STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D0217	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENNITY AT DAPHNE AL, THE	27440 COUNTY ROAD 13 DAPHNE, AL 36526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments On May 16, 2024, an unannounced licensure and complaint survey was conducted for this 92 bed Assisted Living Facility with a census of 44. There were two complaints investigated during this survey. LC#20240418006 and LC#20200129010 were substantiated. There were deficiencies written as a result of the complaint investigations. Deficiencies were cited during the survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, Assisted Living Facilities. The deficient practices caused harm to one resident and the potential for harm to the 43 residents.	A 000		
A 302	420-5-4-.03 (1) (e) Administration. 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 residents. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies shall cover the following: (i) Facility responsibility to protect all	A 302		

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A 302	Continued From page 1 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. (xiv) Dietary Policies. The dietitian, with the approval of the administrator, shall develop written policies and procedures for the	A 302		

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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 potentially hazardous foods such as meat, milk, ice, and eggs.

(IX) Storage of food.

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A 302	Continued From page 3 (X) Procedure for food service in the event of a disaster. Disaster menus shall be developed. The policy shall address how food will be obtained and maintained at safe temperatures if electricity is not available. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow its own policies. This deficient practice caused actual harm to one resident of the facility and placed all residents of the facility at risk of harm. THIS DEFICIENCY WAS CITED AS A RESULT OF COMPLAINT INVESTIGATIONS. Findings: On April 18, 2024, the facility self reported an incident to the ADPH, via the online incident reporting system (OIRS), of a resident who had eloped from the facility. The resident was found by the local police 0.2 miles from the facility at 2:25AM. The resident was face down in the street with injuries to his/her face, hands and knees. On May 8, 2024 a surveyor was dispatched to the facility to investigate the incident. Multiple deficiencies were cited as a result of the investigation including the facility's failure to follow its own policies and procedures. Retention of Residents According to the facility's Policy and Procedure titled, "... Care of Residents-Health Supervision-Admission and Continued Stay ... POLICY: Residents admitted to and retained in this facility will meet the eligibility and continued	A 302		

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stay requirements specified in the Alabama Department of Public Health Rules for Assisted Living Facilities. Residents will be promptly and safely discharged when their needs are beyond the capability of the Facility. ... Continued Stay (Retention) ... The facility will not retain a resident who: ... 4. Residents who cannot safely reside in the facility unless his/her egress is restricted. The facility in whole and in part will not operate in a manner that prevents free and unhindered egress from the facility by a resident. ..." The facility did not transfer or discharge a resident whose level of care exceeded the capabilities of the facility. Refer to deficiencies 606 and 621 for additional information.

Resident Assessments
According to the facility's Resident Evaluation Policy, "... Residents should be evaluated to determine the level of care and services needed ... Policy ... Alabama ... - Monthly - 30-day resident assessment ..." The facility did not complete a monthly assessment for one resident. Refer to deficiency 604 for additional information.

Medication Assistance
According to the facility's Daily Medication Pass Protocol "... At every opportunity for medication use: 1. Staff presents the prescribed medication containers ... to the resident ..." The facility failed to administer medication as ordered by the physician. Refer to deficiency 601 for additional information.

Elopement
According to the facility's Policy and Procedure titled, "Missing Resident/Elopement ... An elopement is an incident in which a resident leaves the community without community associates' knowledge: unsupervised,

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unscheduled and unnoticed. This applies especially when the resident has impaired decision-making abilities and is unaware of his/her own safety needs. This includes residents that leave a secured area without associate knowledge. ... analyze and determine the elopement reason(s) and complete the required reporting documents for submission to required state and regulatory agencies. ..." The administrator did not identify a resident's absence from the facility as an elopement and failed to investigate and report the elopement to the ADPH. Refer to deficiency 303 and 508 for additional information.

Cardiopulmonary Resuscitation certification
According to the facility's Policy and Procedure titled, "Personnel-Training Staff ... PROCEDURE: Initial training shall include, at a minimum: ... 4. Current certification from the American Heart Association or the American Red Cross in Cardio Pulmonary Resuscitation (CPR) within 90 days of hire. ..." The facility did not ensure Cardiopulmonary Resuscitation (CPR) certifications were current. Refer to deficiency 405 for additional information.

Fire Drills
According to the facility's Policy and Procedure titled, "Fire and Safety-Fire Control Plan ... The facility will maintain a current fire control and evacuation plan, which includes staff and resident education through routine fire drill participation. PROCEDURE: ... Fire Drills. Fire drills shall be conducted at least once per month ..." The facility did not ensure fire drills were performed monthly as required. Refer to deficiency 1101 for additional information.

Rounding on Residents

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A 302	Continued From page 6 According to the facility's procedure titled, "Protocol for Rounding on Residents... Rounds include the staff member visually seeing the resident and ensuring their care and safety needs are met during each round ..." The facility did not ensure a staff member visually checked a resident during the night shift resulting in an elopement. Refer to deficiency 606 for additional information. An interview was conducted on May 16, 2024, at approximately 7:30 PM, with Employee Identifier (EI)#1, the Executive Director. EI#1 agreed policies had not been followed and they were in place as a guide to ensure resident welfare, safety and satisfaction.	A 302		
A 303	420-5-4-.03 (2) (a) Administration. The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an administrator shall meet all applicable statutory requirements. 4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the	A 303		

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A 303	Continued From page 7 administrator during absences. 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 being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement. 9. The facility administrator is responsible for ensuring that required training is provided to all staff. 10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting. 11. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and	A 303		

