility failed to ensure physician orders were followed. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 1, 2018 604 - The facility failed to ensure an aphasia screening was completed prior to admission, monthly assessments were completed, monthly	A 301		

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A 301	Continued From page 6 weights were obtained and comprehensive assessments were completed to address decline in health status, behaviors, lethargy and over-sedation. The facility also failed to communicate resident problems with the resident's physician and sponsor and/or family. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON APRIL 27, 2021, AND OCTOBER 4, 2022. 608 - The facility treated a resident who exhibited emergency behavioral symptoms with anti-anxiety and anti-psychotic medications. The facility also treated a resident with an anti-psychotic medication although there was a drug interaction warning. The facility also increased the medication dose without the sponsor being notified. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 611 - The facility failed to develop a current plan of care which contained interventions to meet the care and safety needs of a residents. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON APRIL 27, 2021, AND OCTOBER 4, 2022. 616 - The facility failed to keep medications under control or custody at all times. 620 - The facility admitted a resident who was ineligible to reside in an SCALF. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 621 - The facility failed to discharge or transfer a resident who demonstrated behaviors or symptoms which interfered with the rights or safety of other residents as well as the safety and	A 301		

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A 301	Continued From page 7 well-being of the individual resident. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON APRIL 27, 2021, AND OCTOBER 4, 2022. 702 - The facility failed to properly label food products and ensure adequate equipment and measures were in place to prevent contamination. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON OCTOBER 4, 2022. 804 - The facility failed to maintain cleanliness of the kitchen floors and equipment. 901 - The facility failed to provide adequate, effective and clean lint traps in all dryers. 1001 - The facility failed to maintain water temperature, accessible to residents, no greater than 110 degree Fahrenheit as required. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 1, 2018. 1002 - The facility failed to maintain a safe, functional, decent, sanitary and comfortable environment for residents, staff and the public. 1101 - The facility failed to perform fire drills as required. 1201 - The facility failed to maintain facility equipment in safe operating condition. 1203 - The facility failed to have an operable call system. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.	A 301		

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A 301	Continued From page 8 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON APRIL 27, 2021. 1206 - The facility failed to provided an easily unlockable gate located along the discharge path of travel from the building egress doors to the public way.	A 301		
A 302	420-5-20-.03 (e) Administration. (e) Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). All residents shall be informed of new policies or changes in existing policies that may have bearing on the resident. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies shall cover the following: (i) Facility responsibility to protect all residents from abuse, neglect, and exploitation. (ii) How allegations of abuse, neglect, and exploitation will be handled by the facility. (iii) Resident confidentiality. (iv) Admission and continued stay criteria. (v) Discharge criteria and notification procedures for residents and sponsors.	A 302		

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A 302	Continued From page 9 (vi) Facility responsibility when a resident's personal belongings are lost. (vii) What services the facility is capable and not capable of providing. (viii) Medication management. (ix) Infection control. (x) Meal service, timing, menus and food preparation, storage, and handling. (xi) Fire safety and emergency plan, fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness. (xii) Staffing and conduct of staff while on duty. (xiii) Oxygen administration and storage if used in the facility. (xiv) Dietary Policies. The dietitian, with the approval of the administrator, shall develop written policies and procedures for the guidance of all personnel handling food as outlined by the most current Food and Drug Administration Food Code published by the U.S. Department of Health and Human Services. The facility shall develop and implement dietary policies and procedures to meet the needs of the residents in the facility. In addition to other matters deemed necessary by the facility, dietary policies shall address: (I) Sanitation of dishes, utensils, and service equipment, and sanitary food preparation	A 302		

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A 302	Continued From page 10 and handling. (II) The attire and cleanliness of staff members who prepare, handle, or serve food. (III) A schedule of meals, which shall include between-meal nourishment or snacks, and fluids. (IV) Food substitutions or alternatives. (V) Method to ensure an adequate dietary plan is implemented for any resident with a therapeutic diet or special dietary needs. (VI) Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food. (VII) Provision of necessary services to any resident requiring adaptive devices to eat. (VIII) Procedure for the handling of potentially hazardous foods such as meat, milk, ice, and eggs. (IX) Storage of food. (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. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement its written policies and procedures.	A 302		

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A 302	Continued From page 11 Findings: The facility's policy with the subject "CHANGE IN CONDITION" revealed, "... OBJECTIVE: The Community is a non-medical Community. It is the responsibility of the staff to provide care yet summon medical attention when there is a change in status. When a resident exhibits a change in condition, action will be taken to coordinate appropriate care ... PROCEDURE / POLICY: 1) When a resident displays a change in condition, caregivers notify the Director of Wellness or designee. ... 3) Examples of a Change in Condition may include but are not limited to: b. Decreased mobility / range of motion ... f. Change in level of consciousness ... j. Hallucinations or other unusual behavior ... r. Reaction / side effect to medications ... u. Falls or found on floor. 4) If there is a change in condition the resident's physician and responsible party is notified as appropriate. 6) Document the date and time of contacts with whom you spoke. 7) Clearly document and (any) new directions from the resident's physician and repeat back to the physician ...9) Notify the resident's responsible party of the change in status and action taken ... 11) If the resident status change results in a prohibited health condition, a conference will take place with the Executive director and DW (Director of Wellness) to determine the resident's suitability for retention. ..." Refer to deficiencies 608 and 621 for additional information. The facility's policy with the subject "WEIGHTS" revealed, "... OBJECTIVE: The community monitors resident weight and provides modified diets as ordered by the physician. ... PROCEDURE / POLICY: 1) Weights are obtained and documented monthly for each resident ..."	A 302		

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A 302	Continued From page 12 Residents were not weighed monthly. Refer to deficiency 604 for additional information. The facility's policy with the subject "ADMISSION CRITERIA FOR MEMORY CARE" revealed, "... OBJECTIVE: The Community will admit and retain stable residents in Memory Care with health conditions that can be safely cared for by Community staff and are congruent with state regulatory guidelines. By admitting and retaining the appropriate residents in Memory Care, the community can provide a supportive and safe environment for all. ..." The facility admitted an ineligible resident. Refer to deficiencies 620 and 621 for additional information. The facility's policy with the subject "RESIDENT DISCHARGE AND TRANSFER" revealed, "... OBJECTIVE: To ensure resident discharge and transfer in compliance with state regulations, ... POLICY: For AL (Assisted Living) and MC (Memory Care) communities, it is our policy to only admit residents whose health condition and individual needs align with state admissions criteria and the level of care offered at the community. Residents requiring a higher (or lower) level of care shall be discharged to an alternate facility ..." The facility admitted and retained ineligible residents. Refer to deficiencies 620 and 621 for additional information. The facility's policy with the subject "DOOR ALARM AND MONITORING" revealed, "... OBJECTIVE: To enhance building security, and thus the safety of residents, ... PROCEDURE / POLICY: I. General a. All memory care exterior doors, including courtyard access doors and courtyard gates, must me secured with Maglocks or delayed egress locks, in compliance with local fire codes. ..." Refer to deficiency 1206 for	A 302		

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A 302	Continued From page 13 additional information. Facility policy #936 Titled RESIDENT MEAL SERVICE, dated 7/2021 states: "...Resident's individual choices are actively sought after and honored." , "...Accurately assemble each meal in accordance with Resident request/menu spreadsheet and meal ticket." Encourage Resident participation in meal selection. (May include selection of the entire meal or any component of the meal)". Refer to tag 504 for additional information. On the afternoon of April 15, 2025, EI#1 acknowledged policies and procedures were not followed.	A 302		
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 administrator shall meet all applicable statutory requirements. 4. There must be an individual with experience in the day-to-day operation of the	A 303		

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A 303	Continued From page 14 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 residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting.	A 303		

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A 303	Continued From page 15 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, 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. EI#1 failed to ensure the facility operated in accordance with the rules of the SBOH for SCALFs and failed to ensure previously cited deficiencies were corrected and compliance was maintained. These failures resulted in actual harm for two residents and placed all 20 residents at risk for significant harm. Findings: The Alabama Department of Public Health received three complaints which were substantiated during the onsite survey. One complaint alleged a resident was overdosed on Haloperidol and the sponsor was not notified of an increased dose. A second complaint alleged the facility was understaffed, resident's code	A 303		

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A 303	Continued From page 16	A 303		

status was not documented in charts or in the computer record, residents needed a higher level of care and monthly weights were not obtained. The third complaint was from DHR alleging the facility had reported a resident had been kicked but the facility did not report the allegation of abuse to the ADPH.

The following deficient practices were a result of EI#1's failure to implement the SBOH rules for specialty care assisted living facilities.

EI#1 did not ensure the facility was staffed with at least the minimum required staff at all times. Refer to tag 401

EI#1 did not ensure newly employed personnel were properly screened prior to hire and resident contact. Refer to tag 402

EI#1 did not ensure all staff completed required training. Refer to tag 406

EI#1 did not ensure records were maintained and readily available. Refer to tag 501

EI#1 did not ensure residents were treated with dignity and free of chemical restraint. Refer to tag 504

EI#1 did not ensure incidents were investigated and abuse was reported to ADPH. Refer to tag 508

EI#1 did not ensure physician's orders were followed. This resulted in a significant medication error. Refer to tag 601

EI#1 did not ensure an aphasia screening, monthly assessments and comprehensive

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A 303	Continued From page 17 assessments with changes in condition were completed. Residents were not weighed monthly. Refer to tag 604 EI#1 allowed a resident with emergency behaviors to be treated with anti-anxiety and anti-psychotic medications. Also, a resident was given an anti-psychotic medication even though there was an interaction warning. Refer to tag 608 EI#1 did not ensure resident plans of care were current and appropriate. Refer to tag 611 EI#1 did not ensure the facility kept medications under lock as required. Refer to tag 616. EI#1 admitted a resident who was ineligible to reside in a SCALF. Refer to tag 620 EI#1 retained a resident whose health and/or safety needs were beyond the capability of the facility. Refer to tag 621 EI#1 did not ensure food was labeled properly, adequate equipment and measures were used so that food was not contaminated. Refer to tag 702 EI#1 did not ensure kitchen floors were clean. Refer to tag 804 EI#1 did not ensure laundry lint traps were cleaned. Refer to tag 901 EI#1 did not ensure water temperatures were not greater than 110 degrees Fahrenheit. Refer to tag 1001 EI#1 did not ensure fire drills were conducted as required. Refer to tag 1101	A 303		

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A 303	Continued From page 18 EI#1 did not ensure equipment was maintained in safe operating condition. Refer to tag 1201 EI#1 did not ensure the facility had an operable call system. Refer to tag 1203 EI#1 did not ensure egress was not hindered. Refer to tag 1206 Repeat Deficiencies The facility failed to follow it's policies. Survey conducted 04/07/2021 Investigations of incidents were not completed. Surveys conducted 02/01/2018 (516) and 10/04/2022 Assessments were not completed and monthly weights were not obtained. Surveys conducted 04/07/2021 and 10/04/2022 Care plans were not current and appropriate. Surveys conducted 04/07/2021 and 10/04/2022 Physician's orders were not followed (formerly tag 601). Survey conducted 02/01/2018 The facility retained a resident whose health and/or safety needs were beyond the capability of the facility. Surveys conducted 04/07/2021 and 10/04/2022 Potential for contamination of food. Survey conducted 10/04/2022 Water temperatures were found greater than 110 degrees Fahrenheit. Survey conducted 02/01/2018	A 303		

