STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5202	A. BUILDING: _____ B. WING _____	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE AT PRICEVILLE SCALF, THE	200 TERRACE LANE DECATUR, AL 35603

(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 June 13, 2024, an unannounced licensure survey and complaint investigation was conducted for this 62 bed Specialty Care Assisted Living Facility (SCALF) with a census of 29. There were four (4) complaints investigated during this survey. LC#20240516008 was investigated and substantiated. There were deficiencies written as a result of this complaint investigation. LC#20240110001, LC#20220712006 and LC#20220323014 were investigated and unsubstantiated. No deficiencies were cited as a result of these complaint investigations. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practices resulted in actual harm to one resident and the potential for harm to all 29 residents of the facility.	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:	A 301		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 301	Continued From page 1 1. Each person who has an ownership interest of 10 percent or more of the governing authority. 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.	A 301		

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A 301	Continued From page 2	A 301		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the governing authority failed to ensure the facility operated in compliance with the SBOH rules for SCALFs. The governing authority's lack of adequate oversight resulted in deficient practices which caused actual harm to one resident of the facility and placed all 29 residents of the facility at significant risk for harm due to this failure to apply the SBOH rules for the day to day operations of the facility.

THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

Findings:

The Alabama Department of Public Health received a complaint which alleged one resident of the facility was assaulted by another resident of the facility causing a head injury to one resident. Surveyors were able to substantiate this complaint during the onsite survey and identified deficient practices related to this incident.

Resident Identifier (RI)#8 was admitted to the facility on March 22, 2023 and had diagnoses which included dementia with mood disturbance, anxiety disorder, depression, hypertension, hyperlipidemia, diabetes mellitus type II, heart failure and insomnia. RI#8 repeatedly demonstrated inappropriate behaviors since admission to the facility, including wandering into other residents' rooms, knocking on other residents' doors at night, urinating and defecating in public places, being verbally and physically aggressive with staff and inappropriate sexual

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A 301	Continued From page 3 behaviors with another resident of the facility. RI#8 also sustained eight falls in a nine month period at the facility. RI#9 was admitted to the facility on July 31, 2023 and had diagnoses which included major depressive disorder, Alzheimer's disease, hyperlipidemia, vitamin B12 anemia, vitamin D deficiency, alcohol abuse-in remission, and depression. RI#8 and RI#9 were involved in an incident at the facility on May 16, 2024, at approximately 1:10 AM, which resulted in head trauma to RI#8 and the discharge of both residents from the facility. Less than 24 hours prior to this incident, RI#9 demonstrated agitation and verbalized suicidal ideation. Arrangements were being made to transfer RI#9 to a psychiatric facility. However, the facility policy and procedure for suicidal ideation was not followed when one-on-one supervision of RI#9 was not provided until transfer. This scenario culminated when RI#8 was found on the floor in the hallway on May 16, 2024 with head trauma. RI#9 was also in the hallway near RI#8 and repeatedly admitted to harming RI#8 when RI#8 attempted to enter his/her (RI#9's) room or bother him/her (RI#9) in some way. Refer to deficiencies 302, 303, 508, 605, 611 and 621 for additional information on RI#8 and RI#9. During interviews with staff while surveyors were onsite at the facility, staff reported numerous incidents of the above behaviors demonstrated by RI#8 as well as the agitation and suicidal threat verbalized by RI#9 on May 15, 2024. Employee Identifier (EI)#1 and EI#4 reported to surveyors that they (EI#1 and EI#4) had communicated frequently with corporate staff about RI#8's behaviors but were instructed by corporate (EI#3) not to issue a 30-day discharge notice to RI#8	A 301		

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A 301	Continued From page 4 and to monitor the situation. No 30-day discharge notice had been issued to RI#8 at the time of RI#8's transfer to the hospital on May 16, 2024. During an interview on June 13, 2024, at approximately 1:20 PM, EI#3, Regional Director of Operations, informed the surveyors that she (EI#3) had not instructed the facility not to issue a discharge notice to RI#8. EI#3 added that she (EI#3) was aware of the situation with RI#8's behaviors and had instructed EI#1 and EI#4 to monitor the situation. EI#3 added that corporate staff were supportive when the facility recommended that a resident was not appropriate and needed to be discharged. During an interview on June 25, 2024, at approximately 3:40 PM, EI#2, Regional Director of Health and Wellness, stated that corporate staff may have instructed the administrator to try additional interventions prior to issuing a discharge notice but that it was the administrator's responsibility to ensure that residents were discharged appropriately. EI#2 added that she (EI#2) visited the facility about every two months. The following deficient practices were cited as a result of the governing authority's failure to provide adequate oversight of the day to day operations of the facility. 302 - The facility's policy and procedure for suicidal ideation was not followed. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JANUARY 17, 2019. 303 - The administrator failed to ensure residents were properly transferred or discharged and	A 301		

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A 301	Continued From page 5 failed to ensure previously cited deficiencies were corrected. 504 - A safe and decent environment was not maintained for all residents at all times. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 508 - Incidents were not reported timely or were not reported at all to the ADPH. 605 - The facility failed to make arrangements for transfer of a resident to a higher level of care when the resident no longer met the criteria for retention in a SCALF. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 611 - Residents' care plans did not contain interventions to adequately address the care and safety needs of the residents. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JANUARY 17, 2019. 621 - A resident was retained at the facility who did not meet the criteria for retention in a SCALF. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.	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	A 302		

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A 302	Continued From page 6 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. (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.	A 302		

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A 302	Continued From page 7 (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 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	A 302		

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A 302	Continued From page 8 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 record reviews and interviews, the facility failed to follow its own policy for suicidal ideation. This deficient practice caused actual harm to one resident of the facility and placed all 29 residents of the facility at risk of harm. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JANUARY 17, 2019. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged a resident of the facility sustained head trauma when assaulted by another resident of the facility. Surveyors were able to substantiate this complaint during the onsite survey and identified the following deficient practice as a result of the complaint investigation. Review of resident records, on June 12 and 13, 2024, revealed the following information. RI#9 had resided at the facility since July 31,	A 302		