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A 303	Continued From page 8 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 interviews and record reviews, EI#9, former administrator, failed to perform administrative duties to ensure the care and safety needs of all residents were met. In addition, EI#9 failed to investigate and report an elopement and failed to ensure care plans were current and addressed resident problems with appropriate interventions. EI#9 and EI#1, current administrator, also failed to ensure a resident who required a higher level of care was transferred or discharged to an appropriate setting. These deficient practices resulted in harm for one resident and had the potential for harm to all residents. THIS DEFICIENCY WAS CITED AS A RESULT OF THE INVESTIGATION OF AN ELOPEMENT. Findings: On April 18, 2024, the facility submitted an incident report via the online reporting system of Resident Identifier (RI)#6's elopement with injury. Incident 20240418006 revealed RI#6 left the	A 303		

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facility on April 18, 2024, at approximately 2:00AM. Police found the resident face down, bleeding, in the road at 2:25AM, 0.2 miles from the facility. Staff did not have knowledge of the resident leaving the facility.

Review of RI#6's facility record, on May 14, 2024, revealed the following information. RI#6 was admitted to the facility on December 16, 2023, with diagnoses which included Parkinson's disease, hypertension, coronary artery disease and gastroesophageal reflux disease. Refer to deficiencies 501, 508, 604, 606, 613 and 621 for additional information on RI#6.

The medical record revealed a service plan for RI#6 that documented, "... NEED ... BEHAVIORAL 2/20/24 RESIDENT INTERCEPTED IN PARKING LOT WITH INTENT TO LEAVE ... ACTION ... EXIT SEEKING ... Monitor and report any attempts to leave without signing out with the concierge ... 4/17/24 Elopement from facility ... Resident found in the road 0.2 miles from the facility by ... (Police Department) ..."

Review of RI#6's undated "ASSISTED LIVING LIFESTYLE RESIDENT PROFILE" revealed "... FRONT DESK COPY ... return to Concierge at front desk. ... *Elopement Risk!! ... Has eloped many times! Find sitter if (he/she) leaves the building ..."

An interview was conducted on May 15, 2024, at approximately 4:15PM, with the daughter/sponsor of RI#6. The sponsor said she received a call from the facility on December 26, 2023, informing her that RI#6 had left the facility on foot and had fallen in a ditch by the road.

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A 303	Continued From page 10 On May 16, 2024, a review of incident files from December 1, 2023, to present revealed, there was no incident report or investigation of an elopement by RI#6 in December 2023. Resident sign out sheets revealed RI#6 had not signed out on December 26, 2023. An interview was conducted on May 16, 2024, at approximately 12:45PM, with EI#10, former resident services director. EI#10 said a behavior screening was performed with RI#6 on December 26, 2023, questioning RI#6's eligibility. EI#10 said on December 26, 2023, the police told her (EI#10) school teachers found RI#6 in a ditch and called 911. EI#10 said RI#6 had only been at the facility a week and made an unsafe decision. EI#10 said EI#9 told her the event was not an elopement because RI#6 knew where he/she was going. EI#10 acknowledged the facility's policy of when staff are unaware a resident has left the property and the resident is found down the road, in a ditch and unable to get up, it is an elopement. EI#10 said she told EI#9 that RI#6 should not remain at the facility after the event and a 30 day discharge notice should be issued. An interview was conducted on May 16, 2024, at approximately 4:30PM, with EI#9, former Administrator. EI#9 said she did not report the December 26, 2023, incident because RI#6 knew what he/she was doing and it was not an elopement. EI#9 said she was told RI#6 had signed out and was going home. When EI#9 was asked how RI#6 left without signing out, she answered she did not know what happened. EI#9 was then asked about staff not allowing RI#6 to leave the facility without a sitter or having staff redirect RI#6 back inside if observed leaving. EI#9 said they were trying to keep RI#6 safe. EI#9 was asked if residents whose egress had to	A 303		

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be restricted to keep them safe were eligible to be assisted living facility residents, EI#9 said she was not sure. When asked why RI#6 was not transferred to a higher level of care instead of restricting his/her egress, EI#9 answered RI#6 just needed staff to keep an eye on him/her.

An interview was conducted on May 16, 2024, at approximately 7:00PM with EI#1. EI#1 was asked what should have happened when RI#6 eloped and was found off campus in the ditch. EI#1 said RI#6 should have been sent to the hospital, an emergency discharge attempted or a 30 day notice should have been issued and sitters put in place until a safe discharge. EI#1 defined elopement as a resident who does not notify staff or sign out when leaving the community and is not able to keep themselves safe. EI#1 acknowledged RI#6 eloped on April 18, 2024 and was injured.

According to RI#6's service plan, RI#6 had exit seeking behaviors. RI#6's resident profile documented RI#6 was an elopement risk and had eloped many times.

Although RI#6's care plan documented RI#6's exit seeking behavior, the intervention to monitor and report attempts to leave the facility was inadequate and was not specific as to the type of care staff needed to provide. In addition, there was no documentation of the December 26, 2023 elopement with injury, therefore, there were no interventions implemented to prevent future elopements. Subsequently, RI#6 attempted to elope again on February 20, 2024 and March 7, 2024. RI#6 succeeded in eloping on April 18, 2024, and sustained multiple injuries.