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A 303	Continued From page 19 An inoperable call system. Survey conducted 04/07/2021 On the afternoon of April 15, 2025, EI#1 agreed with the above deficient practices. She responded to each deficiency as either an oversight or it would be corrected. She denied knowledge of insufficient staffing, adding it would be corrected. EI#1 admitted RI#3 was an ineligible admission but did not have a reason for him being admitted while ineligible.	A 303		
A 306	420-5-20-.03 (2) (d) Administration. (d) Protection. 1. A specialty care assisted living facility must meet the applicable provisions of federal law and regulations pertaining to nondiscrimination on the basis of race, color, gender, religion, or national origin; nondiscrimination on the basis of handicap; nondiscrimination on the basis of age; protection of human subjects of research; and protection from fraud and abuse. Although federal law and regulations are not normally surveyed and enforced by the State Board of Health in assisted living facilities, serious violations of these provisions of law may nevertheless constitute grounds for adverse licensure action. 2. A specialty care assisted living facility shall obey all applicable federal, state and local laws, ordinances, and regulations. 3. Licensing of Staff. Staff of the facility shall be currently licensed, certified, or registered in accordance with applicable laws.	A 306		

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A 306	Continued From page 20 4. Compliance with Other Laws. A specialty care assisted living facility shall comply with laws relating to fire and life safety, sanitation, and communicable and reportable diseases. This Rule is not met as evidenced by: Based on interview and record review the facility failed to ensure the license was current for an employee acting as administrator. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged EI#23, a former administrator, was not a licensed administrator. A review of EI#23's license history revealed a valid Alabama Administrator's license was issued for November 2022, through November 2023. EI#23 served as the administrator of the facility from October 4, 2021, until January 9, 2023. However, EI#23 was not a licensed administrator from October 2021 until November 2022. On the afternoon of April 14, 2025, EI#1 confirmed EI#23's dates of employment as administrator.	A 306		
A 401	420-5-20-.04 (1) (2) Personnel. (1) A specialty care assisted living facility	A 401		

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A 401	Continued From page 21 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.	A 401		

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
10	73 - 80 Residents	109 - 120 Residents	145 - 160 Residents

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A 401	Continued From page 22 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 maintained by the Alabama Department of Public Health. This individual may not work unless	A 401		

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A 401	Continued From page 23 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 record review and interview, 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: The Alabama Department of Public Health received a complaint alleging the facility was understaffed. The complaint was substantiated. At the time of the initial onsite survey from April 8-15, 2025, the census of the facility was 20 residents with 19 residents currently in house. Review of employee schedules, revealed the required number of staff were scheduled and time cards reviewed showed they worked their perspective shifts. However, interviews were conducted with staff and it was determined that staff clocked in to work but then were pulled to sister facilities (not on the same campus). Yet they were still clocked in as though they were working in the facility. On the afternoon of April 14, 2025, EI#9, a LPN,	A 401		

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A 401	Continued From page 24 reported staff were pulled to go to another building and the facility was left short-staffed. On the afternoon of April 14, 2025, EI#16, a CA, was asked about being pulled to another facility after clocking in. EI#16 reported he was pulled Sunday, April 6, 2025, during third shift and later EI#17, a CA, was pulled, leaving only two staff members in the building. On the afternoon of April 14, 2025, EI#17 acknowledged he was pulled to another building on April 6, 2025, during third shift leaving only two staff in the building. EI#17 reported EI#2, the Director of Wellness, did that all the time. On the morning of April 15, 2025, EI#9, the former Director, said often they only had two staff members on third shift. EI#9 added EI#2 only scheduled two staff to be on duty because EI#4 and EI#5 said to staffing needed to be cut. On the morning of April 15, 2025, EI#2 was asked why she pulled staff to other buildings leaving only two staff on duty during the third shift. EI#2 answered it should not have happened. EI#2 acknowledged three staff are required for a census of twenty residents. On the afternoon of April 15, 2025, EI#1 acknowledged the minimum number of staff had not been present during some third shifts.	A 401		
A 402	420-5-20-.04 (3) Personnel. (3) Employee Screening. (a) Prior to any resident contact, such as but not limited to assistance with activities of daily	A 402		

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A 402	Continued From page 25 living, newly employed personnel shall have a physical examination certifying that the employee is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to residents through normal staff to resident contact. Employees who develop signs or symptoms of infectious skin lesions or diseases that would be capable of transmission to residents through normal staff to resident contact shall not be permitted to have resident contact until free from such signs and symptoms. (b) Not more than 30 days prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis. (c) Vaccines. Specialty care assisted living facilities shall immunize employees in accordance with current recommended Centers for Disease Control and Prevention (CDC) guidelines (www.cdc.gov/vaccines). Any particular vaccination requirement may be waived or delayed by the State Health Officer in the event of a vaccine shortage. (d) A specialty care assisted living facility shall not hire an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry. This Rule is not met as evidenced by: Based on record review and interview, a newly employed staff member was not properly screened prior to hire and resident contact. Findings: Review of employee files on the morning of April	A 402		

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A 402	Continued From page 26 14, 2025, revealed EI#7, a Licensed Practical Nurse (LPN), had not been screened through the Alabama Department of Public Health Nurse Aide Abuse Registry prior to hire. On the afternoon of April 15, 2025, EI#1 acknowledged there was no abuse registry check for EI#7.	A 402		
A 406	420-5-20-.04 (9) Personnel. (9) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. An RN shall identify staff training needs and shall provide or arrange for needed training. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that, prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on specialty care assisted living facilities. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire. 5. Identifying and reporting abuse, neglect,	A 406		

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A 406	Continued From page 27 and exploitation. 6. Basic first aid. 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environmental safety. (b) Prior to providing any resident care, all staff shall complete The Dementia Education and Training Act (DETA) Care Series Training developed by the Alabama Department of Mental Health or equivalent training approved by the State Health Officer. All licensed staff shall complete DETA Brain Series Training, The Pharmacological Management of Dementia, and the Dementia Assessment Series provided by the DETA Program or equivalent training approved by the State Health Officer prior to resident contact. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained. (c) All staff who have resident contact shall be able to demonstrate diversional methods and redirection. All staff shall be able to demonstrate an understanding of the implications of caring for residents with agnosia, amnesia, aphasia, and apraxia. All staff shall be able to demonstrate an understanding of the facility's fire and evacuation plan and all other policies regarding safety, including policies for preventing elopements, responding to elopements, and fall prevention. (d) Cardiopulmonary Resuscitation. A	A 406		

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A 406	Continued From page 28 specialty care assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of a specialty care assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within 90 days of hire. A specialty care assisted living facility equipped with an automated external defibrillator (AED) shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or the American Red Cross in CPR or AED utilization. (e) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training. (f) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff completed all required training.	A 406		

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A 406	Continued From page 29 Findings: Review of employee files on the morning of April 14, 2025, revealed the following information was missing. EI#1, EI#17, a Care Associate (CA) and EI#18, a CA, had not been trained on the State law and rules for a SCALF. On the afternoon of April 15, 2025, EI#1 confirmed the training had not been completed and that it was being added to their Relias training curriculum.	A 406		
A 501	420-5-20-.05 (1) Records and Reports. (1) General. (a) Responsibility for Records. The administrator shall prepare and file all records, or shall oversee the preparation and filing of records. This duty shall be assigned to other employees in the administrator's absence. (b) All records and reports required by these rules shall be completed in a timely manner, and shall be maintained and filed in an orderly manner within the specialty care assisted living facility premises. (c) Storage and Safety. Provision shall be made for the safe storage of records within the facility. Records shall be stored in a manner to reasonably protect them from water or fire damage. Records shall be safeguarded from unauthorized access. (d) All facility records, including resident	A 501		

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A 501	Continued From page 30 medical records, shall be made readily available for review and copying by representatives of the Alabama Department of Public Health upon request. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain records and make them available to the surveyors. Findings: Meal Selection On the morning of April 9, 2025 at 8:30AM the surveyor requested from the Wellness Director, EI#2, the resident menu selection records for RI#1, RI#5 and RI#4. At 11:30AM, EI#2 stated the facility did not have a meal selection process, therefore, they did not have menu selection records for residents. The surveyor reminded EI#2 that Community Policy #936 indicated menu selection was a standard practice for the community. EI#2 stated she was unaware of the policy. On the morning of April 10, 2025 EI#18 was asked how residents let staff know what they wanted to eat at mealtimes. EI#18 stated residents filled out a menu selection form and told the caregiver what they wanted then the caregivers gave the forms to the kitchen. Hospice On the morning of April 9, 2025, the facility record for RI#3 was reviewed and no hospice records were found. On the afternoon of April 9, 2025, EI#2 said they	A 501		

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A 501	Continued From page 31	A 501		

would have to get the hospice records from the hospice company.

Fire Drills
On the morning of April 10, 2025 the Administrator, EI#1, was asked for the missing Fire Drill Reports and Fire Inspection Reports. EI#1 stated she could not provide them. EI#1 concurred with the surveyor's observation that Fire Drills and Fire Inspections were not done.

Medication Orders
On the morning of April 14, 2025 the Wellness Director, EI#2, was asked for all orders for Haldol for RI#4, in particular the resident's injectable Haldol order. The facility could not provide the order for RI#4's Haldol.
Note: The medication cart contained twenty-seven (27) one-milliliter vials of Haldol 2 mg/mL. EI#2 stated the medication was scheduled for destruction but had not been destroyed.
The pharmacy provided a copy of the injectable Haldol order to the surveyor.

Record of Geriatric Psychiatric Admission for RI#4
On the afternoon of April 14, 2025, review of RI#4's facility record revealed there was no information regarding a discharge to a geri-psych facility.

On the afternoon of April 14, 2025, EI#2 reported she had no information regarding the admission to the geri-psych facility. EI#2 agreed to retrieve the information from that facility

Incident Reports and Investigations
A review of reportable incidents in the OIRS (Online Incident Reporting System) revealed the

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A 501	Continued From page 32 following: 20240801010 - the facility investigation was requested by the surveyor reviewing the online report. However, no investigation was submitted. EI#1 could not locate the investigation for the incident. 20240426015 - the requested investigation for the online report was submitted but it was inadequate. EI#1 could not locate the investigation for the incident. 20240306012 - the requested investigation was submitted for review, however, it did not match what was reported to the department. EI#1 could not locate the investigation for the incident. 20230915003 - the facility investigation was requested by the surveyor reviewing the online report. However, no investigation was submitted. 20230412016 - the facility investigation was requested by the surveyor reviewing the online report. However, no investigation was submitted. EI#1 could not locate the investigation. EI#1 could not explain why she did not have any of these investigations that occurred during her tenure as administrator.	A 501		
A 504	420-5-20-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission, of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights	A 504		

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A 504	Continued From page 33 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. 1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility. 2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints. 3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy. 4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time. 5. Every resident shall have freedom to participate in and benefit from social, religious, and community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. 6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian	A 504		

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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.

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.

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.

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.

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.

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

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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.

12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person without restraint, interference, coercion, discrimination, or reprisal.

13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file.

14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the facility, provided that:

(i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care.

(ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless

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A 504	Continued From page 36 the service is to be performed without compensation. (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. 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. 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. 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. 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.	A 504		

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A 504	Continued From page 37 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. 20. Every resident shall have the right to 30 days prior written notice of any involuntary change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. 21. Every resident shall have the right to wear his or her own clothes, and to keep and use his or her own personal possessions, including toilet articles, except for personal possessions too large to be stored in the resident's room. 22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings. 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure residents	A 504		

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A 504	Continued From page 38 were treated with dignity and were free from chemical restraint. The facility also treated a resident with an anti-psychotic medication even though there was a drug interaction warning in the facility records and increasing the dose without the sponsor being notified. Findings: Dignity At 12:02 PM on April 8, 2025, an observation was made of lunch being served but no drinks were served with the meal. Fifty minutes later at 12:52 PM, tea was served. At 7:17 AM on the morning of April 9, 2025 an observation was made of fifteen residents seated in the dining room waiting for breakfast to be served. It was noted the tables were completely empty and there was nothing available for residents to drink while they waited. Food was served at 7:51 AM. At 8:01 AM residents were observed eating breakfast with only water to drink. At 8:03 AM coffee and juice were delivered but there was no milk. On the morning of April 9, 2025, EI#1 was asked what was supposed to happen when residents were seated in the dining room before breakfast. EI#1 said staff should be serving fluids to the residents while they waited for their meals to be delivered. On the morning of April 9, 2025 it was observed that residents meals were not identical. EI#15 said residents notify the caregivers of their selection from the menu and the caregivers give the information to the kitchen. EI#2 was asked for the menu selections of three residents. EI#2 stated the community did not have a meal	A 504		

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selection process as described by the caregivers. Facility policy #936 Titled RESIDENT MEAL SERVICE, dated 7/2021 states: "...Resident's individual choices are actively sought after and honored." , "...Accurately assemble each meal in accordance with Resident request/menu spreadsheet and meal ticket." Encourage Resident participation in meal selection. (May include selection of the entire meal or any component of the meal)".

On the morning of April 15, 2025, EI#2 was asked why residents were seated in the dining room with no fluids to drink. EI#2 said that should not have happened. EI#2 was asked why residents were not served the food they had ordered or given the opportunity to choose what they wanted. EI#2 said staff failed to follow procedure.

Chemical restraint
RI#4 was admitted to the facility on October 20, 2015, with admitting diagnoses that included dementia, hypertension, colon cancer, anxiety, Alzheimer's disease and history of urinary tract infections. RI#4's medications included two different psychotropic medications, Haldol and Ativan.

On the morning of April 9, 2025, during a medication administration observation, it was revealed that a medication error had occurred with the administration of RI#4's Haloperidol 2 mg tablet, (Refer to 613 for further details). The physician was notified by the Wellness Director and a statement from the prescriber was obtained. The error resulted in the resident being over sedated and chemically restrained causing potential harm to the resident.

On the morning of April 9, 2025 the surveyor

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A 504	Continued From page 40 attempted to interview RI#4. RI#4 was unable to coherently answer questions, even simple yes or no questions. Every question was answered with a muffled, mumbled response that was completely incoherent. The surveyor was unable to effect meaningful communication with RI#4. RI#3 The Alabama Department of Public Health received a complaint which alleged a resident was overdosed on Haldol and the sponsor was not notified of the increased dose. The complaint was substantiated during the onsite survey. RI#3 Resident treated with an anti-psychotic medication (Haloperidol), even though there was a drug interaction warning Review of RI#3's facility record revealed RI#3 was admitted on October 7, 2024. The October 2024, MAR (Medication Administration Record) revealed RI#3's oral medications were not administered until October 20, 2024. RI#3 was admitted with a prescription for "... Donepezil 10 mg (milligrams) 1 (one) tab (tablet) @ (at) bedtime ..." On October 17, 2025, the record revealed, "... DONEPEZIL 10 MG TABLET INTERACTS WITH HALOPERIDOL 5MG TABLET ... DONEPEZIL/QT PROLONGING AGENTS SEVERITY LEVEL 2-SEVERE INTERACTION ACTION IS REQUIRED TO REDUCE THE RISK OF SEVERE ADVERSE INTERACTION ..." NOTE: QT prolonging agents are medications that can increase the QT interval on an electrocardiogram (ECG), potentially leading to a dangerous heart rhythm.	A 504		

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A 504	Continued From page 41 On November 5, 2024, the record revealed, "... DONEPEZIL 10 MG TABLET INTERACTS WITH HALOPERIDOL LACTATE 2MG/ML (MILLILITER) ORAL CONCENTRATE ... DONEPEZIL/QT PROLONGING AGENTS SEVERITY LEVEL 2-SEVERE INTERACTION ACTION IS REQUIRED TO REDUCE THE RISK OF SEVERE ADVERSE INTERACTION ..." The October 2024, MAR revealed the Haloperidol had a diagnosis of "behavior" and on October 20, 2024, RI#3 began receiving Donepezil 10 mg at bedtime along with Haloperidol 5 mg at bedtime. This was a total of eleven doses in October. The MAR for November 2024, revealed RI#3 received Donepezil 10 mg at bedtime along with Haloperidol that was changed to oral concentrate (liquid) and increased to 10 mg twice daily. NOTE: This twenty mg/day was administered to RI#3, an elderly resident in his/her nineties, for fifteen days by facility staff. The pharmacy dispersion forms revealed, "... Patient: (Names RI#3) ... Drug Prescribed: Haloperidol 5 mg tablet ... Directions: 1 tab po (by mouth) at bedtime ... Effective Date: 10/16/2024 ... Drug Prescribed: Haloperidol Lactate Oral Concentrate 2 MG/ML ... Directions: 5ml po bid (twice a day) ... Effective Date: 10/30/2024 ..." Review of the "Client Medication Report" dated October 10, 2024, revealed, "... HALOPERIDOL 5MG TABLET 10/17/2024 CENTRAL NERVOUS SYSTEM AGENTS ..." Review of the "PHYSICIAN CERTIFICATION STATEMENT" dated October 29, 2024, revealed, "... What is patient's diagnosis / condition that requires an ambulance transport? ... Dementia, bed bound ..." NOTE: Two days later RI#3's dose of Haloperidol was increased from 5 mg once a day at bedtime, to 10 mg twice a day even though	A 504		

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A 504	Continued From page 42 RI#3 was bedbound and lethargic. Review of assessments performed by EI#2 for RI#3 revealed: "... Assessment Date: 10/04/2024 Reason for Assessment: Pre-Admission Completed By: (Names EI#2) ... Behaviors Resident does not have current or history of ..." "... Assessment Date: 10/08/2024 Reason for Assessment: Initial Completed By: (Names EI#2) ... Behaviors Resident does not have current or history of ..." "... Assessment Date: 11/07/2024 Reason for Assessment: Change of condition Completed By: (Names EI#2) ... Behaviors Resident does not have current or history of ..." TAG 504 Review of the facility record revealed there was no documentation of behaviors and no apparent reason for an increase in the dose of Haloperidol. In addition there was no documentation of notification of the sponsor of the increase in dose. On the afternoon of April 9, 2025, RI#3's sponsor reported RI#3 was supposed to get Haloperidol at bedtime to help him/her sleep but she did not have knowledge of the increase in dose. RI#3's sponsor claimed the facility added an AM dose of the Haloperidol without her knowledge and RI#3 subsequently suffered a huge decline. RI#3's sponsor attributes his/her decline to unauthorized use of Haloperidol. On the morning of April 15, 2025, EI#2 said RI#3 was not on Haloperidol when admitted to the facility. EI#2 was asked why RI#3 was given Haloperidol. EI#2 said it was given for behaviors. EI#2 acknowledged there was no documentation of behaviors for RI#3 nor evidence of behavior monitoring. EI#2 acknowledged the family, doctor	A 504		

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A 504	Continued From page 43 and nurse supervisor should be notified of any changes. When asked why the family was not notified of RI#3's increased dose of Haloperidol, EI#2 said she was not aware the sponsor was not notified. EI#2 acknowledged medications administered to RI#3 could have had an adverse effect. EI#2 was asked about the Ambulance Transport Certification dated October 29, 2024. EI#2 said the diagnosis was bedbound and that was concerning. EI#2 was asked what was done about the drug interaction warning and she said nothing was done that she was aware of. EI#2 confirmed the risk of giving Haloperidol to the elderly had the potential for an adverse effect. EI#2 was asked why, with the well documented lethargy, was the Haloperidol dose increased from 5 mg at bedtime to 10 mg twice a day for this very elderly resident. EI#2 said the hospice staff said family had requested it. RI#3's sponsor denied EI#2's statement. Review of RI#3's facility record revealed RI#3 was admitted on October 7, 2024. The October 2024, MAR (Medication Administration Record) revealed RI#3's oral medications were not administered until October 20, 2024. RI#3 was admitted with a prescription for "... Donepezil 10 mg (milligrams) 1 (one) tab (tablet) @ (at) bedtime ... Memantine 10 mg ... Aricept 10 mg ... Acetaminophen 325 mg ... Ammonium Lactal 12% ..." The October 2024, MAR revealed on October 20, 2024, RI#3 began receiving Haloperidol 5 mg at bedtime. The MAR for November 2024, revealed RI#3 received Haloperidol that was changed to oral concentrate (liquid) and increased from 5mg once a day to 10mg twice a day. NOTE: RI#3 was very elderly and was given this higher dose of an extremely powerful first-generation antipsychotic for fifteen days by facility staff.	A 504		

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A 504	Continued From page 44 Haldol (haloperidol) is on the Beers Criteria list for potentially inappropriate medication use in older adults. The list recommends avoiding Haldol for behavioral problems associated with dementia unless non-pharmacological options have failed and the patient is a danger to themselves or others. The 2023 AGS Beers Criteria specifically notes that haloperidol is classified as a high-risk medication for older adults. Review of the facility record revealed no reason for the increase in the dose of Haloperidol or notification of the sponsor of the increase in dose. On the afternoon of April 15, 2025, EI#1 was asked about the interaction warning for Haloperidol and Donepezil. EI#1 said if there is a warning, the assumption is they should not be given together.	A 504		
A 508	420-5-20-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in a specialty care 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 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. 1. Incidents which require investigation are: (i) An accident or injury of known or unknown origin that was unusual or suspicious in	A 508		

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A 508	Continued From page 45	A 508		

nature such as extensive 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.

(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.

(iii) The onset of wandering behavior by any resident who is not fully cognitively intact.

(iv) Elopement by a resident.

(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.

(vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules.

(vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules.