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A 302	Continued From page 9 2023. Refer to deficiencies 301, 303, 605 and 611 for additional information on RI#9. A facility incident report, written by EI#9 and dated May 15, 2024 at 10:32 AM, documented that RI#9 was in the dayroom yelling at staff, "You are keeping me here. If not I would be home with my family. I'm getting out of here one way or the other. I will commit suicide. I will find a way to do it". The report documented that RI#9 had increased agitation. RI#9's physician was in the building at the time of the incident, overheard RI#9 yelling and wrote an order, dated May 15, 2024, which read, "Send to Sanctuary (psychiatric facility) for psych evaluation". The facility then contacted the Certified Registered Nurse Practitioner (CRNP) with Behavioral Health to come and evaluate RI#9. EI#5, Assistant Director of Resident Care, was in charge at the facility at the time of the incident. On June 12, 2024, EI#5 stated that the CRNP was contacted because Behavioral Health was following RI#9 and was familiar with RI#9. The CRNP's SOAP (Subjective, Objective, Assessment and Plan) note, dated May 15, 2024, read, "Pleasant and cooperative...denies depression or anxiety...no SI/HI (suicidal ideation/homicidal ideation), plan, or intent...He was assessed by medical doctor and decision made to send to inpatient psych". The CRNP wrote an order, dated May 16, 2024, which read, "Frequent checks due to statements R/T (related to) self-harm May 15, 2024". The CRNP spoke with the psychiatric facility where RI#9's physician had ordered for RI#9 to be sent and there were no beds available for admission until possibly May 16, 2024. RI#9's information was then sent to another psychiatric facility, but they did not accept RI#9's insurance. RI#9's information was also sent to two additional psychiatric facilities and the facility was awaiting details on acceptance. RI#9 was not sent out of the facility	A 302		

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A 302	Continued From page 10 until around 1:10 AM on the morning of May 16, 2024, when RI#9 was involved in an altercation with another resident and admitted repeatedly to assaulting the resident. RI#9 was not injured during the incident and returned to the facility that same morning after being assessed at the emergency department. Upon RI#9's return to the facility on May 16, 2024, arrangements were made for RI#9 to be admitted to a psychiatric facility and RI#9 was sent to the psychiatric facility later during the morning of May 16, 2024. The facility's policy on "Suicidal Ideation Recognition Guidelines", dated September 1, 2018, was reviewed by the surveyors on June 12, 2024. According to the facility's policy, "...Suicidal ideation is defined as self-reported thoughts, or behavior which reasonably suggests thoughts of engaging in suicide related behavior...". The following procedures were documented in the policy, "...A resident who makes a statement indicating Suicidal Ideation is not to be left unattended (provide one-to-one supervision) until he/she is either transported to an acute care hospital for evaluation, or until he/she is evaluated by a professional mental health worker and deemed in writing to no longer be a current danger to him/herself or others...". RI#9's physician wrote an order, on May 15, 2024, for RI#9 to be admitted to a psychiatric facility. This order was not carried out until the following day, approximately 24 hours later. During interviews, on June 11, 2024, both EI#9 and EI#10 stated that one-on-one supervision was not provided continuously for RI#9 during the approximate 24 hours until RI#9 was admitted to a psychiatric facility. No staff were with RI#9 at the time that RI#9 assaulted another resident and there were no witnesses to the incident on May 16, 2024, at approximately 1:10 AM. There was no	A 302		

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A 302	Continued From page 11 documentation in facility records which read that RI#9 was not a current danger to him/herself. The facility failed to follow their policy and procedure for suicidal ideation by failing to provide one-on-one supervision of RI#9 to ensure RI#9 and all residents of the facility were safe. Surveyors conducted an interview with EI#5 on June 12, 2024, at approximately 9:30 AM. EI#5 stated, "I decided to do hourly checks due to the CRNP order for frequent checks". EI#5 also stated she (EI#5) did not know that the facility had a suicidal ideation policy. On June 13, 2024, at approximately 12:50 PM, EI#1 stated she (EI#1) was aware of the suicidal ideation policy and wished that EI#5 had contacted her (EI#1) at the time of the incident so that the policy could have been utilized.	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.	A 303		

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A 303	Continued From page 12 4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days. 5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age. 6. The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character. 7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week. 8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment and adequate care actually being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement. 9. The facility administrator is responsible for ensuring that required training is provided to all staff. 10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate	A 303		

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A 303	Continued From page 13 setting. 11. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when needed. 12. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan. 13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained. This Rule is not met as evidenced by: Based on record review and interview, the administrator failed to manage and direct staff to always maintain a safe environment and to follow the facility's policies. In addition, the administrator failed to transfer or discharge residents promptly to ensure the health or safety needs of the residents were met, failed to ensure residents' care plans were adequate to meet the care and safety needs of the residents and failed to ensure previously cited deficiencies were corrected and compliance with the SBOH rules for SCALFs was maintained.. Findings: Management and Direction of Staff to Maintain a Safe Environment/Facility Policies Not Followed On May 16, 2024, an incident occurred at the	A 303		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5202	A. BUILDING: _____ B. WING _____	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE AT PRICEVILLE SCALF, THE	200 TERRACE LANE DECATUR, AL 35603

(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 303	Continued From page 14 facility involving two residents. Refer to deficiencies 301, 302 and 621 for additional information on this incident and the two residents. One resident (RI#9) had verbalized suicidal intent and a plan the day before the incident occurred (May 15, 2024) and was not sent out to a psychiatric facility until May 16, 2024. One-on-one supervision was not provided continuously for RI#9 until RI#9 was sent to the psychiatric facility as directed in the facility's policy and procedure. During the 24 hour period that RI#9 remained at the facility, RI#9 admittedly assaulted RI#8, resulting in head trauma to RI#8. On June 13, 2024, at approximately 12:30 PM, EI#1, Administrator, stated she (EI#1) was not working at the time of the suicidal threat by RI#9 but she (EI#1) wished staff had contacted her (EI#1) for guidance in following the facility's policy for suicidal ideation. EI#1 stated, "If I would have known about the details of the incident, I would have done one on one supervision". EI#1 also stated EI#5 told her (EI#1) that EI#5 had taken care of everything and didn't want to bother EI#1. Discharge or Transfer Resident to an Appropriate Level of Care/Care Plans RI#8 had resided at the facility since March 22, 2023. Refer to deficiencies 301, 302, 508, 605, 611 and 621 for additional information on RI#8. RI#8 demonstrated numerous inappropriate behaviors while residing at the facility, including wandering into other residents' rooms, knocking on other residents' doors during the night, urinating and defecating in public places, aggressive and combative behaviors toward staff and inappropriate sexual behaviors with another resident of the facility. In addition, RI#8 sustained eight falls at the facility in a nine-month period of	A 303		