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A 405	Continued From page 12	A 405		
A 405	420-5-4-.04 (6) Personnel. (6) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained in the facility. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on assisted living facilities. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire. 5. Identifying and reporting abuse, neglect, and exploitation. 6. Basic first aid. 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environment safety.	A 405		

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A 405	Continued From page 13 10. Special needs of the elderly, mentally ill, and mentally retarded. 11. Safety and nutritional needs of the elderly. 12. Identifying signs and symptoms of dementia. (b) Cardiopulmonary Resuscitation. An assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of an assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within 90 days of hire. An assisted living facility equipped with an automated external defibrillator (AED) shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or American Red Cross in CPR or AED utilization. (c) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training. (d) Continuing Education. All staff must receive annual continuing education sufficient to	A 405		

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A 405	Continued From page 14 remain knowledgeable of the training specified above. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff Cardiopulmonary Resuscitation (CPR) certifications had not expired for 3 staff members. Findings: On May 16, 2024, a review of employee files revealed EI#3, EI#4 and EI#7 had CPR certifications that had expired. On May 16, 2024, at approximately 7:00PM, EI#1 said 100 percent of staff should be CPR certified and that a class had already been scheduled for CPR certification.	A 405		
A 501	420-5-4-.05 (1) Records and Reports. (1) General. (a) Responsibility for Records. The administrator shall prepare and file all records, or shall oversee the preparation and filing of records. This duty shall be assigned to other employees in the administrator's absence. (b) All records and reports required by these rules shall be completed in a timely manner, and shall be maintained and filed in an orderly manner within the assisted living facility premises. (c) Storage and Safety. Provision shall	A 501		

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A 501	Continued From page 15 be made for the safe storage of records within the facility. Records shall be stored in a manner to reasonably protect them from water or fire damage. Records shall be safeguarded from unauthorized access. (d) All facility records, including resident medical records, shall be made readily available for review and copying on demand by representatives of the State Board of Health upon request. This Rule is not met as evidenced by: Based on interview and record review, the former licensed administrator, EI#9, failed to complete the required documentation of an elopement of a resident. THIS DEFICIENCY WAS CITED AS A RESULT OF THE INVESTIGATION OF AN ELOPEMENT. Findings: An interview was conducted on May 15, 2024, at approximately 4:15PM with the daughter/sponsor of RI#6. The sponsor said she received a call from the facility on December 26, 2023, informing her RI#6 had left the facility on foot without staff knowledge and had fallen in a ditch near the road. On May 16, 2024, a review of incident files since December 1, 2023, revealed, no documentation of the elopement by RI#6 on December 26, 2023. An interview was conducted on May 16, 2024, at approximately 4:30PM with EI#9. EI#9 said she did not document the elopement because RI#6	A 501		

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A 501	Continued From page 16 knew what he/she was doing so she (EI#9) did not feel it was an elopement.	A 501		
A 508	420.5.4-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in an assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review. 1. Incidents which require investigation are: (i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as bruising, pain, or injury that is not consistent with actions necessary in providing day to day care to a resident or for which medical treatment was sought. (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.	A 508		

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A 508	Continued From page 17 (v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. (vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules. (vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules. (viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I of 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	A 508		

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A 508	Continued From page 18 sedation. (xiii) Ingestion by a resident of a toxic substance that requires medical attention. (xiv) Any indication of malfunction of the sprinkler system, or fire alarm system. 2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following: (i) Names of all residents involved. (ii) Names of all staff involved including person in charge at the time of the incident. (iii) When the administrator was notified (date and time). (iv) Circumstances under which the incident occurred. (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.	A 508		

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A 508	Continued From page 19 (xi) Names, telephone numbers, and addresses of witnesses. (xii) Date and time relatives or sponsor were notified. (xiii) Out-of-facility treatment. (xiv) Follow-up care. (xv) Outcome resolution. (xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future. (xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation. (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	A 508		

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A 508	Continued From page 20 incident: (i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention as defined in these rules. (ii) Elopement by a resident. (iii) Suspected, alleged, confessed, or witnessed abuse, neglect, or exploitation 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. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file. (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	A 508		

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A 508	Continued From page 21 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 of the Alabama Administrative Code Sec. 420-4-1-.04. shall be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1-.04. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than 3 years. (x) Any indication of malfunction of the sprinkler system, or fire alarm system. 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.	A 508		

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A 508	Continued From page 22 (viii) Any injury or injuries to resident(s). (ix) Action taken by the facility in response to the incident. This Rule is not met as evidenced by: Based on interviews and record reviews, EI#9, failed to investigate an elopement and report the elopement to the Alabama Department of Public Health's Online Incident Reporting System. THIS DEFICIENCY WAS CITED AS A RESULT OF THE INVESTIGATION OF AN ELOPEMENT. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON JANUARY 7, 2016. Findings: On December 26, 2023, RI#6's sponsor was informed by the facility via a telephone call that RI#6 had left the facility on foot, without staff knowledge, and was found lying in a ditch on the side of the road. On May 16, 2024, a review of incident files since December 1, 2023, revealed there was no documentation of an elopement by RI#6 on December 26, 2023. An interview was conducted on May 16, 2024 at approximately 12:45PM, with EI#10, former resident service director. EI#10 said on	A 508		

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A 508	Continued From page 23 December 26, 2023, the police told her (EI#10) that school teachers found RI#6 in a ditch along side the road and called 911. EI#10 said EI#9 told her (EI#10) the incident was not an elopement because RI#6 knew where he/she was going. When asked about the facility's elopement policy, EI#10 acknowledged, based on the facility policy, that when staff are unaware a resident has left the property and the resident is found down the road in a ditch, unable to get up by himself/herself, it was an elopement. An interview was conducted on May 16, 2024, at approximately 4:30PM, with EI#9, former executive director/administrator. EI#9 said she did not report the December 26, 2023 incident because RI#6 knew what he/she was doing, therefore, it was not an elopement. EI#9 was asked what her investigation into the event revealed. EI#9 said she did not complete an investigation. An interview was conducted on May 16, 2024, at approximately 7:15PM, with EI#2, current resident service director. EI#2 said after an elopement occurs, it should be reported to the ADPH OIRS and then investigated.	A 508		
A 601	420-5-4-.06 (1) Care of Residents. (1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician. (a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her choice. If the resident is unable to designate an attending physician, or does not wish to	A 601		