(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 to Alabama Administrative Code Sec. 420-4-1-.04 (for

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A 508	Continued From page 46 example food-borne illness, scabies, influenza, or Staphylococcus aureus). (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. (x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (xi) An unplanned occurrence that results in media attention. (xii) A medication error, overdose, or over sedation. (xiii) Ingestion by a resident of a toxic substance that requires medical attention. (xiv) Any indication of malfunction of the sprinkler system, or fire alarm system. 2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following: (i) Names of all residents involved. (ii) Names of all staff involved including person in charge at the time of the incident. (iii) When the administrator was notified (date and time). (iv) Circumstances under which the incident occurred.	A 508		

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A 508	Continued From page 47 (v) When the incident occurred (date and time). (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken. (viii) The extent and description of injury, if any, to the affected resident or residents. (ix) Immediate treatment rendered. (x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified. (xi) Names, telephone numbers, and addresses of witnesses. (xii) Date and time relatives or sponsor were notified. (xiii) Out-of-facility treatment. (xiv) Follow-up care. (xv) Outcome resolution. (xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future. (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.	A 508		

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A 508	Continued From page 48 (xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request. (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. (xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff. 3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident: (i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention. (ii) Elopement by a resident. (iii) Suspected, alleged, confessed, witnessed, or actual abuse, neglect, or exploitation of a resident or 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.	A 508		

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A 508	Continued From page 49 (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. (v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (vi) An unplanned occurrence that results in media attention. (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. (viii) Ingestion by a resident of a toxic substance that requires medical attention. (ix) Notifiable diseases and health conditions listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04. shall also 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 maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than three years. (x) Any indication of a malfunction of the sprinkler system, fire alarm system, or a door locking device. 4. The report to the Department's Online Incident Reporting System shall include the following:	A 508		

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A 508	Continued From page 50 (i) Facility name and direct phone number. (ii) Time and date of the report. (iii) Reporter's name. (iv) Name of resident(s), staff, or visitor(s) involved in the incident. (v) Names of staff on duty at the time of the incident. (vi) Date and time of the incident. (vii) A brief description of the incident. (viii) Any injury or injuries to resident(s). (ix) Action taken by the facility in response to the incident. (i) Vital Statistics Reports. A record shall be kept of all births, deaths, and stillbirths that occur within the specialty care assisted living facility. By the fifth day of each month, the administrator shall make a report of such births, deaths, and stillbirths for the preceding month on such forms as the State Board of Health shall provide to the county health officer, or in counties without a county health officer, to the State Registrar. This report shall be in addition to the official birth, death, and stillbirth certificates. If there are no births, deaths, or stillbirths in any month, a report shall be made stating that fact to the county health officer.	A 508		

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A 508	Continued From page 51 This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure incident investigations were completed and requested information was provided to the ALF unit. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON FEBRUARY 1, 2018, (formerly tag 516) AND OCTOBER 4, 2022. Findings: Review of reportable incidents found in the OIRS (Online Incident Reporting System) revealed the following: 20240801010 - On July 31, 2024, at 3:30PM, the resident was found on the floor laying on his/her left side. The resident sustained a left hip fracture. The incident report documented the resident's spouse refused to allow the facility to send the resident to the hospital for care. A complete investigation was requested by the ALF unit on August 1, 2024 for review. The facility did not respond to the ALF unit's request. During the survey, the surveyor requested the facility's investigation. EI#1 could not find one. There was no investigation into how the fall with injury occurred and/or why the facility did not ensure the resident received emergency care. 20240426015 - On April 26, 2024, at 1:30AM, the resident was found on the floor. The resident was transported to ER (Emergency Room) via ambulance. The resident was admitted to hospital	A 508		

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A 508	Continued From page 52	A 508		

with a left hip fracture. The incident report documented the resident was unable to verbalize how the fall occurred. A complete investigation was requested by the ALF unit on April 29, 2024 for review. On April 30, 2024, the facility submitted only the information that had been included in the incident report without any investigation to determine how the resident sustained a left hip fracture. During the survey, the surveyor requested the facility's investigation. EI#1 could not find one.

20240306012 - On March 6, 2024, an incident report was received that indicated on March 5, 2024, at 5:20PM there was a resident on resident altercation. A resident was observed by a care associate to hit another resident with his/her cane and knock that person to the floor. The injured resident had bruising to his/her abdomen. The following information was requested regarding the combative resident. The most recent Physicians' Medical Examination prior to 03/05/24, the most recent Behavior Screen prior to 03/05/24, the Care Plan and if the combative resident was sent out for medical assessment. The following information was requested for the injured resident; did the resident receive medical attention. The information submitted by the facility indicated a resident eloped, ran out into traffic and hit a caregiver with his/her cane. During the survey, the surveyor requested the facility's investigation. EI#1 could not find one.

20230915003 - On September 15, 2023, at 5:00AM a resident was found on the floor with a laceration to his/her forehead. The resident was unable to verbalize how he/she fell. The resident was transported via ambulance to the ER and returned with a diagnoses of fall with hematoma. A complete investigation was requested by the

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A 508	Continued From page 53 ALF unit on September 18, 2023. During the survey, the surveyor requested the facility's investigation. EI#1 could not find one. 20230412016 - An incident report was submitted that indicated on April 11, 2023, at 3:00PM, a nurse noted a resident had edema to his/her left ankle. Assessment revealed pitting edema with discoloration. An x-ray revealed a left ankle fracture. A complete investigation was requested by the ALF unit on September 18, 2023. The information submitted was only a repeat of what the incident report contained with no investigation. During the survey, the surveyor requested the facility's investigation. EI#1 could not find one. On the afternoon of April 14, 2025, EI#1 acknowledged there were no investigations. EI#1 could not give an explanation for the missing investigations.	A 508		
A 601	420-5-20-.06 (1) Care of Residents. (1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician. (a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her choice. If the resident is unable to designate an attending physician, or does not wish to designate an attending physician, the facility shall assist the resident in identifying an attending physician who will serve the resident. A resident shall be permitted to change the designation of his or her attending physician at any time. Whenever a resident requires medical attention,	A 601		

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A 601	Continued From page 54 an attempt shall first be made to contact the resident's attending physician, except in medical emergencies requiring activation of the local EMS system (911 or other emergency call). (b) Back-up Physician Support. Each specialty care assisted living facility shall have an agreement with one or more duly licensed physicians to serve in those instances when a resident's own attending physician cannot be reached, and to provide temporary medical attention to any resident whose attending physician is temporarily not available. A nurse practitioner or physician's assistant shall not serve as the back-up physician in a specialty care assisted living facility. (c) All physician orders shall be written in accordance with community standards. If verbal orders are used, they are to be used infrequently. A physician verbal order shall only be accepted by an RN or LPN employed by the facility and authorized to do so by facility policy and procedures and state law. All verbal orders shall be reduced to writing on the physicians' order sheet by a licensed facility nurse and shall be dated and signed by the nurse receiving the order. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, or another practitioner who is responsible for the care of the resident and authorized to write orders by facility policy. All verbal orders must be authenticated within such time period as provided by facility policy, but in no case shall exceed 30 days following entry of the order. This Rule is not met as evidenced by:	A 601		

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A 601	Continued From page 55 Based on record review, interview and observation the facility failed to follow physician orders. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 1, 2018. Findings: On the morning of May 15, 2025 during a medication administration observation the nurse was observed administering Haldol 2 mg tablet to RI#4. It was revealed during record review that the order for Haldol 2mg by mouth twice daily had expired. The Medication Administration Record (MAR) indicated the Haldol 2 mg tablet was to be given twice daily, the physician order dated March 3, 2025 indicated that the medication was for only 14 days. It was revealed that during monthly MAR validation process, the Haldol 2 mg tablet dosage had not been validated by the facility. The physician order had expired, however, the facility continued to administer the medication for an additional eight days. April 1, 2025 0800 1700 April 2, 2025 0800 1700 April 3, 2025 1700 April 4, 2025 0800 1700 April 5, 2025 0800 1700 April 6, 2025 0800 April 7, 2025 0800 1700 April 8, 2025 0800 The surveyor contacted the pharmacy for copies of any additional orders extending the use of Haloperidol 2 mg tablet twice daily, none were found. The community could not provide a copy of any continuation order for Haloperidol 2 mg tablet beyond the initial 14 day usage. The	A 601		

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A 601	Continued From page 56 physician was notified by the Wellness Director and a statement from the prescriber was obtained. The pharmacy verified that a PRN dosage of Haloperidol 1 mg tablet was extended. The facility was not aware of the error until the day of the survey when the surveyor made the observation. On the morning of April 9, 2025 surveyor attempted to interview RI#4, RI#4 was unable to coherently answer questions, even simple yes or no questions. Every question received a muffled mumble response that was completely incoherent, surveyor was unable to effect good communication, RI#4 would respond to questions with incoherent rambling on random non-connected thoughts. Interviews conducted with staff (EI#8, EI#10, EI#13, EI#15) revealed that RI#4 was able to communicate with staff members prior to the administration of Haldol.	A 601		
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	A 604		

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A 604	Continued From page 57 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 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.	A 604		

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A 604	Continued From page 58 (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 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.	A 604		

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A 604	Continued From page 59 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Registered Nurse (RN) or Care Coordinator completed an aphasia screening of prospective residents prior to admission, completed monthly assessments as required, ensured weights were obtained and recorded monthly and performed comprehensive assessments to address declines in health status, behaviors, lethargy and over-sedation. In addition, the RN failed to communicate significant changes with the residents physician and sponsor and family. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON APRIL 27, 2021, AND OCTOBER 4, 2022. Findings: RI#1 was admitted to the facility on February 5, 2021, with diagnoses to include adjustment disorder with anxiety, memory dysfunction, osteoarthritis, right knee pain, coronary artery disease, cerebral infarction, vascular dementia, hypertension and diabetes mellitus type II. RI#1 had no monthly assessments completed for December 2023, or April 2024. RI#1 had no weight obtained for March 2025. RI#2 was admitted to the facility on June 22, 2024, with diagnoses to include coronary artery disease, cerebral infarction, vascular dementia, hypertension and diabetes mellitus type II. RI#2 had no monthly assessment completed for August 2024. RI#2 had no weight obtained for July 2024, August 2024, October 2024, November 2024, and February 2025.	A 604		

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A 604	Continued From page 60 RI#3 was admitted to the facility on October 7, 2024, with diagnoses to include vascular dementia and chronic kidney disease. There was no aphasia screening of RI#3. RI#3's facility record included a speech therapy assessment dated October 24, 2024, with a diagnoses of aphasia that was not identified on admission because the screening was not completed as required. On the morning of April 15, 2025, EI#2 said they do not perform aphasia screenings. RI#3's facility record revealed the following. Rehab (Rehabilitation) note dated October 22, 2024, "... Pt (patient) required max-total assist for self-care skills due largely to pt's lack of alertness. Patient is max (maximum) assist to total(ly) dependent for all mobility. ,,, unable to sit independently ... Overall patient would benefit from next level of care at this time due to (his/her) cognition and overall level of mobility. ... Patient unable to follow commands ..." A "PHYSICIAN CERTIFICATION STATEMENT (PCS) for AMBULANCE TRANSPORT" document revealed, "... (Name of RI#3) ... What is patient's diagnosis / condition that requires an ambulance transport? ... Dementia, bed bound ..." Facility nurses' notes revealed: October 29, 2024, "... Spoke with hospice regarding resident's change of condition. Relayed information regarding resident's behavior. Resident is shaking and slumped over in w/c (wheelchair), drooling. Resident grabbing tires on w/c and moaning/yelling but staff not able to understand what resident is trying to say. ... Hospice stated to speak with daughter and see if she wants resident sent to ER (Emergency Room) that (he/she) probably needs further	A 604		

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A 604	Continued From page 61 assessment. ..." October 30, 2024, "... Resident appeared sleepy the entire shift. ... Not able to verbalize needs. ..." November 4, 2024, "... Writer talked with Hospice nurse this evening. She stated, "I could not give (him/her) a good bath today, (he/she) was fighting me. (He/She) need(s) two people with (him/her) to give (him/her) a bath and shave. ..." No assessments were found to address these findings that began on October 22, 2024, until November 7, 2024. Therefore, there was no discussion of a decline in health status or behavior that should have occurred with the physician and sponsor. On the morning of April 15, 2025, EI#2 said the process had not been followed to ensure monthly assessments, including weights, were completed. EI#2 said RI#3 should have had a change in condition assessment when the need for hospice was identified (two days after admission) because his/her eating decreased and he/she went from a walker to wheelchair. RI#4 A review of RI#4's facility record revealed the following. On September 10, 2024 Eufaula Medical Center Barbour stated in RI#4 discharge record "he is a danger to self and others" and "insight and judgement is poor" yet the resident was re-admitted to the facility. There was no comprehensive assessment for this event. On June 28, 2024, RI#4 was observed walking down hallways with wire clothes hangers threatening staff members and residents. On this	A 604		