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A 303	Continued From page 15 time. RI#8's behaviors and falls were not adequately addressed on RI#8's facility care plan. Although RI#8's behaviors and falls had persisted for several months, no 30-day discharge notice was issued to RI#8. RI#8 was discharged from the facility following an admitted assault by another resident of the facility when RI#8 attempted to enter the resident's room. EI#1 and EI#4 informed the surveyors that they (EI#1 and EI#4) had discussed with EI#3, Corporate Nurse, the need for RI#8 to receive a discharge notice. Both EI#1 and EI#4 stated they were instructed by EI#3 to monitor the situation and not to issue a discharge notice at that time. Repeat Deficiencies During the previous licensure survey, conducted on January 17, 2019, deficiencies were cited for failure to follow the facility's policies and inadequate resident care plans. These same deficiencies were cited during the current survey. Refer to deficiencies 302 and 611 for additional information. On June 13, 2024, EI#1 agreed with the surveyors' findings that there were repeat deficiencies.	A 303		
A 504	420-5-20-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission, of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by	A 504		

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A 504	Continued From page 16 the administrator or the administrator's designee and by the resident or sponsor, when appropriate. 1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility. 2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints. 3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy. 4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time. 5. Every resident shall have freedom to participate in and benefit from social, religious, and community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. 6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the premises, an individual account record for each	A 504		

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A 504	Continued From page 17 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 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	A 504		

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A 504	Continued From page 18 is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record. 12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person without restraint, interference, coercion, discrimination, or reprisal. 13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file. 14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the facility, provided that: (i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care. (ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation.	A 504		

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A 504	Continued From page 19 (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. 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.	A 504		

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A 504	Continued From page 20 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 interviews and record reviews, the facility failed to provide a safe and decent environment for all residents at all times. THIS DEFICIENCY WAS CITED AS A RESULT	A 504		

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A 504	Continued From page 21 OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged a resident of the facility was assaulted by another resident, resulting in head trauma to one resident. Surveyors were able to substantiate this complaint during the onsite survey and identified deficient practices which interfered with all residents' right to a safe and decent environment. Surveyors identified the following deficient practices which jeopardized the safety and wellbeing of residents. The facility policy and procedure for providing one-on-one supervision of a resident who verbalized suicidal ideation was not followed (Deficiency 301). Arrangements were not made to discharge a resident who repeatedly demonstrated behaviors which were not allowed in a SCALF and which were harmful or offensive to other residents and staff (Deficiencies 605 and 621). These deficient practices resulted in actual harm to one resident and placed all 29 residents of the facility at significant risk of harm.	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	A 508		

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A 508	Continued From page 22 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 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	A 508		

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A 508	Continued From page 23 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 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.	A 508		

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A 508	Continued From page 24 (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. (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	A 508		

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A 508	Continued From page 25 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. (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	A 508		

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A 508	Continued From page 26 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. (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.	A 508		

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A 508	Continued From page 27 (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: (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	A 508		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 508	Continued From page 28 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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report incidents timely to the Department's Online Incident Reporting System (OIRS) and failed to report incidents involving suspected sexual abuse of residents. Findings: Incidents Not Reported to the OIRS Timely On June 6, 2024, surveyors reviewed incidents reported to the Department's Online Incident Reporting System. The following incidents were reported greater than 24 hours after the incident occurred. * A fall was reported on April 8, 2024 at 8:49 AM which occurred on April 6, 2024 at 6:20 PM. * A fall was reported on September 29, 2023 at 4:06 PM which occurred on September 25, 2023 at 6:00 PM. * A fall was reported on February 15, 2023 at 11:36 AM which occurred on February 13, 2023 at 4:00 PM. * A fall was reported on May 30, 2023 at 2:10 PM which occurred on May 29, 2023 at 10:50 AM. * A fall was reported on June 18, 2023 at 5:49 PM	A 508		

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	P5202	A. BUILDING: _____ B. WING _____	06/26/2024

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A 508	Continued From page 29 which occurred on June 17, 2023 at 11:30 AM. * A disease report was reported on January 3, 2023 at 1:52 PM which occurred on December 30, 2022 at 6:00 AM. * A disease report was reported on July 12, 2022 at 2:02 PM which occurred on July 5, 2022 at 4:15 PM. * A fall was reported on September 7, 2021 at 10:30 AM which occurred on September 5, 2021 at 11:50 PM. Incidents Not Reported to the OIRS Review of facility records, on June 12 and 13, 2024, revealed the following incidents which were not reported to the OIRS. On September 29, 2023, a facility Progress Note, documented by EI#18, reported that RI#8 was found in another resident's room and both residents were naked. When redirected, RI#8 became aggressive with staff. On November 9, 2023, a facility Progress Note, documented by EI#9, reported that EI#9 was called into the Day Room by staff who reported RI#8 was kissing and holding hands with another resident. RI#8 exhibited increased agitation and EI#9 was unable to redirect RI#8. RI#8 was yelling at staff that "I can do what I want to. You can't stop me. I'm not going anywhere." Review of the facility's OIRS, on June 13, 2024, revealed neither incident was reported to the OIRS as required for suspected sexual abuse. During an interview on June 25, 2024, at approximately 7:00 AM, EI#4 stated that some incidents had not been reported timely because they occurred on the weekend and nurses	A 508		

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TERRACE AT PRICEVILLE SCALF, THE	200 TERRACE LANE DECATUR, AL 35603

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A 508	Continued From page 30 working at the time failed to report the incidents to ADPH. EI#4 added that she (EI#4) would report the incidents when she (EI#4) returned to work, usually on the following Monday. EI#4 was unsure if the incidents of suspected sexual abuse were reported to ADPH.	A 508		
A 605	420-5-20-.06 (3) (f) Care of Residents. (f) Observation. Each specialty care assisted living facility shall provide general observation and health supervision of the residents to identify changes in all residents' health conditions and physical abilities, and awareness of the need for medical attention or nursing services as the changes develop. Whenever a resident requires medical attention, nursing services, or changes in personal care and assistance with activities of daily living provided by the facility, the facility shall arrange for or assist the residents in obtaining necessary services. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to utilize general observation and health supervision of a resident to identify changes in the resident's health conditions and physical abilities and arrange for or assist the resident in obtaining necessary services. THIS DEFICIENCY WAS CITED AS A RESULT	A 605		