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A 601	Continued From page 24	A 601		

designate an attending physician, the facility shall assist the resident in identifying an attending physician who will serve the resident. A resident shall be permitted to change the designation of his or her attending physician at any time. Whenever a resident requires medical attention, an attempt shall first be made to contact the resident's attending physician, except in medical emergencies requiring activation of the local EMS system (911 or another emergency call).

(b) Back-up Physician Support. Each assisted living facility shall have an agreement with one or more duly licensed physicians to serve in those instances when a resident's own attending physician cannot be reached, and to provide temporary medical attention to any resident whose attending physician is temporarily not available. A nurse practitioner or physician's assistant shall not serve as the back-up physician in an assisted living facility.

(c) All physician orders shall be written in accordance with community standards. If verbal orders are used, they are to be used infrequently. A physician verbal order shall only be accepted by an RN or LPN employed by the facility and authorized to do so by facility policy and procedures and state law. All verbal orders shall be reduced to writing on the physicians' order sheet by a licensed facility nurse and shall be dated and signed by the nurse receiving the order. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, or another practitioner who is responsible for the care of the resident and authorized to write orders by facility policy. All verbal orders must be authenticated within such time period as provided by facility policy, but in no

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A 601	Continued From page 25 case shall exceed 30 days following entry of the order. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to follow a physician's order for a medication prescribed for RI#6. Findings: RI#6 was admitted to the facility on December 16, 2023, with diagnoses which included Parkinson's disease. Refer to deficiency 303, 501, 508, 604, 606 and 621 for additional information on RI#6. Review of RI#6's "ADMISSION MEDICAL EXAMINATION" dated December 11, 2023, revealed, "... MEDICATIONS: NAME Carbidopa/Levodopa STRENGTH 25mg(milligrams)/100mg DOSAGE 2 tablets ROUTE PO (by mouth) FREQUENCY 3 times daily ... 1 tablet ... at bedtime ..." Review of RI#6's Medication Administration Record (MAR) for January 2024, revealed, no doses of Carbidopa/Levodopa were administered January 5, 6, or 7, 2024. The 8:00AM, 12:00PM, 4:00PM and 8:00PM doses were not given on those days. An interview was conducted on May 16, 2024, at approximately 7:15PM with EI#2, resident services director. EI#2 said staff thought RI#6's Carbidopa/Levodopa was not available. However, EI#2 said the medicine was in the facility and it was unacceptable that it was not administered. EI#2 added all staff should have known where to	A 601		

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A 601	Continued From page 26 look for the medication. Facility wide training was completed to ensure an error like this did not happen again.	A 601		
A 604	420-5-4-.06 (3) (a) (b) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility shall assess prospective residents for facility eligibility. This assessment shall document identified care needs and serve as a baseline for future assessments. (b) Monthly Assessments. The facility shall assess each resident monthly and more often when necessary to identify changes in resident's status. In addition to other items that may be required by the facility's own policies and procedures, the monthly assessment shall: 1. Assess the resident's ability to safely self-manage medications or safely self-administer medications with assistance. 2. Accurately weigh and record the weight of each resident. A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half or greater weight loss in a period of three months or less, or a ten percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician.	A 604		

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A 604	Continued From page 27 3. Document identified changes in resident status. 4. Assess the appropriateness of each resident's plan of care. Any decline in resident status requires immediate implementation and documentation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a monthly assessment was completed for RI#6. Findings: RI#6 was admitted to the facility on December 16, 2023. Ten days after admission, RI#6 eloped from the facility. RI#6 was considered an elopement risk after the incident. In addition, RI#6 did not receive multiple doses of his/her medication for Parkinson's disease during January 2024. Refer to tag 601 for missed medications. A review of RI#6's medical record revealed there was no monthly assessment completed for January 2024. The facility did not assess RI#6 after an elopement and missed medication, to identify any changes in RI#6's status and to document those changes as needed. An interview was conducted on May 16, 2024, at approximately 7:15PM, with EI#2. EI#2 acknowledged RI#6 did not have a monthly assessment completed in January of 2024. EI#2	A 604		

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A 604	Continued From page 28 said RI#6's earlier behavior warranted an assessment even more. When EI#2 was asked why, EI#2 said to assess the resident for changes and appropriateness for the ALF.	A 604		
A 606	420-5-4-.06 (3) (d) Care of Residents. (d) Services Beyond Capability of Assisted Living Facility. Whenever a resident requires hospitalization, medical, nursing, or other care beyond the capabilities and facilities of the assisted living facility, arrangements shall be made to discharge the resident to an appropriate setting, or to transfer the resident promptly to a hospital or other health care facility able to provide the appropriate level of care. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to promptly discharge or transfer residents, who required care beyond the capabilities of the assisted living facility, to an appropriate setting. THIS DEFICIENCY WAS CITED AS A RESULT OF THE INVESTIGATION OF AN ELOPEMENT. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON JANUARY 7, 2016. Findings: RI#1 RI#1 was admitted to the facility in March 2022 with diagnoses to include cognitive impairment,	A 606		

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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 606	Continued From page 29	A 606		

hypertension, chronic anxiety, peripheral vascular disease and tremors. RI#1's medical examination dated March 11, 2022, documented RI#1 required assistance with dressing, ambulation and medications. RI#1 was a fall risk.