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A 604	Continued From page 62 occasion RI#4 grabbed another resident's arm. Emergency Medical Services (EMS) and the police were called to assist with RI#4's behavior. There was no comprehensive assessment for this event. On July 17, 2024 a caregiver reported that RI#4 walked up to another resident's visitor and threatened the visitor. There was no comprehensive assessment for this event. On August 26, 2024 RI#4 was observed by staff standing over a resident, taking the resident's walker and threatening another resident. There was no comprehensive assessment for this event. In the month of August there were three additional episodes of aggression, one additional episode in October of 2024, three additional episodes in November 2024, and one additional episode in December 2024. There were no comprehensive assessments for these events. On March 25, 2025 RI#4 was admitted to EAMC for acute kidney injury and returned to the facility on March 26, 2025. There was no comprehensive assessment performed. On the afternoon of April 14, 2025, EI#1 said, "(Names RI#4) should have been discharged sooner." She adds she has emails where EI#2 and she (EI#1) notified the company (management) that he/she needed to be discharged but to no avail.	A 604		
A 608	420-5-20-.06 (3) (j) Care of Residents (j) Mechanical Restraint and Seclusion.	A 608		

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A 608	Continued From page 63 No form of physical restraint or seclusion shall be applied to residents of a specialty care assisted living facility except in extreme emergency situations when the resident presents a danger of harm to himself or herself or to other residents. In such an event, the facility shall use the least restrictive intervention that will be effective to protect residents, immediately notify the resident's physician and sponsor, and appropriate treatment, transfer to an appropriate health care facility, or both shall be provided without any avoidable delay. In no event shall emergency behavioral symptoms of residents be treated with sedative medications, anti-psychotic medications, anti-anxiety medications, or other psychoactive medications in a specialty care assisted living facility. This Rule is not met as evidenced by: Based on interview and record review, the facility treated a resident who exhibited emergency behavioral symptoms with anti-anxiety and anti-psychotic medications. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: Emergency behavioral symptoms treated with anti-anxiety and anti-psychotic medications Review of RI#4's facility record revealed RI#4 was admitted on October 20, 2015, RI#4 was prescribed Lorazepam 1 mg tablet by mouth twice daily for anxiety on February 19, 2025, On March 3, 2025 RI#4 was prescribed Haloperidol 2 mg tablet by mouth twice daily for 14 days for severe agitation. In addition, RI#4 was prescribed	A 608		

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A 608	Continued From page 64 Haloperidol 1 mg tablets by mouth as needed every 8 hours for agitation and disruptive behaviors. NOTE: The Beers Criteria, developed by the American Geriatrics Society, is a widely recognized guideline that lists medications that are generally not recommended for older adults due to the increased risk of adverse effects. Haloperidol, also known as Haldol, is on the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. Specifically, the Beers Criteria advises against using haloperidol for behavioral problems in older adults with dementia.	A 608		
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	A 611		

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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 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,

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A 611	Continued From page 66 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 personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to develop a current plan of care which contained interventions to meet the care and safety needs of residents. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON APRIL 27, 2021, AND OCTOBER 4, 2022. Findings: RI#3 RI#3, a discharged resident, was admitted to the facility on October 7, 2024. A review of the facility record revealed RI#3's care plan did not address	A 611		

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a significant diagnosis of vascular dementia or the medication Haloperidol. RI#3's care plan indicated RI#3 had "... No behavior issues ...". However, RI#3's MAR indicated a diagnosis of "behavior" when he/she was was prescribed Haloperidol. RI#3's care plan indicated, "... Mobility/Ambulation ... Level of Assistance-Mobility: Moderated Care Associate Resident may require hands on assistance from staff member(s). ... Level of Assistance-Transferring: Moderate Resident requires occasional hands on assistance with transfers and or changes in position. ... Level of Assistance-Bathing: Moderate Resident requires assistance with bathing, requires assistance or cueing with parts of bathing including assistance getting in/out of tub/shower ... Level of Assistance-Grooming/Personal Hygiene: Moderate Resident performs grooming/personal hygiene but requires physical assistance to complete task ... Level of Assistance-Dressing: Moderate Resident can dress/undress and select clothing with physical assistance ... Level of Assistance-Toileting: Moderate Resident requires stand by assistance for toileting tasks. Resident is occasionally incontinent of bowel and/or bladder ..."

Therapy recommendations for RI#3 as of the last visit dated November 14, 2024, revealed, "... environmental modifications for feeding to increase independence, including divided plate, finger foods/cut-up foods, clothing protector, covered cup with straw, ..."

On the afternoon of April 9, 2025, EI#12, a CA, was asked about the assistance RI#3 required for activities of daily living (ADLs). EI#12 said RI#3 had required two - three person assistance for toileting. EI#12 said RI#3 would always require

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three person assistance for bathing.

On the morning of April 10, 2025, EI#7, an LPN, said RI#3 was incontinent on admission and did not assist with any ADLs.

On the morning of April 14, 2025, EI#13, a CA, was asked about RI#3's required ADL assistance. EI#13 said on admission RI#3 was incontinent of bowel and bladder, RI#3 would have to be fed at times, RI#3 did not assist in dressing, grooming or bathing, RI#3 was in a wheelchair and could not self propel. EI#13 said staff had to do everything for RI#3 and she did not think he/she was appropriate for a SCALF. EI#13 said it took three people to toilet RI#3.

On the afternoon of April 14, 2025, EI#20, an LPN, was asked what ADL assistance RI#3 required. EI#20 said RI#3 was incontinent and was a three to four person assist for ADLs.

On the afternoon of April 14, 2025, EI#8, an LPN, said RI#3 was incontinent of bowel and bladder on admission. EI#8 said RI#3 did not assist with dressing, grooming or bathing.

On the morning of April 15, 2025, EI#2 was asked about RI#3's dementia, Haloperidol, hearing deficit, the need for three person assistance and RI#3's speech therapy recommendations. EI#2 admitted they were not care planned.

On the afternoon of April 15, 2025, EI#1 acknowledged the plan of care should include how to provide care for the resident including medications and diagnoses.

RI#4
RI#4 was admitted on October 20, 2015. RI#4's

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A 611	Continued From page 69 admitting diagnoses included dementia, hypertension, colon cancer, anxiety, Alzheimer's disease and history of urinary tract infections. Resident medications include psychotropic medications, two different psychotropic medications, Haldol and Ativan. A review of RI#4's care plan revealed the following. .."Neurocognitive Communication: No impairment Resident is able to communicate effectively and make needs known, with or without assistive device(s)." ... ...Psychosocial section indicated the resident had "No anxiety issues"... ...Escorts Level of Assistance - Escorts: Independent... ...Medication Antibiotics given 2 days for Pneumonia... ...Meal Consumption Level of Assistance: Independent... On the morning of April 9, 2025, the surveyor attempted to interview RI#4. RI#4 was unable to coherently answer questions, even simple yes or no questions. Every question received a muffled, mumble response that was completely incoherent. The surveyor was unable to effect good communication with RI#4. RI#4's care plan documented RI#4 could communicate effectively and make his/her needs known. On the morning of April 9, 2025 a review of the medication administration record for the month of April 2025 revealed RI#4 had orders for Lorazepam 1 mg tablet by mouth twice daily for anxiety, haloperidol 2 mg tablet by mouth twice daily for agitation, and an order for as needed Haloperidol 1 mg tablet every 8 hours for agitation. The anti-anxiety and psychotropic medications had MODERATE side effect interactions. Levofloxacin 500 mg tablet by mouth	A 611		

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A 611	Continued From page 70 daily for 5 days for urinary tract infection was to be completed April 4, 2025. RI#4's care plan documented RI#4 was independent with meals. However, on the morning of April 9, 2025 RI#4 was observed at breakfast requiring verbal queuing and verbal reinforcement by a caregiver to sit at breakfast and consume a meal. RI#4 care plan was not current and did not address anxiety even though RI#4 was prescribed medication for anxiety.	A 611		
A 616	420-5-20-.06 (5) (i) (j) (k) (l) (m) Care of Residents. (i) Medications kept under the control or custody of a specialty care assisted living facility shall be packaged by the pharmacy and shall be maintained by the facility in unit dose packaging. Medications kept under the control or custody of the specialty care assisted living facility that are not available in unit dose packaging must be packaged by the pharmacy and administered by a physician, RN, or LPN. (j) Unless a resident can and does self-manage his or her own medications, a specialty care assisted living facility shall require each resident to use a single pharmacy. This does not apply to emergency pharmacy services. All residents need not use the same pharmacy that is used by other residents unless express policy of the specialty care assisted living facility provides otherwise and all residents are informed of such policy and provided a copy of such policy prior to or at the time of admission. The specialty care assisted living facility shall require	A 616		

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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 616	Continued From page 71 pharmacies used for medication supply for residents not self-managing their medications to review all ordered medication regimens for possible errors or adverse drug interactions and to advise the facility and the prescribing health care provider when these are detected. (k) If controlled substances prescribed for residents of any specialty care assisted living facility are kept in the custody of the specialty care assisted living facility, they shall be stored in a manner that is compliant with state and federal laws, the requirements of the Alabama State Board of Pharmacy, and any requirements prescribed by the Alabama State Board of Health. At a minimum, controlled substances in the custody of the facility shall be stored using a double lock system, under proper temperature and humidity controls and permit only authorized personnel access. The facility shall maintain a system to account for all controlled substances in its possession. All other medications in the custody of the facility shall be stored using at least a single lock, under proper temperature and humidity controls and permit only authorized personnel access. This shall include medications stored in a resident's room when the staff and not the resident have access to the medications. Medications may be kept in the custody of an individual resident who can safely manage his or her medications. Such medications may be stored in a locked container accessible only to the resident and staff, or may be stored and secured in the resident's living quarters, if the room is single occupancy and has a locking entrance. (l) Medication administration records and written physician orders for all over-the-counter drugs, legend drugs, and	A 616		

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A 616	Continued From page 72 controlled substances shall be retained for a period of not less than 3 years. They shall be available for inspection and copying on demand by agents of the State Board of Health. They shall be made available for inspection at reasonable times by residents, anyone authorized by the resident, and by the sponsors of residents. (m) Labeling of Drugs and Medicines. All containers of prescribed medicines and drugs shall be labeled in accordance with the rules of the Alabama State Board of Pharmacy and shall include appropriate cautionary labels, such as, "Shake Well," or "For External Use Only." This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure the medication cart was locked when unattended. On the morning of April 9, 2025, during a medication administration observation it was revealed that the medication cart was left unsecured by the attending wellness nurse, EI#7. The nurse departed the front of the cart and progressed down the hallway leaving the cart unsecured. The surveyor called the nurse back from down the hall to the cart and notified EI#7 that the medication cart was unsecured. EI#7 observed that the medication cart was unsecured and concurred with the surveyor. EI#7 then secured the cart and returned down the hallway.	A 616		
A 620	420-5-20-.06 (9) (a) Care of Residents	A 620		

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A 620	Continued From page 73 (9) Admission and Retention of Residents. Residents admitted to and retained in specialty care assisted living facilities must meet all eligibility and continued stay requirements specified in these rules. (a) Admission. 1. A specialty care assisted living facility shall not admit any individual who: (i) Is receiving or requires skilled nursing care. (ii) Has a wound that requires care beyond basic first aid. (iii) Has unmanageable behaviors or behaviors that may be dangerous to themselves or others. (iv) Has a PSMS score greater than 23 or a score of five in feeding, dressing, grooming, bathing, or a score of four or five in physical ambulation. (v) Is receiving or in need of hospice services. (vi) Is diagnosed with an active acute infectious pulmonary disease, such as influenza or active tuberculosis, or with other diseases capable of transmission to other individuals through normal person-to-person contact. This Rule is not met as evidenced by:	A 620		