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A 605	Continued From page 31 OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged a resident of the facility sustained head trauma when assaulted by another resident of the facility. Surveyors were able to substantiate this complaint during the onsite survey and identified the following deficient practice as a result of the complaint investigation. Review of facility records on June 12 and 13, 2024 revealed the following information. RI#8 had resided at the facility since March 22, 2023. Refer to deficiencies 301, 302, 303, 508, 611 and 621 for additional information on RI#8. During the sixteen months that RI#8 resided at the facility, RI#8 sustained eight falls in a nine month period, had multiple episodes of inappropriate sexual behaviors (one requiring admission to a psychiatric facility), demonstrated aggressive and combative behaviors with staff resulting in injury to one staff member, had multiple episodes of verbally aggressive behaviors and urinating/defecating in public places as well as exit seeking and wandering behaviors which were offensive to other residents. RI#8's wandering behaviors included knocking on other residents' doors at night and wandering into other residents' rooms, sometimes urinating in the rooms. Interviews were conducted with numerous staff members during the onsite survey from June 10-13, 2024. EI#4, EI#5, EI#9, EI#10, EI#11, EI#12, EI#13, EI#14 and EI#15 each reported having observed inappropriate behaviors	A 605		

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A 605	Continued From page 32 exhibited by RI#8, including hitting staff with RI#8's hand and with a walker. During separate interviews on June 13, 2024, both EI#1 and EI#4 agreed with the surveyors that RI#8 demonstrated repeated behaviors which deemed RI#8 ineligible for retention in the SCALF and placed both RI#8 and all residents of the facility at risk of harm. Both EI#1 and EI#4 stated that corporate level staff had been kept aware of RI#8's status and behaviors but corporate staff (EI#3) had instructed EI#1 and EI#4 to retain RI#8 at the facility and monitor the situation. On May 16, 2024, RI#9 admitted to assaulting RI#8 at the facility. Although the exact circumstances of the incident are unknown due to no witnesses, RI#9 stated to multiple staff that he/she (RI#9) pushed/kicked/beat RI#8 because RI#8 attempted to enter his/her (RI#9's) room or bother RI#9 in some way. Surveyors also noted that RI#9 had been very agitated and verbalized suicidal ideation less than 24 hours prior to the incident and facility policy was not followed in maintaining one-on-one supervision of RI#9 until RI#9 was sent to a psychiatric facility as ordered by RI#9's physician. During an interview on June 13, 2024, at approximately 12:30 PM, EI#1 stated that she (EI#1) would have arranged for one-on-one supervision of RI#9 per facility policy if she (EI#1) had been made aware of the situation. The facility failed to arrange for RI#8 to be discharged to a higher level of care. In addition, the facility failed to arrange for one-on-one supervision of RI#9 until RI#9 could be transferred to an appropriate facility. These failures resulted in harm to RI#8 in the form of	A 605		

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A 605	Continued From page 33 head injury and placed all 29 residents of the facility at significant risk of harm.	A 605		
A 611	420-5-20-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. The RN shall develop written plans of care for each resident prior to or at the time of admission. The plans of care shall be based on resident's assessments, diagnoses, and recommendations of the resident's physician. The plan of care shall be developed in cooperation with the resident, if appropriate, and the sponsor. The RN shall identify resident care problem areas and formulate written interventions to address those problems. The RN shall evaluate the implementation of the interventions and the resident's response to the interventions and modify the plan of care as necessary. 1. The plan shall at all times reflect the current condition of the resident. All entries on the plan of care shall be accurately dated. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following: 2. A listing of the resident's individual needs or problems that require intervention by the facility.	A 611		

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A 611	Continued From page 34 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, 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	A 611		

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A 611	Continued From page 35 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 observations, interviews and record reviews, residents' care plans did not contain adequate or any interventions to address the residents' care and safety needs. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JANUARY 17, 2019. Findings: Review of residents' facility records, on June 12 and 13, 2024, revealed the following information. RI#4 RI#4 was admitted to the facility on May 13, 2022, and had diagnoses which included vascular dementia, hyperlipidemia, adjustment disorder with mixed anxiety and depressive mood, insomnia, encephalopathy, cerebral infarction, gastroesophageal reflux disease, constipation, chronic kidney disease, restlessness, and agitation. RI#4 was prescribed oxygen at 2-4 liters per minute (LPM) via nasal cannula as needed. EI#4's facility care plan, initiated on May 12, 2022, did not contain any information on how to care for RI#4's tubing and nasal cannula. RI#4's facility care plan also did not state who was responsible for administering oxygen and did	A 611		

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A 611	Continued From page 36 not address the safe storage of oxygen tanks. RI#5 RI#5 was admitted to the facility on April 29, 2024 and had diagnoses which included vascular dementia, bipolar disorder, fibromyalgia, hypertension, chronic obstructive pulmonary disease, osteoarthritis, hyperlipidemia, anemia and low back pain. RI#5 sustained falls at the facility on May 16, 18 and 27, 2024. RI#5's facility care plan read "I have had an actual fall on 05/16/2024, 05/17/2024 and 05/27/2024". The interventions added after RI#5's falls were multiple immediate interventions for evaluation of RI#5 and monitoring for three days after the falls. However, the care plan did not document any additional specific interventions to prevent a recurrence. RI#6 RI#6 was admitted to the facility on November 4, 2022 and had diagnoses which included Alzheimer's disease, irritable bowel syndrome with diarrhea, major depressive disorder, anxiety disorder, hypothyroidism, insomnia, hypertension, hyperlipidemia and paroxysmal atrial fibrillation. RI#6 sustained a fall at the facility on May 28, 2024. RI#6's facility care plan read "I have had an actual fall on 05/28/2024" with multiple immediate interventions for evaluation of RI#6 and monitoring for three days after the fall. However, the care plan did not document any additional specific interventions to prevent a recurrence of the fall. Interviews with staff during the onsite survey revealed RI#6 frequently demonstrated behaviors of touching female and male residents of the	A 611		