RI#1's undated, Lifestyle Resident Profile documented RI#1 wanders and is an elopement and fall risk.

On the morning of May 9, 2024, at 9:20AM, RI#1 was shown his/her 1:00PM medications by EI#3, LPN. RI#1 identified his/her name on the medication packet but was unable to determine the correct time of day to take the medication. When asked if he/she (RI#1) would take the 1:00PM medicine at 9:20AM that morning, RI#1 said, "I don't know." RI#1 said he/she would have to "study on it." RI#1 was not able to protect himself/herself from a medication error by staff.

During an interview with EI#8 on May 9, 2024 at 3:50AM, EI#8 was asked about residents who have attempted to elope. EI#8 named RI#1. EI#8 said she heard RI#1 had sitters during the day.

On May 9, 2024, at 4:30AM, EI#7 told the surveyor she had heard that RI#1 would attempt to leave the facility without staff knowledge.

On May 9, 2024, at 5:23AM, EI#5 told the surveyor during an interview that RI#1 was at risk to elope. When asked what measures were in place to prevent elopement, EI#5 said you really can't do anything about elopements since the ALF is not a locked unit. Residents can come and go as they please if it is safe. When asked what she (EI#5) had been told to do about RI#1's risk to elope, EI#5 said she was told nothing. EI#5 said common sense told her when RI#1 packs her

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A 606	Continued From page 30 clothes every day and is sundowning, that's a concern. On May 9, 2024, at 5:47AM, EI#6 told the surveyor RI#1 was an elopement risk. When asked what training was provided on resident elopement, EI#6 said none. EI#6 said she thought the facility should have had an inservice on elopements since there were residents who wanted to leave. RI#6 On April 18, 2024, the facility self reported an incident to the ADPH, via the online reporting system, of a resident who had eloped from the facility and sustained multiple injuries. On May 8, 2024 a surveyor was dispatched to the facility to investigate the incident. Investigation into the incident revealed RI#6 had a history of exit seeking behavior and had eloped from the facility before. Review of RI#6's facility record on May 14, 2024, revealed the following information. RI#6 was admitted to the facility on December 16, 2023, with diagnoses which included Parkinson's disease, hypertension, coronary artery disease and gastroesophageal reflux disease. Refer to deficiency 303, 501, 508, 604, 613 and 621 for additional information on RI#6. An interview was conducted on May 15, 2024, at approximately 4:15PM, with the daughter/sponsor of RI#6. The sponsor said she received a call from the facility on December 26, 2023, informing her that RI#6 had left the facility on foot, without staff knowledge, and had fallen in a ditch by the road. School teachers passing by the area found RI#6 and reported the incident to 911.	A 606		

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A 606	Continued From page 31 On May 16, 2024, a review of incident report files starting with December 1, 2023, revealed there was no incident report or investigation of an elopement for RI#6 in December 2023. Resident sign out sheets revealed RI#6 had not signed out on December 26, 2023. An interview was conducted on May 16, 2024, at approximately 12:45PM, with EI#10, former resident service director. EI#10 said a behavior screening was performed with RI#6 on December 26, 2023, questioning his/her eligibility. EI#10 said the police told her (EI#10) that school teachers found RI#6 in a ditch and called 911. EI#10 said RI#6 had only been at the facility one week and made an unsafe decision. EI#10 said she told EI#9, former administrator, that RI#6 should not remain in the facility after the event and a 30 day notice should be issued. Review of RI#6's undated "ASSISTED LIVING LIFESTYLE RESIDENT PROFILE" revealed the following comments, "... FRONT DESK COPY ... return to Concierge at front desk. ... *Elopement Risk!! ... Has eloped many times! Find sitter if (he/she) leaves the building ..." RI#6's record revealed a service plan for RI#6, dated December 12, 2023, that documented, "... NEED ... BEHAVIORAL 2/20/24 RESIDENT INTERCEPTED IN PARKING LOT WITH INTENT TO LEAVE ... ACTION ... EXIT SEEKING ... Monitor and report any attempts to leave without signing out with the concierge ... 4/17/24 Elopement from facility ... Resident found in the road 0.2 miles from the facility by ... (Police Department) ..." The same service plan also documented RI#6	A 606		

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A 606	Continued From page 32	A 606		

had sitters during waking hours from 8AM-8PM. In addition, the service plan documented a verbal 30 day discharge notice was given to RI#6's daughter on April 4, 2024. The notice was to move RI#6 from the facility to a memory care facility due to RI#6's history of exit seeking and unsafe decision making.

An email of a conversation between EI#2, resident service director, and RI#6's sponsor dated March 7, 2024, revealed RI#6 was "intercepted again" at the front door at 11:30AM that day. EI#2, went on to say that staff was constantly having to watch RI#6 and the facility did not have enough staff to assign care staff to RI#6 at all hours of the day and night. EI#2 expressed her concern for RI#6's safety, stating RI#6 was not making safe decisions and was constantly waiting and looking for a way out of the facility. RI#6's sponsor refused 24 hour sitters for RI#6. The facility did not implement nighttime sitters for RI#6.

An email of a conversation between EI#1, administrator, and RI#6's sponsor, dated March 27, 2024, revealed EI#1 discussed RI#6's unsafe decisions to leave the community and that a plan was needed to keep RI#6 safe. EI#1 discussed placing 24 hour sitters with RI#6. RI#6's sponsor refused and would only allow sitters 12 hours a day during the daytime/evening hours. The facility did not implement additional sitters for the nighttime hours.