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A 620	Continued From page 74 Based on record review and interview, the facility admitted a resident in need of hospice services, whose PSMS score exceeded the allowable score in physical ambulation and who was resistive to care. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: Review of the facility record revealed RI#3 was admitted to the facility on October 7, 2024, and transferred to a long-term care facility on November 22, 2024. Review of the admission assessment dated October 8, 2024, revealed RI#3 scored a four (4) in physical ambulation on the Physical Self-Maintenance Scale (PSMS) which exceeded the allowable score for a SCALF resident. In addition, RI#3 required skilled nursing services as evidenced by RI#3 receiving hospice services prior to admission. Hospice records indicated RI#3 had hospice services from September 30, 2024, through October 7, 2024, at a previous facility. On October 9, 2024, two days after RI#3's admission to the facility, a hospice referral was made for RI#3 to reinstate hospice services, including skilled nursing visits. On the afternoon of April 9, 2025, RI#3's sponsor said she was told by EI#2 to have RI#3 taken off of hospice so he/she could be admitted to the facility. Review of RI#3's therapy note dated October 22, 2024, revealed, "... Patient unable to follow commands for AROM (Active Range of Motion) at this time. ..."	A 620		

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A 620	Continued From page 75 On the afternoon of April 9, 2025, EI#12 was asked about what assistance RI#3 required for activities of daily living (ADLs). EI#12 said RI#3 required a two-three person assist for toileting and bathing. EI#12 said RI#3 would always require three persons for bathing, being described as dead weight. On the morning of April 10, 2025, EI#7 was asked why RI#3 would be admitted on October 7, 2024, and need a hospice consult on October 9, 2024. EI#7 said RI#3 should not have been admitted. EI#7 said RI#3 would feed himself/herself at first, but the sponsor would feed him/her and RI#3 began not to feed himself/herself. During a follow-up interview, EI#7 said RI#3 was incontinent on admission, did not assist staff during ADL care and was resistive to care. On the morning of April 14, 2025, EI#13 was asked about RI#3's required ADL assistance. EI#13 said on admission RI#3 was incontinent of bowel and bladder, RI#3 would have to be fed at times, RI#3 did not assist in dressing, grooming or bathing and RI#3 could not self propel his/her wheelchair. EI#13 said staff had to do everything for RI#3 and she did not think RI#3 was appropriate for a SCALF. EI#13 said RI#3 appeared to be a nursing home resident. When asked if RI#3 was resistive to care, EI#13 said yes, it took three people to toilet RI#3. On the afternoon of April 14, 2025, EI#20 was asked what ADL assistance RI#3 required. EI#20 said RI#3 was incontinent and a three to four person assist because RI#3 was "dead weight." EI#20 said RI#3 was resistive to care most of the time and would not feed himself/herself. EI#20 said these things were evident when RI#3 was	A 620		

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A 620	Continued From page 76 admitted. On the afternoon of April 14, 2025, EI#8 said RI#3 was incontinent of bowel and bladder on admission. EI#8 said RI#3 did not assist with dressing, grooming or bathing. EI#8 said she went to EI#2 after she (EI#8) admitted RI#3 and told EI#2 that RI#3 was not a good candidate for admission. EI#8 said EI#2 stated she had evaluated RI#3 and found him/her appropriate. EI#8 said RI#3 was not an appropriate admission because RI#3 usually required a three person assist and that was a nursing home patient. On the morning of April 15, 2025, EI#9, the former Director, was asked about RI#3's admission. EI#9 said she went with EI#2 for RI#3's preadmission screening. EI#9 said RI#3 was not appropriate for admission and was surprised RI#3 had moved in. EI#9 said RI#3 was a three or more person assist. EI#9 said she voiced her concern to EI#2, and in her opinion, EI#2 did not deny RI#3 admission because there was a push to admit residents. On the morning of April 15, 2025, EI#2 acknowledged RI#3 was not an appropriate admission due to RI#3's need for hospice, physical ambulation status, and difficulty in providing care. EI#2 acknowledged the therapy note from October 22, 2024, indicated the resident could not follow commands and was not appropriate for a SCALF. EI#2 confirmed RI#3 did not assist with his/her ADLs. When asked about RI#3's documented lethargy, hand tremors and significant decline two days after admission, EI#2 said RI#3 should not have been at the facility. On the afternoon of April 15, 2025, EI#1	A 620		

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A 620	Continued From page 77 acknowledged she was responsible for ensuring residents were appropriate for admission even though EI#2 did the pre-admission screening. EI#1 acknowledged RI#3's ambulation status and need for hospice made RI#3 ineligible for admission.	A 620		
A 621	420-5-20-.06 (9) (b) Care of Residents. (b) Retention. 1. A specialty care assisted living facility shall not allow any resident to return to the specialty care assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the specialty care assisted living facility is licensed to provide or the facility is capable of providing. 2. A specialty care assisted living facility shall not retain a resident that has a PSMS score greater than 23 or a score of five in feeding, dressing, grooming, bathing or a score of four or five in physical ambulation. 3. A specialty care assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility. 4. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in a specialty care assisted living facility. 5. A specialty care assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless:	A 621		

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A 621	Continued From page 78 (i) The individual is capable of performing and does perform all tasks related to his or her own care; OR (ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity but the individual has sufficient cognitive ability to direct his or her own care and the individual is able to direct facility staff and does direct facility staff to provide the physical assistance needed to complete such tasks, and the facility staff is capable of providing such assistance and does provide such assistance. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. 6. If a resident of a specialty care assisted living facility is diagnosed with a terminal illness and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90 days. If the facility is unable or becomes unable to meet the needs of a resident receiving hospice care, or if a resident receiving hospice care requires care beyond what the facility may lawfully provide pursuant to this section, then the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for specialty care assisted living facilities. The facility would in all cases remain responsible for ensuring the appropriate delivery	A 621		

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A 621	Continued From page 79 of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to discharge or transfer a resident who demonstrated behaviors or symptoms which interfered with the rights or safety of other residents as well as the safety and well-being of the individual resident. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON APRIL 27, 2021, AND OCTOBER 4, 2022. Findings: The Alabama Department of Public Health received a complaint which alleged a resident needed a higher level of care. Surveyors were able to substantiate this complaint during the onsite survey and identified the following deficient practice as a result of the complaint investigation. RI#4 was admitted to the facility on October 20, 2015, with admitting diagnoses that included dementia, hypertension, colon cancer, anxiety, Alzheimer's disease and history of urinary tract infections. RI#4's medications included two different psychotropic medications, Haldol and Ativan. RI#4's record documented RI#4 needed	A 621		

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A 621	Continued From page 80 geriatric-psychiatric (geri-psych) placement due to behaviors. The facility did not transfer RI#4. A note observed by the surveyor from Integrated Behavioral Health (IBH) dated August 28, 2024, recommended geri-psych placement at that time. Instead, on February 20, 2025, a full seven months after notification that RI#4 required geri-psych placement, the facility issued a 30-day notice of involuntary discharge to RI#4. During the month of August 2024, RI#4 exhibited three episodes of aggression, one additional episode in October of 2024, three additional episodes in November 2024, and one additional episode in December 2024. On September 10, 2024 Eufaula Medical Center Barbour stated in RI#4's discharge record RI#4 "is a danger to self and others" and "insight and judgement is poor." During the seven months between IBH's recommendation of geri-psych placement and the facility's issuance of a 30 day discharge notice, RI#4 had repeated episodes of behaviors that infringed on the rights and safety of the residents in the facility. Review of EI#2's email sent on December 11, 2024, to EI#11, EI#1, and EI#3, revealed, "... (RI#4) is no longer eligible for a continued stay." This email listed events from June 28, 2024 through December 7, 2024 that demonstrated RI#4 had behaviors that were unmanageable or behaviors that may be dangerous to himself/herself or others. On afternoon of April 14, 2025, during an interview with EI#8, Wellness Nurse, EI#8, stated RI#4 was not an appropriate resident. EI#8 said	A 621		

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A 621	Continued From page 81 RI#4 should have been placed in a psychiatric facility after the facility received him back from the hospital on September 10, 2024. On the morning of April 15, 2025, during an interview with the Wellness Nurse, EI#9, EI#9 said RI#4 would have days when he/she was fine, but other times RI#4 was total care including feeding and dressing. EI#9 also stated RI#4 threatened to kill her. RI#4 stated to EI#9, "I will kill you". EI#9 stated that was when EI#2 said "(RI#4) has to go" and issued RI#4 a 30-day notice. The facility retained RI#4 until April 9, 2025, even though RI#4 was identified as needing a higher level of care on August 28, 2024.	A 621		
A 702	420-5-20-.07 (2) Food Service. (2) Food Handling Procedures. (a) Dish and Utensils Washing, Disinfection, and Storage. 1. Wash water shall be changed with sufficient frequency to avoid gross contamination, and final rinse water shall be kept clean and clear. 2. Hand washed repeated service and multi-service utensils and dishes, after washing and rinsing, shall be sanitized by either of the following methods: (i) Utensils and dishes shall be completely immersed for a period of not less than 30 seconds in water that is at least 171 degrees Fahrenheit (pouring scalding water over utensils	A 702		

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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 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

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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. 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.

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A 702	Continued From page 84 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 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	A 702		

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A 702	Continued From page 85	A 702		

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.

(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.

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A 702	Continued From page 86 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 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	A 702		

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A 702	Continued From page 87 permitted in food preparation or service areas. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to properly label food products and to ensure adequate equipment and measures were used to prevent food contamination. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON OCTOBER 4, 2022. Findings: On the morning of April 10, 2025 during a tour of the facility it was revealed that the kitchen had dirty, greasy floors with debris, and the dishes on the bottom of a serving table were not protected from contamination. The areas under the oven/range were grease laden and had debris build up under the appliance. The range top was grease and grime laden with baked on debris. Multiple garbage cans in the kitchen did not have lids as required. In the walk -in freezer the overhead, explosion proof light, was missing the appropriate cover exposing the bulb and socket. The intake air ventilation conduit and return conduit diffuser were grease laden, with dust/dirt build up. The diffuser appeared to have an unknown black build up on the louvers. Multiple kitchen ceiling tiles were dislodged, dirty, and stained. The walls and floors were dirty. Some areas of wall had peeling paint and/or blistered wall surfaces resulting in damaged wall material. The handwash station in the kitchen area above the sink wall was damaged and was not a smooth surface that could easily be cleaned. The eye wash station did not have eye wash solution bottles. In the refrigerator, some left overs were	A 702		