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A 611	Continued From page 37 facility as well as holding hands and sometimes kissing other residents. In fact, RI#6 had been admitted to a geriatric psychiatric facility due to becoming aggressive with staff when they tried to separate RI#6 from another resident of the facility due to inappropriate sexual behaviors. These inappropriate behaviors were not addressed at all on RI#6's facility care plan. RI#8 RI#8 had resided at the facility since March 22, 2023. Refer to deficiencies 301, 302, 303, 508, 605 and 621 for additional information on RI#8. RI#8 sustained eight falls at the facility from July 2023 until April 2024. The eight falls were listed on RI#8's facility care plan from July 2023 until April 2024. An immediate intervention for evaluation of RI#8 and monitoring for three days after each fall was documented on RI#8's care plan. The most recent updated interventions were documented on April 19, 2024 and read "My caregivers will evaluate the environment at the time and location of my fall and attempt to identify any factors that may have contributed to the fall, such as uneven surfaces, bed not in lowest position, poor lighting or glare present, my not wearing footwear with non-skid soles, my not using/wearing assistive devices (sensory-glasses, hearing aid; function-walker, cane etc.), frequently used items not within my reach, etc, and report findings to supervisor". There was no documentation of any new specific interventions after each fall to prevent a recurrence. Staff also reported that RI#8 had exhibited inappropriate sexual behaviors with another resident of the facility and was sometimes difficult to redirect and would become aggressive toward staff when these behaviors occurred and staff	A 611		

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A 611	Continued From page 38 attempted to redirect RI#8. In fact, RI#8 had been sent out to a geriatric psychiatric facility for treatment due to aggressive behaviors following inappropriate sexual behaviors toward another resident. These inappropriate behaviors were not addressed on RI#8's facility care plan. In addition, staff reported RI#8 would urinate and defecate in public areas of the facility. Documentation of RI#8's falls revealed that several of the falls could possibly have been caused by slipping in feces. This behavior was not addressed on RI#8's facility care plan with appropriate interventions to control the behavior and prevent further falls. RI#9 RI#9 had resided at the facility since July 31, 2023. Refer to deficiencies 301, 302, 303 and 605 for additional information on RI#9. On May 15, 2024, RI#9 threatened suicide at the facility and stated he/she had a plan for carrying out the suicide. Although the facility's policy stated one-on-one supervision was required for residents with suicidal ideation, RI#9's facility care plan did not address one on one supervision. In fact, there were no interventions documented on RI#9's care plan to address RI#9's suicidal ideation. During interviews on June 13, 2024, both EI#1 and EI#4 agreed the care plans were not appropriate to meet the care and safety needs of these residents.	A 611		
A 621	420-5-20-.06 (9) (b) Care of Residents. (b) Retention.	A 621		

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A 621	Continued From page 39 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: (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	A 621		

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A 621	Continued From page 40 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 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	A 621		

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A 621	Continued From page 41 interfered with the rights or safety of other residents as well as the safety and wellbeing of the individual resident. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged a resident of the facility sustained a head injury as a result of an altercation with another resident. Surveyors were able to substantiate this complaint during the onsite survey and identified the following deficient practice as a result of the complaint investigation.. Review of resident records, on June 12 and 13, 2024, revealed the following information. RI#8 had resided at the facility since March 22, 2023. Refer to deficiencies 301, 302, 303, 508, 605 and 611 for additional information on RI#8. The following timeline of events involving RI#8 occurred at the facility. March 13, 2023 - RI#8's pre-admission Behavior Screen documented that RI#8 wandered at night and did not recognize his/her spouse. March 22, 2023 - RI#8 was admitted to the facility. May 2, 2023 - RI#8 was walking in hallways carrying shoes, picture frames and blanket. RI#8 refused to sit down and refused offers from staff to place items in his/her room. May 22, 2023 - RI#8 came out of his/her room several times during the night shift without his/her clothes on. RI#8 attempted to urinate in the kitchenette trash can.	A 621		

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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 621	Continued From page 42 July 10, 2023 - RI#8 was found on the floor following a fall. Physical and occupational therapy were ordered. August 23, 2023 - RI#8 tested positive for COVID-19. September 9, 2023 - RI#8 became agitated and hit his/her hand on the toilet paper holder. September 12, 2023 - RI#8 was in the Dining Room, patting another resident on their bottom. September 22, 2023 - RI#8 was wandering throughout the facility during the night, hollering for his/her spouse. Resident urinated in the hallway after being toileted. September 29, 2023 - RI#8 was found naked in another resident's room and became aggressive with staff when staff attempted to redirect him/her. October 2, 2023 - There was a discussion by staff with RI#8's spouse regarding RI#8's behaviors and spouse wanted to see how the new medication did before sending RI#8 to a psychiatric facility. October 4, 2023 - RI#8 was wandering into other residents' rooms and going from exit door to door trying to open the doors. RI#8 was in the hallway, pulled down his/her pants and had a bowel movement in the hallway floor. November 9, 2023 - Staff reported RI#8 was in the Day Room, kissing and holding hands with another resident. Staff were unable to redirect RI#8. RI#8 became agitated and was yelling at staff that "I can do what I want to. You can't stop me. I'm not going anywhere." November 16, 2023 - RI#8 was admitted to a psychiatric facility. While RI#8 was in the psychiatric facility, the following events occurred. On November 16, 2023, RI#8 became combative with staff while they were helping him/her clean up after a bowel movement. On November 17, 2023, RI#8 was pacing the floor and wandered	A 621		