An assessment for memory care admission was conducted on April 5, 2024. The assessment included a behavior screen which documented RI#6's history of exit seeking. RI#6 remained in the facility.

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A 606	Continued From page 33 On April 18, 2024, the facility submitted an incident report of an elopement by RI#6. Incident 20240418006 revealed RI#6 left the facility on April 18, 2024, at approximately 2:00AM. Police found the resident face down in the road at 2:25AM, 0.2 miles from facility. RI#6 was bleeding and sustained a contusion to his/her eye and abrasions to his/her forehead, knees and hands. Staff did not have knowledge of the resident leaving the facility. In fact, in a printed text message documented by the facility as EI#7's statement, EI#7 typed that she performed room checks at 11:00PM, 1:30AM, and 2:15AM and observed RI#6's spouse in the room. However, EI#7 documented because there was no light on in the residents' room she could not see RI#6. EI#7 documented she did not see RI#6 during the entire shift. EI#7 said she was notified by a coworker, who was notified by the nurse at the specialty care assisted living facility on the same campus, that RI#6 had eloped. On May 8, 2024, during an interview with the surveyor that afternoon, RI#6 said he/she couldn't recall why he/she (RI#6) left the facility on foot, in the dark, in the early morning hours on April 18, 2024. RI#6's spouse spoke up and said the facility did not do enough to keep RI#6 from leaving. RI#6 said after falling he/she had doubts that it was a safe decision to leave the facility. An interview was conducted on May 16, 2024, at approximately 4:30 PM, with EI#9. EI#9 was asked why was RI#6 not sent to a higher level of care instead of attempting to restrict his/her egress. EI#9 answered RI#6 just needed us to keep an eye on him/her.	A 606		

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A 613	Continued From page 34	A 613		
A 613	420-5-4-.06 (5) (a) (b) (c) (d) (e) Care of Residents. (5) Medications. (a) Medications as defined in these rules, may be administered to a resident of an assisted living facility only after the drugs have been prescribed specifically for the resident by an individual currently licensed to prescribe medications in Alabama. A currently licensed physician in good standing with the Medical Licensure Commission of any state may prescribe medications to a resident of an assisted living facility only during the initial physical examination. (b) A physician order is required for a resident to manage and have custody of his or her own medications. (c) A resident may have custody of and manage over the counter topical medications with the written approval of a physician. A physician order is not required for over the counter topical medications that are self-administered by residents and approved by the physician for resident possession. (d) Nothing in these rules shall preclude a facility from using a licensed nurse employed by the facility or nursing agency to administer medication to any resident. An RN or LPN shall administer medications to residents in the assisted living facility only in accordance with physician orders and the Nurse Practice Act. (e) A resident who is incapable of recognizing his or her name, or understanding	A 613		

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A 613	Continued From page 35	A 613		

the facility unit dose medication system, or does not have the ability to protect himself or herself from a medication error shall require medication administration. Medication administration shall be provided only by a physician or by an RN or LPN. If the resident cannot understand or be trained to understand the unit dose medication system used by the facility or cannot protect himself or herself from medication errors by facility staff, the resident will be appropriately discharged.

This Rule is not met as evidenced by:
Based on observation and interview, the facility failed to ensure a resident was capable of utilizing the facility's unit dose packaging system to protect themselves from a medication error by staff.

Findings

RI#1 was admitted to the facility in March 2022 with diagnoses to include cognitive impairment, hypertension, chronic anxiety, peripheral vascular disease and tremors. RI#1's medical examination dated March 11, 2022, documented RI#1 required assistance with dressing, ambulation and medications. RI#1 was a fall risk. RI#1 was prescribed greater than 20 routine and PRN medications.

On the morning of May 9, 2024, at 9:20AM, RI#1 was shown his/her 1:00PM medications by EI#3, LPN. RI#1 identified his/her name on the medication packet but was unable to determine the correct time of day to take the medication. When asked if he/she would take the 1:00PM medicine at 9:20AM that morning, RI#1 said, "I don't know." RI#1 said he/she would have to "study on it." RI#1 was not able to protect

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A 613	Continued From page 36 himself/herself from a medication error by staff. A Change in Condition Physician Exam dated December 20, 2023, under the section titled New or Change in Diagnosis/Change in Condition, the physician documented increase confusion and prescribed Nuplazid. Nuplazid, is an atypical antipsychotic which is approved for the treatment of Parkinson's disease psychosis and is also being studied for the treatment of Alzheimer's disease psychosis, schizophrenia, agitation, and major depressive disorder. During separate interviews with staff on May 9, 2024, when asked which residents were at risk to elope, three (3) staff members (EI#5, EI#7 and EI#8) named RI#1. On May 9, 2024, at 9:00AM, during an interview, the surveyor asked RI#1 if facility staff asked him/her to identify his/her medications when medications were given. RI#1 said no.	A 613		
A 621	420-5-4-.06 (11) (b) Care of Residents. (b) Retention 1. An assisted living facility shall not allow any resident to return to the assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the facility is licensed to provide or the facility is capable of providing. 2. An 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.	A 621		

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A 621	Continued From page 37 3. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in an assisted living facility. 4. An 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 able to direct others and does direct others 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. 5. If a resident of an assisted living facility is diagnosed with a terminal illness other than dementia 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	A 621		