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A 702	Continued From page 88 not appropriately marked with an expiration date; red pepper jelly, penne pasta, mini-marshmallows and unknown sauce in a bottle. Executive Chef, EI#19, concurred with the surveyor's observations. EI#19 was asked when the kitchen was last deep cleaned. EI#19 responded "Its been a while since they done it." The surveyor notified the Executive Director, EI#3, and Administrator, EI#1 of the concern. EI#1 stated she would talk with the kitchen staff about it.	A 702		
A 804	420-5-20-.08 (4) Physical Facilities. (4) Food Service Facilities. (a) Floors. Floors in food service areas shall be of such construction as to be easily cleaned, sound, smooth, non-absorbent, without cracks or crevices, and shall be provided with approved and conveniently located facilities for the disposal of floor wash water. (b) Walls and Ceilings. Walls and ceilings of food service areas shall be of tight and substantial construction, and smoothly finished. The walls and ceilings shall be without horizontal ledges and shall be washable up to the highest level reached by splash and spray. Roofs and walls shall be maintained free of leaks. All openings to the exterior shall be provided with doors or windows, which prevent the entrance of rain or dust during inclement weather. (c) Screens or Outside Openings. Openings to the outside shall be effectively screened, or suitable provisions made equal to screening (such as fly fans). Screen doors shall be equipped with self-closing devices.	A 804		

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A 804	Continued From page 89 (d) Lighting. The kitchen, dishwashing area, and the dining room shall have adequate light. (e) Ventilation. Vent/exhaust hoods, vented to the outdoors, shall be provided over cooking surfaces to aid in removing cooking odors. Group homes with residential stoves may use a residential hood sized for the stove. Commercial exhaust hoods shall be installed when commercial cooking equipment is used. Congregate facilities shall use a commercial exhaust hood system. (f) Employee Toilet Facilities. Toilet rooms, if provided, shall not open directly into any room or space in which food is prepared, stored, displayed, or served, nor into any room in which utensils are washed or stored. Toilet rooms shall include a lavatory with a soap dispenser and disposable towels, and shall be well lighted and ventilated. (g) Hand washing Facilities. Each Group and Congregate specialty care assisted living facility shall provide a hand washing lavatory in the kitchens which shall be equipped with a soap dispenser and a supply of soap, disposable towels, and hot and cold running water through a mixing valve or combination faucet. The use of a common towel and common bar soap is prohibited. Hands shall not be washed in sinks where food is prepared. (h) Refrigeration Facilities. Adequate refrigeration facilities, automatic in operation for the storage of perishable foods, shall be provided Refrigeration shall be maintained at 41 degrees Fahrenheit or less. All refrigerators shall be	A 804		

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A 804	Continued From page 90	A 804		

provided with thermometers. All refrigerators shall be kept clean.

(i) Equipment and Utensil Construction. Equipment and utensils, except single service utensils, shall be so constructed as to be easily cleaned and shall be kept in good repair. No cadmium plated, lead, or readily corrodible utensils or equipment shall be used.

(j) Separation of Kitchen from Resident Rooms and Sleeping Quarters. Any room used for sleeping quarters shall be separated from the food service area by a solid wall with no direct openings. Sleeping accommodations shall not be permitted within the food service area.

(k) Clean Rooms. Floors, walls, and ceilings of rooms in the food service area shall be clean and free of an accumulation of rubbish, dust, grease, dirt, etc.

(l) Clean Equipment. Equipment in the food service area shall be clean and free of dust, grease, dirt, etc.

(m) Clean Counters, Tables, Tablecloths, and Napkins. Tables and counters, which are used for food service, shall be kept clean. Tablecloths and cloth napkins shall be laundered after each use.

(n) Location and Space Requirements. Food service facilities shall be located in a specifically designated area and shall include the following rooms and space: kitchen, dishwashing, food storage, and dining room.

(o) Equipment. Minimum equipment in

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A 804	Continued From page 91 the kitchen shall include the following: 1. Range. In a Group specialty care assisted living facility, a residential use range is permitted. A Congregate specialty care assisted living facility shall have a heavy duty range suitable for institutional use with double oven, or equivalent. 2. Refrigerator. A Group specialty care assisted living facility may use a residential refrigerator. A Congregate specialty care assisted living facility shall have a heavy-duty refrigerator suitable for institutional use. 3. Fire extinguisher. Five-pound type BC for residential hoods and K type for commercial hoods. 4. Dishwashing. The dishwashing equipment for Group assisted living facilities shall be either residential type using cold water sanitizers or commercial type with a booster water heater. Dishwashing equipment for all Congregate assisted living facilities shall be commercial type using a booster water heater or an automatic dispensing sanitizing chemical system. 5. A three-compartment sink with a booster heater or chemical sanitizing system for the third compartment shall be provided in Congregate assisted living facilities. 6. Garbage cans with cover. (p) Food Storage. A well-ventilated, cool food storage room, pantry, or cabinets shall be provided. Adequate shelving, bins, suitable cans,	A 804		

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A 804	Continued From page 92 and raised platforms shall be provided and kept clean. Perishable food shall be stored at least six inches above the floor. The storeroom shall be of such construction as to prevent the invasion of rodents and insects, the seepage of dust and water, leakage, or any other source of contamination. (q) Dining Room. 1. A resident dining room, or rooms, shall be provided which is large enough to seat not less than 100 percent of the bed capacity. (r) Water Heating Equipment. Equipment for heating an ample supply of water, under pressure, for all washing purposes shall be provided. Hot water shall be piped to all hand-washing facilities, and to each compartment of all dishwashing and laundry sinks. Water heaters shall be of the automatic type. This Rule is not met as evidenced by: Based on interview and observation, the facility failed to maintain cleanliness of the kitchen floors and equipment. Findings: On the morning of April 10, 2025, during a tour of the facility, it was revealed that the kitchen had dirty, greasy floors with debris. The dishes on the bottom of a serving table were not protected from contamination. The areas under the oven/range	A 804		

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A 804	Continued From page 93 were grease laden and had debris build up under the appliance. The range top was grease and grime laden with baked on debris. Multiple garbage cans in the kitchen did not have lids as required. In the walk -in freezer the overhead explosion proof, light was missing the appropriate cover exposing the bulb and socket. The intake air ventilation conduit and return conduit diffuser were grease laden with dust/dirt build up. The diffuser appeared to have an unknown black build up on the louvers. Multiple kitchen ceiling tiles were dislodged, dirty, and stained. The walls and floors were dirty. Some areas of the wall had peeling paint or blistered wall surfaces resulting in damaged wall material. The handwash station in the kitchen area above the sink wall was damaged and not a smooth surface that could easily be cleaned. Executive Chef, EI#19, concurred with the surveyor observations. EI#19, was asked when was the kitchen deep cleaned last. EI#19 responded, "Its been a while since they done it." The surveyor notified EI#3, and EI#1 of the concerns. EI#1 stated she would talk with the kitchen staff about it.	A 804		
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 901		

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A 901	Continued From page 94 (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 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 interviews the facility failed to provide adequate, effective and clean lint	A 901		

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A 901	Continued From page 95 traps in all dryers. Findings: On the morning of April 8, 2025 during a tour of facility with EI#3, Executive Director, it was revealed by the surveyor that the lint trap of the operational dryer was clogged with debris and lint presenting a potential fire hazard. EI#3 concurred with the surveyor observation.	A 901		
A1001	420-5-20-.10 (1) Sanitation and Housekeeping. (1) Sanitation. (a) Water Supply. 1. If at all possible, all water shall be obtained from a public water supply. If it is impossible to connect to a public water system, the private water supply shall meet the approval of the local County Health Department. 2. Water under pressure of not less than 15 pounds per square inch shall be piped within the building to all sinks, toilets, lavatories, tubs, showers, and other fixtures requiring water. Tubs, showers, sinks, lavatories, and other fixtures used by residents shall have hot water supplied. Hot water accessible to residents shall in no case exceed 110 degrees Fahrenheit. (b) Disposal of Liquid and Human Wastes. 1. There shall be installed within the building a properly designed waste disposal system, connecting to all fixtures to which water under pressure is piped.	A1001		

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A1001	Continued From page 96	A1001		

2. All liquid and human waste, including floor wash water and liquid waste from refrigerators, shall be disposed through trapped drains into a public sewer in localities where such system is available.

3. In localities where a public sanitary sewer is not available, liquid and human waste shall be disposed through trapped drains into a sewage disposal system approved by the local County Health Department. The sewage disposal system shall be of a size and capacity based on the number of residents and personnel housed and employed in the institution. Where the sewage disposal system is installed at an existing facility prior to granting of a license, it shall be inspected and approved by the local County Health Department.

(c) Premises. The premises shall be kept neat and clean. The property shall be free of rubbish, weeds, ponded water, or other conditions, which may create a health, safety, or sanitation hazard.

(d) Control of Insects, Rodents, and other Pests. Each facility shall be kept free of ants, flies, roaches, rodents, and other pests. Proper and lawful methods for their eradication or control shall be used. Droppings shall be evidence of infestation by pests.

(e) Toilet Room Cleanliness. Floors, walls, ceilings, and fixtures of all toilet rooms shall be kept clean and free of objectionable odors. These rooms shall be kept free of an accumulation of rubbish, cleaning supplies, toiletry articles. The use of a common towel and

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A1001	Continued From page 97 common bar soap is prohibited. (f) Garbage Disposal. 1. Garbage must be kept in water-tight suitable containers with tight-fitting covers. Garbage containers must be emptied at frequent intervals and shall be thoroughly cleaned and aired before using again. 2. Garbage and waste shall be disposed of in accordance with local and state regulations. (g) Control of Odors. The facility shall be free of objectionable odors. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain water temperature, accessible to residents, no greater than 110 degree Fahrenheit as required. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 1, 2018. Findings: On the afternoon of April 9, 2025, during an accompanied tour of the community, it was revealed that water temperatures in the following room were above the allowed 110 degrees. Room Temperature 217 157.9 F 218 153.2 F	A1001		

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A1001	Continued From page 98 105 119.3 F 106 118.2 F EI#2 and EI#12, accompanied the surveyor and concurred with the observations of the surveyor. The administrator was notified immediately by the Wellness Director, and EI#1 submitted an Emergency Action Plan to correct water temperatures.	A1001		
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 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.	A1002		

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A1002	Continued From page 99 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 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 maintain a safe, functional, decent, sanitary, and comfortable environment for residents, staff and public. Findings:	A1002		

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A1002	Continued From page 100 On the morning of April 8, 2025, during a tour of the facility, it was revealed that one of the two laundry dryers in the laundry room had an inoperable dryer with partially disassembled parts that was not properly safety tagged as out of service. The failure to tag the dryer as inoperable presented a potential safety hazard to personnel if used. Also the electric receptacle box for the damaged dryer was separated from proper mounting in the wall. EI#3 concurred with the surveyors observations and agreed the inoperable dryer should have been properly tagged out of service for safety.	A1002		
A1101	420-5-20-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All specialty care assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly,	A1101		

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A1101	Continued From page 101 filed, and kept for at least three years. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs. (d) Roller latches are prohibited on doors separating corridors from adjacent spaces. (e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that: 1. Minimizes leaks and spills. 2. Adequately protects against inappropriate access. 3. Complies with the requirements of the currently adopted Life Safety Code. (f) Fire Alarm and Sprinkler System. 1. Fire Alarm System. Where fire alarm systems are required, a corridor smoke detection system shall be installed on each floor, including areas open to the exit access corridor, to comply with NFPA 72, connected to the facility's fire alarm system. In lieu of corridor smoke detection, smoke detectors connected to the building fire alarm system may be installed in each resident's room, open areas, and at smoke doors (except that corridor smoke detection shall not be deleted when its use is dictated by other requirements).	A1101		