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A 621	Continued From page 43 into another patient's room. On November 18, 2023, RI#8 was exit seeking and going around the unit to every door trying to open it and asking staff to let him/her go home. On November 20, 2023, documentation stated that RI#8 had three falls the previous day while exit seeking. December 11, 2023 - RI#8 returned to the facility from the psychiatric facility. December 15, 2023 - RI#8 was found on the floor in the bathroom. RI#8 refused to allow vital signs to be checked. December 23, 2023 - RI#8 was found on the floor, incontinent of bowel and had feces smeared on clothing. RI#8 refused for vital signs to be checked. A Behavior Screen documented RI#8 wandered around the unit and was verbally aggressive with staff at times. January 12, 2024 - RI#8 was found on the floor, incontinent of bowel and covered in feces. RI#8 was very unsteady. January 13, 2024 - RI#8 was found on the floor in the hallway. A Behavior Screen documented RI#8 wandered around the unit and was verbally aggressive with staff. January 18, 2024 - RI#8 was verbally abusive to staff, cursing and holding onto his/her shoes, refusing to get dressed. RI#8 was yelling at staff to shut up and could be heard from another resident's room by staff. Staff attempted three times to redirect RI#8. A Behavior Screen documented RI#8 wandered around the unit and was verbally aggressive with staff at times. January 22, 2024 - RI#8 was found on the floor in feces. February 1, 2024 - RI#8 was ambulating unassisted and was unsteady. Staff attempted three times to assist RI#8 and RI#8 would state "Don't touch me", becoming more agitated each time staff attempted to assist him/her. Staff offered to take RI#8 to his/her room, the	A 621		

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A 621	Continued From page 44 bathroom and offered a snack; RI#8 refused all offers. Staff were unable to redirect and protect RI#8. A Behavior Screen documented RI#8 wandered around the unit and was verbally aggressive with staff. February 16, 2024 - RI#8 fell in the Day Room. RI#8 refused to have vital signs checked and was agitated, not wanting anyone to touch him/her. March 6, 2024 - Staff were assisting RI#8 to the bathroom and RI#8 became agitated, stating "I can do what I want. I can go where I want to go." RI#8 refused to use the rolling walker and had an unsteady gait. RI#8 was yelling at staff. March 6, 2024 - RI#8 attempted to follow staff while they were assisting another resident to the bathroom. When staff attempted to redirect RI#8, RI#8 became agitated stating, "I can do what I want. I can go where I want to go". RI#8 had an unsteady gait and refused to use his/her walker. A Behavior Screen documented RI#8 wandered around the unit and was verbally aggressive with staff. April 15, 2024 - RI#8 hit a staff member three times in the back when the staff member attempted to direct RI#8 to a chair. April 19, 2024 - RI#8 was found on the floor in the bathroom, incontinent of watery feces with feces smeared everywhere. May 12, 2024 - RI#8 hit a staff member in the mouth causing a cut to the lip. A Behavior Screen documented RI#8 wandered around the unit and was verbally aggressive with staff. May 13, 2024 - Dark purple/black discoloration was noted by family and staff to RI#8's forearms. RI#8 was assessed by the nurse practitioner. During an interview on June 24, 2024, at approximately 1:45 PM, the CRNP who assessed RI#8 when the bruises were discovered was interviewed. The CRNP reviewed his note with surveyors. The note documented bruises to	A 621		

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A 621	Continued From page 45 bilateral forearms from an unknown source. The CRNP stated that the bruises could have been caused from RI#8's physical aggression with staff the previous day and added there was no allegation of restraints being used which could have caused bruising. The CRNP added that a family member was present and the interaction with the resident and family member was pleasant. May 16, 2024 - RI#8 was found on the floor in the hallway, bleeding from the nose and the mouth with both eyes swollen shut. RI#9 was in the hallway also, stating he/she (RI#9) beat the "h _ _ _" out of him/her (RI#8). RI#8 was sent to the hospital where RI#8 was diagnosed with brain bleeds and was admitted to the intensive care unit. RI#8 did not return to the facility. A police report, dated May 16, 2024, documented the police officer overheard RI#9 telling the Lifeguard medics that someone was trying to come into his/her home and he/she defended himself/herself. Staff interviews were conducted throughout the onsite survey and nine staff members (EI#4, EI#5, EI#9, EI#10, EI#11, EI#12, EI#13, EI#14 and EI#15) all stated that they had witnessed inappropriate behaviors from RI#8, including yelling, physical aggression, entering other residents' rooms, knocking on other residents' doors at night, urinating and defecating in public places and sexually inappropriate behaviors with another resident. Four staff members (EI#9, EI#10, EI#11 and EI#15) stated RI#9 admitted to being physically aggressive toward RI#8 on May 16, 2024. A facility Incident Report, dated May 16, 2024, documented that both RI#8 and RI#9 were found in the hallway, outside RI#9's door, and RI#8 was on the floor. RI#8 "looked to have been struck in the face perhaps several times and RI#9 had no injuries".	A 621		

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A 621	Continued From page 46 RI#8 had been retained at the facility with numerous behaviors and multiple falls. RI#8's medications had been adjusted numerous times while RI#8 resided at the facility. RI#8 had been treated at a psychiatric facility, had received physical therapy services through home health and was being followed and treated by the behavioral health CRNP. However, RI#8's inappropriate behaviors and falls continued. During interviews on June 13, 2024, both EI#1 and EI#4 agreed that RI#8 should have been discharged from the facility or, at least, have been issued a 30-day discharge notice. Both EI#1 and EI#4 stated that there was constant communication between the facility and the governing authority but they (EI#1 and EI#4) had been instructed by the governing authority (EI#3) to monitor the situation with RI#8 and not to issue a 30-day discharge notice. When interviewed on June 13, 2024, at approximately 1:20 PM, EI#3 stated the governing authority was responsive to the facility when a resident did not meet the criteria to remain in the facility and asked the facility to keep them updated on changes in the resident's condition.	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.	A 702		

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A 702	Continued From page 47 2. Hand washed repeated service and multi-service utensils and dishes, after washing and rinsing, shall be sanitized by either of the following methods: (i) Utensils and dishes shall be completely immersed for a period of not less than 30 seconds in water that is at least 171 degrees Fahrenheit (pouring scalding water over utensils and dishes does not meet this requirement); or (ii) A cold water sanitizer: A sanitizing solution shall be used in accordance with the manufacturers' instructions. Utensils and dishes shall be completely immersed for a period of not less than 10 seconds in a clean solution containing not less than 50 ppm, and not more than 200 ppm, of available chlorine bleach or its equivalent or 30 seconds 12.5 ppm of iodine or the amount of time specified by the manufacturer in a 200 ppm quaternary ammonium solution. Water temperature must be at least 75 degrees Fahrenheit. Water temperatures and chemical concentrations shall be monitored and documented prior to dishwashing. A record of each test shall be maintained for at least three months. 3. Dishes and utensils shall be allowed to air dry. 4. After washing, rinsing, sanitizing, and 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.	A 702		