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A 621	Continued From page 38 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 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. 6. All skilled services provided in the facility, such as but not limited to wound care or insertion of a urinary catheter, shall be provided by the staff of properly licensed or certified agencies. Skilled services shall not be delegated to facility staff. 7. Residents that develop acute infectious pulmonary disease, such as active tuberculosis, or other diseases capable of transmission to other individuals through normal person-to-person contact shall be immediately transferred to an appropriate level of care until certified by a physician to be free of a contagious condition. 8. No assisted living facility shall be operated in whole or in part in a manner that prevents free and unhindered egress from the facility by any of its residents. 9. An assisted living facility shall not retain any resident who cannot safely reside in the facility unless his or her egress from the facility is restricted.	A 621		

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A 621	Continued From page 39 This Rule is not met as evidenced by: Based on observation, interview and record review, the facility retained a resident who could not safely reside in the facility unless the resident's egress was restricted. THIS DEFICIENCY WAS CITED AS A RESULT OF THE INVESTIGATION OF AN ELOPEMENT. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON JANUARY 7, 2016. Findings: RI#6 RI#6's facility record revealed a service plan for RI#6 that indicated, "... NEED ... BEHAVIORAL 2/20/24 RESIDENT INTERCEPTED IN PARKING LOT WITH INTENT TO LEAVE ... ACTION ... EXIT SEEKING ... Monitor and report any attempts to leave without signing out with the concierge ... 4/17/24 Elopement from facility ... Resident found in the road 0.2 miles from the facility by ... (Police Department) ..." Review of the undated "ASSISTED LIVING LIFESTYLE RESIDENT PROFILE" revealed, "... FRONT DESK COPY ... return to Concierge at front desk. ... *Elopement Risk!! ... Has eloped many times! Find sitter if (he/she) leaves the building ..." An interview was conducted on May 16, 2024, at approximately 4:30 PM, with EI#9. When asked about RI#6's egress being prevented, EI#9 said they were trying to keep him/her safe. EI#9 was asked if residents whose egress had to be restricted for safety reasons were eligible to be	A 621		

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A 621	Continued From page 40	A 621		

ALF residents. EI#9 said she was not sure. When asked why RI#6 was not sent to a higher level of care instead of preventing his/her egress from the facility, EI#9 answered RI#6 just needed us to keep an eye on him/her.

An interview was conducted on May 16, 2024, at approximately 7:00PM with EI#1. EI#1 said preventing a resident's egress violates the regulation and the resident's rights.

An interview was conducted on May 16, 2024, at approximately 7:15PM with EI#2. EI#2 said retaining residents whose egress has to be prohibited makes that resident ineligible. EI#2 said the concern with retaining an ineligible resident is the potential for harm or decline.

During an interview with EI#1 on the afternoon of May 8, 2024, EI#1 told the surveyor sitters were provided for RI#6 from 8:00AM-8:00PM due to RI#6's exit seeking behavior. When asked about the nighttime hours of 8:00PM-8:00AM, EI#1 said the daytime/evening sitters stayed until RI#6 and his/her spouse were in bed asleep. EI#1 said there were no sitters provided during the night. EI#1 said RI#6's sponsor refused to provide sitters from 8:00PM-8:00AM. EI#1 said RI#6's sponsor told her she would not provide sitters until RI#6 attempted to leave the facility at night.

During an interview with EI#3 on May 9, 2024, at 10:00AM, EI#3 told the surveyor RI#6 and his/her spouse had sitters from 8:00AM-3:00/4:00PM. However, EI#3 said they had to extend the evening hours because RI#6 and his/her spouse left the building without signing out. EI#3 said they were redirected back into the building by the concierge.

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A 621	Continued From page 41 On May 9, 2024 at 10:50AM, EI#11, concierge, was asked when RI#6's exit seeking behavior began. EI#11 said, "The day they (RI#6 and spouse) moved in." On May 9. 2024, at 11:25AM, during an interview with EI#12, sitter, EI#12 stated she provided sitting service for RI#6. EI#12 said RI#6 and his/her spouse would plot in their room about what time they were going to break out of the facility. EI#12 said they complained of being in prison. RI#6 eloped from the facility on December 26, 2023 and attempted to elope again on February 20, 2024 and March 7, 2024. RI#6 succeeded in eloping on April 18, 2024, and sustained multiple injuries.	A 621		
A 703	420-5-4-.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	A 703		

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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 703	Continued From page 42	A 703		

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.

(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.

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A 703	Continued From page 43 This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain a three day emergency supply of non-perishable foods. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: On May 14, 2024, at approximately 11:00AM an observation was made of the facility's emergency food supply storage room. The list of what items should be on hand was also reviewed. There were no emergency food items. This observation was made in the presence of EI#1. On May 14, 2024 at approximately 11:15AM EI#1 said, "We don't have the emergency food items that we are supposed to have."	A 703		
A1101	420-5-4-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift of Group and Congregate facilities. All fire drills shall be initiated by the fire alarm system.	A1101		

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A1101	Continued From page 44 The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the currently adopted Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs. (d) Roller latches are prohibited on doors separating corridors from adjacent spaces. (e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that: 1. Minimizes leaks and spills. 2. Adequately protects against inappropriate access. 3. Complies with the requirements of the currently adopted Life Safety Code. (f) Fire Alarm and Sprinkler System. 1. Fire Alarm System. Where fire alarm	A1101		