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A1101	Continued From page 102 2. Fire alarm and sprinkler system outages of more than 4 hours require evacuation of the facility or the establishment of a continuous fire watch. The fire watch procedure must be coordinated with the Department and the local Fire Marshal. Outages and fire watch documentation shall be reported to the Department within 12 hours or no later than the next duty day, and shall be corrected expeditiously. 3. The fire alarm system and the sprinkler system shall be inspected by licensed, trained, and qualified personnel at least semiannually for compliance with the respective codes. Inspection and Testing reports shall be maintained in the facility for a period of at least 3 years. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to perform fire drills as required. Findings: On the morning of April 10, 2025 during record review of fire drills it was revealed that the facility did not perform fire drills for the following time periods. 2023- May, June, September, October, November and December 2024- January, February, March, April, May, June, July, August, September and October. Both the Administrator, EI#1, and Maintenance	A1101		

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A1101	Continued From page 103 Technician, EI#6 concurred with surveyor that the fire drill records were not present. EI#1 concurred with the surveyor that the fire drills were not done.	A1101		
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. (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	A1201		

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A1201	Continued From page 104 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. (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,	A1201		

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A1201	Continued From page 105	A1201		

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 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

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A1201	Continued From page 106 failed to maintain facility equipment in safe operating condition. Findings: On the morning of April 8, 2025 during an accompanied tour of the facility EI#3, the Executive Director, it was revealed that the laundry room had an inoperable dryer with partially disassembled parts. The dryer was not properly tagged as out of service and presented a potential safety hazard to personnel if used. EI#3 concurred with the surveyors observation and agreed the inoperable dryer should have been properly tagged as out of service. On the morning of April 8, 2025, during a tour of the facility, accompanied by EI#3, it was revealed that the the upstairs exit lighting, adjacent to room 213, mounting was loose presenting a potential hazard. The exit light in the west wing hallway ,over the exit door, was damaged and missing the clear lens from the right side of the light as you faced the light. EI#3 concurred with the surveyors observation and agreed that the lights were loose and damaged.	A1201		
A1203	420-5-20-.12 (5) Physical Environment. (5) General Building Requirements - Group and Congregate. (a) Structural Soundness and Repair. The building shall be structurally sound, free from leaks and excessive moisture, in good repair, and painted with sufficient frequency to be reasonably attractive inside and out. The interior and exterior of the building shall be kept clean and orderly.	A1203		

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A1203	Continued From page 107 (b) Temperature to be Maintained. The facility shall maintain a comfortable temperature. A comfortable range is between 71-81 degrees Fahrenheit. (c) Lighting. Each resident's room shall have artificial light adequate for reading and other uses as needed. All entrances, hallways, stairways, inclines, ramps, cellars, attics, storerooms, kitchens, laundries, and service units shall have sufficient artificial lighting to prevent accidents and promote efficiency of service. Night lights shall be provided in all hallways, stairways, and bathrooms. (d) Screens. All screen doors and operable windows shall be equipped with tight-fitting, full-length 16 mesh screens. Screen doors shall be equipped with self-closing devices. (e) Emergency Lighting. 1. All specialty care assisted living facilities shall provide an emergency artificial lighting system to adequately illuminate halls, corridors, and stairwells in case of electrical power failure. As a minimum, dry cell battery-operated lighting shall be provided to light such spaces. 2. Emergency lighting must provide illumination in accordance with the currently adopted Life Safety Code for at least 90 minutes. (f) Floors. 1. All floors shall be level, smooth and free of cracks, and finished so as to be easily kept clean. The basic requirement for floor	A1203		

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A1203	Continued From page 108 finishes shall be wall-to-wall with such finishes as paint, stain, sealer, carpet, sheet vinyl, vinyl tile, hard tile, or other appropriate floor finish. 2. Any differences in floor levels shall not prevent a resident from navigating safely throughout the facility. (g) Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface and shall be kept clean and in good repair. (h) Windows. Operable windows shall be so constructed and maintained so that they fit snugly, and are capable of being opened and closed easily. Windows in specialty care facilities may have devices which prevent full opening of the window. (i) Ceiling Height. Each room occupied by residents shall have a ceiling height of eight feet or more. Existing facilities with ceiling heights less than eight feet shall be acceptable when the height complies with the codes. (j) Handrails. If handrails are installed in halls or corridors, the handrails shall be mounted at 30 - 36 inches above the floor and returned to the wall at each end. (k) Stairways. Stairways shall be well lighted, kept in good repair, and have handrails. Open space under stairs shall not be used for storage purposes. All walls and doors under stairs shall meet the same fire rating as the stairwell.	A1203		

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A1203	Continued From page 109 (l) Doors. 1. In each new specialty care assisted living facility, doors of resident bathrooms connected to resident bedroom shall swing into the bedroom. 2. Bedroom and bathroom doors may be equipped with hardware that will permit a resident to lock himself within the room, provided a master key is readily accessible for the staff at a central location. 3. Resident bedroom and other exit access doors in specialty care assisted living facility shall be at least three feet wide. 4. Exterior egress doors except the main entry/exit door, may be equipped with a delayed egress locking system installed in accordance with NFPA 101. Other exterior egress doors may be arranged to prevent free and unhindered egress from specialty care assisted living facilities, in accordance with the Special Requirements portion of this section. 5. Exit doors swinging outward shall swing out over a landing having a minimum length and width equal to the door's width at the same level as the floor level, except existing doors shall not have more than a four inch step down. (m) Ventilation. The building shall be well ventilated at all times to prevent accumulation of objectionable odors. Kitchens, laundries, service rooms, toilets, and bathrooms shall be ventilated by windows, gravity vents, or mechanical means as necessary to prevent	A1203		

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A1203	Continued From page 110	A1203		

offensive odors from entering other parts of the facility.

(n) Fire Extinguishers. Fire extinguishers shall be provided for each hall, kitchen, and laundry, of type and capacity appropriate to the need.

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

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

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

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

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

(r) Exit marking. In all facilities, a sign

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A1203	Continued From page 111 bearing the word "EXIT" in plain legible block letters shall be placed at each exit. Additional signs shall be placed in corridors and passageways wherever necessary to indicate the direction of exit. Letters of signs shall be at least four inches high. All exit and directional signs shall be kept clearly legible by continuous internal electric illumination and have battery back-up or emergency power. (s) Heating, Lighting, and other Service Equipment. 1. Central or individual room gas heating systems shall be of the enclosed flame type equipped with automatic flame shut-off control and shall be vented directly to the outside. Heating units of any type shall be located to avoid direct contact with any combustible material and shall be maintained in accordance with manufacturer's recommendation. 2. Open flame and portable heaters are prohibited in specialty care assisted living facilities. This does not apply to a fire place with gas logs protected as noted elsewhere in these rules. 3. Lighting shall be restricted to electricity. Electric wiring, motors, and other electrical equipment in all specialty care assisted living facilities shall be in accordance with local electrical codes and the NFPA National Electrical Code. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to have an operable call system.	A1203		

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A1203	Continued From page 112 THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON APRIL 27, 2021. Findings: The Alabama Department of Public Health received a complaint which alleged call lights were not answered timely. Surveyors were able to substantiate this complaint during the onsite survey and identified the following deficient practice as a result of the complaint investigation. On the afternoon of April 9, 2025 during a random test of the call system, it was revealed that the call system did not properly function and was not working in Room 104, 110, 112, 114, and 215. The administrator, EI#1, and Maintenance Technician, EI#6, both concurred with the surveyor observations. EI#1, stated, "The maintenance will get this fixed immediately". On the morning of April 15, 2025, when EI#2 was asked why call lights were not working, she answered that should not be the case. EI#2 admitted there was a process for checking the call lights but it was not done.	A1203		
A1206	420-5-20-.12 (8) Physical Environment (8) Additional Requirements for Specialty Care Assisted Living Facilities. (a) Facilities shall be certified and licensed for housing residents with dementia, and must comply with these special requirements for	A1206		

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A1206	Continued From page 113	A1206		

the physical plant. Facilities should confirm local code requirements, which may vary from those indicated below.

(b) Additional Smoke Detection. Smoke detectors (electrical or system type) shall be provided in the sleeping rooms and any bedroom suite sitting areas, which house dementia residents. These detectors shall initiate at least a local alarm or supervisory signal, through the fire alarm system or call system.

(c) Windows in specialty care facilities may have devices which prevent opening of the window.

(d) Areas to Wander and Secure Perimeter.

1. Each facility shall have a secure boundary or perimeter to safely accommodate residents in all aspects of its physical plant. Exterior building walls and doors, and walled or fenced outdoor areas may form this boundary. Such walls or fences shall be at least six feet high.

2. Each walled or fenced area shall have at least one gate, located along the discharge path of travel from the building egress doors to the public way. Gates shall be readily unlockable from either side by the staff or by automatic means. "Automatic means" shall be in the same manner as locked or delayed-egress exit doors.

3. If the facility's emergency plan utilizes fenced or walled outdoor spaces as refuge areas for containment of residents, each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P4102	A. BUILDING: _____ B. WING _____	C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMER VILLAGE MAGNOLIA PLACE	1553 PROFESSIONAL PARKWAY AUBURN, AL 36830

(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
A1206	Continued From page 114 refuge area shall be of sufficient size to accommodate all occupants at a distance of not less than 50 feet from the building while providing a net area of 15 square feet per person. A gate shall be located within this refuge area. 4. If the facility's emergency plan uses the fenced or walled outdoor spaces merely as areas that are immediately passed through and exited, not as refuge areas for containment of residents, there is no size or area requirement for the fenced or walled spaces. 5. An outdoor courtyard, which is completely surrounded by the building, must have at least two separate doorways, located remotely from each other, leading into separate smoke compartments of the building. (e) Locking of Exit Doors. Locks on exit doors of each specialty care assisted living facility, if installed, shall be electrical locked or electrical delayed-egress locking devices. Buildings shall be protected throughout by an approved supervised automatic sprinkler system connected to the fire alarm system. 1. Delayed-egress locks must comply with the requirements for "Special Locking Arrangements" found in NFPA 101 Life Safety Code. 2. Electrically locked doors shall comply with the following: (i) A control panel shall be provided at one or more stations with the capability to remotely unlock all exit doors, simultaneously. Locks may be arranged to unlock in Specialty	A1206		

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A1206	Continued From page 115 Care compartments based on a zoning concept, where each zone is a rated fire or smoke compartment and the locks on all egress doors unlock within the alarmed zone or compartment. This zoning concept is permitted to apply to automatic functions required by the Life Safety Code. (ii) A key, code, or card release switch shall be provided inside the facility at each locked door, which shall override the locking system to allow exiting from the compartment or building. (iii) All locks shall release automatically upon activation of the facility fire detection, or fire sprinkler system, or upon disablement of the fire alarm system. (iv) Locks shall release automatically upon loss of electric power controlling the lock. (v) The facility shall provide the residents sponsors with adequate information about the facility's door locking arrangements. (vi) The facility shall assure, at least monthly, that locked or delayed-egress exit doors function properly, in accordance with required fire safety provisions. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a gate that was easily unlockable from either side, along the discharge path of travel from the building egress doors to the public way.	A1206		

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A1206	Continued From page 116 Findings: On the morning of April 10, 2025 during the fire drill it was revealed that the garden atrium area gate located in the rear of the facility was found to be secured with a rusted chain and padlock. The surveyor asked EI#6, Maintenance Technician, what the procedure was for unlocking this gate during a fire. EI#6 responded the key to the padlock was kept in the concierge desk in a key box. EI#6 said staff had to get the key from the concierge to unlock the gate. The surveyor asked if there was another key, readily accessible to staff, if a fire broke out in the concierge area. EI#6 responded that the key was kept at the concierge desk. THERESA HARRISON, REGISTERED NURSE GREGORY ZEITLIN, REGISTERED NURSE	A1206		