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A 702	Continued From page 48 5. The results from the use of dishwashing machines shall be equivalent to those obtained from the method outlined above, as documented in material provided from the manufacturer and kept on file at the facility. (b) Ice. Crushed or chipped ice shall be protected from splash, drip, and hand contamination during storage and service. The ice scoop shall be stored in a holder inside the ice bin in a manner to prevent ice from coming into contact with the handle, or it may be stored in an airtight container outside the ice bin. (c) Protection of Food from Contamination. 1. Food and food ingredients shall be stored, handled, and served so as to be protected from pests, dust, rodents, droplet infection, unsanitary handling, overhead leakage, sewage backflow, and any other contamination. Sugar, syrup, and condiment receptacles shall be provided with lids and shall be kept covered when not in use. 2. Medications, biologicals, poisons, detergents, and cleaning supplies shall not be kept in the refrigerator nor in other areas used for storage of food. 3. Food shall not be stored on the floor. 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	A 702		

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A 702	Continued From page 49 temperature of 0 degrees Fahrenheit. Thermometers shall remain in refrigerators and freezers at all times. 5. All leftover foods shall be labeled and dated with a "use by date," so that it may be consumed or discarded by that date, which is no more than three days from the date is was prepared. 6. All food products shall be used by the manufacturer's indicated date or discarded. 7. Food shall be prepared either in the licensed facility or another location even when that location is not part of the licensed facility. All food preparation areas used by the facility shall be subject to the same inspections as though part of the licensed facility. The licensed facility is responsible to ensure adequate equipment and measures are used so that food is not contaminated in transport and foods that are transported are held and served at the appropriate temperature at all times. 8. Hot food shall be maintained at a minimum temperature of 135 degrees Fahrenheit and cold foods at a maximum temperature of 41 degrees Fahrenheit. 9. Frozen food items (raw and cooked) shall be thawed under refrigeration or under 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).	A 702		

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A 702	Continued From page 50 10. Laundry shall not be brought through the food preparation or service area. (d) Storage and Service of Milk and Ice Cream. 1. Milk and fluid milk products shall be served only from the original containers in which they were received from the distributor. This shall not apply to cream for coffee, cereals, and milk for milk drinks which may be dispensed from a readily cleanable container approved for such use. 2. Milk and fluid milk products shall be stored in such a manner that bottles or containers from which the milk or milk product is to be poured or drunk will not become contaminated from drip or contact with foods. Milk shall be maintained and stored at a maximum temperature of 41 degrees Fahrenheit and shall not be served at a temperature warmer than 45 degrees Fahrenheit unless specifically requested to be served at a warmer temperature by a resident. 3. Contaminating substances shall not be stored with or over open containers of ice cream. Ice cream dippers, spatulas, and other serving utensils shall be cleaned between uses. (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	A 702		

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A 702	Continued From page 51 accumulate in the kitchen and shall be removed from the premises at frequent intervals. 2. After being emptied, all garbage cans and trash cans shall be washed and dried before reuse. (f) Employees' Cleanliness. 1. Employees engaged in the handling, preparation, and serving of food shall wear clean clothing at all times. Employees shall wear hair restraints, for example, hairnets, headbands, caps, or other adequate means to prevent contamination of food from hair. Employees whose duties include contact with residents shall change clothing or wear a clean covering over clothing before handling, preparing, or serving food. 2. Employees handling food shall wash their hands thoroughly before starting work each day, immediately after contact with any soiled matter, and before returning to work after each visit to the rest room. 3. Street clothing not worn by the employee shall be stored in lockers, dressing rooms, or closets designated for staff use. (g) Live Fowl or Animals. Live fowl or animals shall not be allowed in the food service 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.	A 702		

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A 702	Continued From page 52 (i) Dining in Kitchen. Dining in the kitchen shall not be permitted in Congregate assisted living facilities. (j) Paper for Food Wrapping. Only new paper, foil, or plastic wrap shall be used for wrapping of foods. (k) Laundering of clothing shall not be permitted in food preparation or service areas. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide proper handling and serving of food to prevent contamination and there was no thermometer in the refrigerator or freezer in the kitchenette. Findings: Food Handling and Serving On June 11, 2024, at approximately 11:40 AM, during the lunch meal, surveyors observed employees (EI#19 and EI#20) serving food to residents without wearing aprons. These employees also provided personal care to residents. This finding was discussed with EI#1 who agreed aprons should be worn. During the tour of the facility with EI#4, on June 11, 2024, a large plastic container of sugar was observed in the kitchenette. A mug was located in the sugar causing contamination of the sugar when the mug was used for scooping sugar out of the container. No Thermometer in Refrigerator and Freezer	A 702		

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A 702	Continued From page 53 During a tour of the facility with EI#4 on June 11, 2024, surveyors observed a refrigerator/freezer in the kitchenette on the unit. There was no thermometer in the refrigerator or the freezer and no documentation that temperatures had been checked. EI#4 agreed with the surveyors' findings.	A 702		
A 703	420-5-20-.07 (3) Food Service. (3) Dietary Service. (a) Number of Meals. No fewer than three meals shall be provided each 24 hours. Food service shall be provided in a resident's room during temporary illness if necessary. The diet shall be well-balanced, palatable, properly prepared, and sufficient in quantity and quality to meet the nutritional needs of the residents in accordance with Dietary Reference Intakes of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The food must be adapted in type and preparation to the habits, preferences, and physical abilities of the residents. (b) Timing of Meals. A time schedule for serving meals to residents and personnel shall be established. Meals shall be served approximately five hours apart with no more than 14 hours between the evening meal and breakfast. The time schedule of meals shall be posted with the menu. The facility shall make evening snacks available after service of the evening meal. The facility shall provide fluids throughout the day and shall make between-meal nourishment (snacks) available.	A 703		