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A1101	Continued From page 45 systems are required, a corridor smoke detection system shall be installed on each floor, including areas open to the exit access corridor, to comply with NFPA 72, connected to the facility's fire alarm system. In lieu of corridor smoke detection, smoke detectors connected to the building fire alarm system may be installed in each resident's room, open areas, and at smoke doors (except that corridor smoke detection shall not be deleted when its use is dictated by other requirements). 2. Fire alarm and sprinkler system outages of more than 4 hours require evacuation of the facility or the establishment of a continuous fire watch. The fire watch procedure must be coordinated with the Department and the local Fire Marshal. Outages and fire watch documentation shall be reported to the Department within 12 hours or no later than the next duty day, and shall be corrected expeditiously. 3. The fire alarm system and the sprinkler system shall be inspected by licensed, trained, and qualified personnel at least semiannually for compliance with the respective codes. Inspection and testing reports shall be maintained in the facility for a period of at least 3 years. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure fire extinguishers were visually inspected monthly and that fire drills were performed every month as required.	A1101		

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A1101	Continued From page 46 THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON SEPTEMBER 11, 2019. Findings: FIRE EXTINGUISHERS On May 14, 2024, at approximately 9:00AM, an observation was made of the fire extinguishers. The records of monthly checks revealed the fire extinguishers had not been assessed in January or February 2024. This was observed on 12 of 12 fire extinguishers. FIRE DRILLS On May 15, 2024, at approximately 5:15PM, documentation of fire drills revealed no drills had been performed for March or April 2024. On May 16, 2024, at approximately 7:00PM. EI#1 said the fire extinguishers should be checked and fire drills conducted monthly.	A1101		
A1203	420-5-4-.12 (5) Physical Environment. (5) General Building Requirements - Family, 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. (b) Temperature to be Maintained. The facility shall maintain a comfortable temperature. A comfortable range is between 71-81 degrees Fahrenheit.	A1203		

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A1203	Continued From page 47 (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 insect screens. Screen doors shall be equipped with self-closing devices. (e) Emergency Lighting. 1. All assisted living facilities shall provide emergency artificial lighting to adequately illuminate halls, corridors, kitchens, dining areas, 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 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.	A1203		

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A1203	Continued From page 48 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. (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 purpose. All walls and doors under stairs shall meet the same fire rating as the stairwell. (l) Doors. 1. In each new assisted living facility, doors of resident bathrooms connected to resident bedrooms shall swing into the bedroom. 2. Bedroom and bathroom doors may be equipped with hardware that will permit a	A1203		

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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 each assisted living facility shall be at least three feet wide. Bedroom doors in Family assisted living facilities shall not be less than 32 inches 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 special locking arrangements are permitted only in specialty care assisted living facilities.

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. Exit doors of Family facilities may swing inward.

(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 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.

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A1203	Continued From page 50 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 designated staff of the facility and documented on the attached extinguisher tag by the designated staff person. (o) Call System. Except in Family facilities, 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 Group and Congregate facilities, a sign 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	A1203		

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A1203	Continued From page 51 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 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 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, interviews and record review, the facility failed to ensure the building was free from leaks in the ceiling. The facility further failed to provide a functional call system for each resident. Findings: Ceiling Observations were made on May 14, 2024, at approximately 7:00AM, of a flyer with "STOP" signs on it and yellow caution signs stating,	A1203		

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A1203	Continued From page 52 "SLIPPERY WHEN WET" and "Please watch out for water leaks! If you see a bucket or trash can in the halls or rooms please be aware the floors could be slippery!" This flyer was at the concierge desk just inside the front door where visitors and guests sign in. A copy of this same flyer was on the bulletin board outside the activity room and on the door of a restroom across the hall from the dining room. An observation was made on May 14, 2024, at approximately 7:15AM, of a yellow, standing, wet floor sign, a white trash can and a puddle of water in front of one dining room entryway. The puddle was approximately 12-16 inches wide and approximately 48 inches long. The ceiling stain above the puddled water had crumbling sheetrock falling from its center. Across the hall from the dining room another standing, wet floor sign and white trash can was positioned in front of the door to one of two bathrooms available to residents, guests, or staff. Above the door to the restroom, a semi-circular dark stain was observed on the ceiling. The edges of the stain were dark brown and the center had a black area approximately 3 inches wide and 6 inches long. An observation was made on May 14, 2024 at approximately 7:30AM, of wet carpet in the room with a pool table on the second floor. Call System On May 14, 2024, at approximately 1:30PM, a call pendant was activated in room 104 by the resident to assess staff response. However, EI#13, a resident assistant who entered the room, entered randomly and stated she had not heard an alert that the call light had been activated. EI#13, proceeded to check as to why no alarm	A1203		

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A1203	Continued From page 53 had sounded. An observation was made on May 14, 2024, at approximately 2:15PM, of another call light in room 107 that was activated by the resident to assess for staff response. After seven minutes, EI#13 who had identified the call light was not working in room 104 came to room 107 and reported the call light was not working and she had notified management. An immediate plan of action was requested by the surveyor and implemented by EI#1 and EI#2 on May 14, 2024, at approximately 2:15PM. The plan of action included identifying the cause of the malfunction, making rounds to check on residents, and ensuring residents had a phone and the number to call for assistance. On May 15, 2024, at approximately 1:30PM all call lights were functioning properly. An interview was conducted on May 16, 2024, at approximately 7:30PM with EI#1, the Executive Director. EI#1 said the call lights should be working and checked monthly for proper functioning. When asked why, EI#1 responded for resident safety and care needs. Regarding the environmental issues, EI#1 said work orders should be completed and the building should be kept up to a safe standard. EI#1 acknowledged the identified call system failure and needed repairs to prevent leaks. THERESA HARRISON, REGISTERED NURSE	A1203		