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A 703	Continued From page 54 (c) Menu. The menu shall be planned and written at least 1 week in advance. The current week's menu shall be posted in the food service area and shall be kept on file for the following 2 weeks. For any resident with a physician's order for a therapeutic diet, the facility shall have a copy of the diet and the facility shall document the adjustment of its menu to accommodate the resident's needs. (d) Alternate food selections or substitutes shall be made available to all residents. (e) A facility shall not obtain food from charitable organizations. A facility shall not avoid serving a meal by sending or transporting residents to missions, soup kitchens, or other charitable facilities for meals. (f) The amount of food on hand shall be sufficient to serve three meals per day to all residents for 3 days. Non-perishable food and potable water shall be maintained in the facility in sufficient quantity to serve three meals per day to all residents for 3 days. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain adequate emergency water for all residents. In addition, a time schedule for meals and weekly menu were not visibly posted. Findings: Emergency Water	A 703		

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A 703	Continued From page 55 The surveyor performed a kitchen tour with EI#17, on June 12, 2024 at approximately 1:00 PM. The surveyor observed the emergency water was not sufficient to maintain all residents for three days. The facility had 24 gallons of water on hand for approximately 60 residents (Assisted Living Facility & SCALF). EI#17 agreed with the surveyor's findings and advised that she (EI#17) would order more emergency water. On June 13, 2024, EI#17 advised surveyors that the additional emergency water had been ordered. Meal Schedule and Weekly Menu During observation of lunch on June 11, 2024, at approximately 11:40 AM, the surveyors noted there was no visible menu or meal schedule postings. EI#17 agreed with the surveyors' findings.	A 703		
A 901	420-5-20-.09 (1) (2) Laundry. (1) General. (a) Direction and Supervision. Responsibility for laundry services shall be assigned to an employee. (b) Linen. Linens shall be handled, stored, processed, and transported in a manner consistent with generally accepted infection control practices. (2) Location and Space Requirements. (a) Each specialty care assisted living facility shall have laundering facilities unless	A 901		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE AT PRICEVILLE SCALF, THE	200 TERRACE LANE DECATUR, AL 35603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 901	Continued From page 56 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 interview, the facility failed to maintain the commercial dryer free of lint build up. Findings:	A 901		

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A 901	Continued From page 57 During a facility tour on June 11, 2024, at approximately 10:15 AM, surveyors observed the Laundry Room with EI#4. The surveyors noted the commercial dryer which was being used for soiled laundry had a large amount of lint build up. During an interview on June 13, 2024, EI#1 agreed with the surveyors' findings.	A 901		
A1002	420-5-20-.10 (2) Sanitation and Housekeeping. (2) Housekeeping and Physical Plant Maintenance. The facility must provide a safe, functional, decent, sanitary, and comfortable environment for residents, staff, and the public. (a) Equipment and Supplies. The home shall maintain an adequate quantity of 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 58 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 observations and interviews, the facility failed to maintain the Laundry Room in a safe, decent and sanitary manner. In addition, chemicals were unsecured. Findings:	A1002		

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A1002	Continued From page 59 Laundry Room On June 11, 2024, at approximately 10:15 AM, the surveyors observed the Laundry Room with EI#4. The Laundry Room was cluttered and crowded with various items, including multiple laundry baskets on the floor, dryer sheets and an accumulation of dust behind the washing machine and dryer and various medical equipment being stored in the room. EI#4 agreed with the surveyors' findings. Kitchenette/Unsecured Chemicals On June 11, 2024, at approximately 8:40 AM, the surveyors observed the kitchenette with EI#4. In the unlocked cabinet under the sink, surveyors observed the following items: comet cleaner with bleach, hand soap, shampoo, vinegar, and wasp spray. The door leading into the kitchenette was also unlocked and open. Surveyors noted at various times during the survey that the door to the kitchenette remained open and the kitchenette was not always attended by staff. On June 13, 2024, EI#1 agreed with the surveyors' findings.	A1002		
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 60 (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 61 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 62 (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 63 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	A1203		

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A1203	Continued From page 64 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 observations and interview, the kitchenette was not maintained in good repair.	A1203		

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A1203	Continued From page 65 Findings: During a tour of the facility on June 11, 2024, at approximately 10:15 AM, surveyors observed the cabinets in the kitchenette area were not in good repair. The cabinet doors were loose and some were hanging and would shift when opened and closed. Boards on the cabinets were broken also. On June 13, 2024, EI#1 agreed that the kitchenette was in need of repair and stated the facility was planning to complete repairs in that area of the unit.	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 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.	A1206		

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A1206	Continued From page 66 (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 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	A1206		

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A1206	Continued From page 67 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 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	A1206		

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A1206	Continued From page 68 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 observations and interviews, the facility failed to ensure that all door locks released upon fire alarm activation. In addition, an exterior gate was not a safe means for egress. Findings: Door Locks Failed to Release Automatically Upon Activation of the Fire Alarm System On June 12, 2024, at approximately 10:28 AM, the surveyors requested a fire drill be conducted. During the fire drill, surveyors observed that one door between the 200 and 300 halls which lead to the courtyard did not release the lock upon activation of the fire alarm system. The door was marked with an exit sign. EI#8, Maintenance Director, agreed the door did not function properly. On June 12, 2024, at approximately 4:50 PM, EI#8 advised the surveyors that the door leading	A1206		

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A1206	Continued From page 69 to the courtyard had been repaired. The fire alarm system was activated by EI#8 and the door lock released automatically. Exterior Gate Not a Safe Means of Egress During a facility tour with EI#4, on June 11, 2024 at approximately 8:40 AM, surveyors observed a gate along an exterior fence which was padlocked from the outside. The gate was in the courtyard fence and there was no method in place to release the lock from inside the courtyard. An additional gate in the courtyard had a magnetic release system in place. Surveyors asked EI#4 about the gate which was padlocked and she (EI#4) advised to speak with EI#8. On June 11, 2024, surveyors asked EI#8 about the exterior gate which was padlocked and he (EI#8) stated it was a temporary gate which had been placed during installation of a new fence. EI#1 and EI#8 stated the gate would be removed since there was not a gate in that location prior to the new fence being installed and there was a means of egress from the courtyard without that gate. On June 12, 2024, EI#8 informed the surveyors that the gate had been removed. CONNIE CHERRY, REGISTERED NURSE TROY BLACK, REGISTERED NURSE	A1206		