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A 000	Initial Comments On January 26, 2023, an unannounced complaint investigation was conducted for this 75 bed Assisted Living Facility (ALF) with a census of 50. There was one complaint investigated during this survey. LC#20230119010 was substantiated and deficiencies were cited as a result of the complaint investigation. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities. The deficiencies cited caused actual harm to one resident and placed all residents of the facility at risk of harm.	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 residents from abuse, neglect, and exploitation.	A 302		

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A 302	Continued From page 1	A 302		

(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 guidance of all personnel handling food as

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A 302	Continued From page 2 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.	A 302		

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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 observations, interviews and record reviews, the governing authority failed to establish and implement a written policy to ensure residents were adequately monitored. 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 fall and was left alone on the floor of their room for approximately nine hours on the night of January 16-17, 2023. Review of facility policies on January 24, 2023, revealed there was no policy which specifically documented the frequency for conducting checks on each resident by designated facility staff; to ensure the resident was present, safe and resident care needs were met. On January 24, 2023, Employee Identifier (EI)#1 informed the surveyor there was no facility policy which addressed the required frequency for checking on each resident. On January 24, 2023, the facility's camera footage was reviewed by the surveyor with EI#1 and EI#2. Two night shifts were reviewed, January 11-12, 2023 and January 16-17, 2023,	A 302		

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A 302	Continued From page 4 between the hours of 10:00 PM and 6:00 AM. Resident Identifier (RI)#1's room was not entered by facility staff during the night shift on either date. The one doorway to RI#1's room could easily be viewed on the camera footage and staff did not attempt to open the door or enter RI#1's room during the entire eight hour shift for either date reviewed. EI#2 told the surveyor that EI#9, Care Associate (former employee) was assigned to care for RI#1 on both nights. During interviews with facility staff on January 24, 2023, six of six staff (EI#4, EI#5, EI#6, EI#7, EI#8 and EI#9) all reported they knew that residents should be checked on at least every two hours. Only two of the six staff (EI#5 and EI#7) stated they had been trained by the facility to check on residents every two hours. The facility had no documented policy in place that directed staff to monitor residents within a specific time interval.	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.	A 303		

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A 303	Continued From page 5 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. 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.	A 303		

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A 303	Continued From page 6 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 observations, interviews and record reviews, the facility administrator failed to manage and direct staff activities to maintain an orderly and safe environment for all residents and failed to ensure adequate care was provided for the residents at all times. 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 fall and was left alone on the floor of their room for approximately nine hours on the night of January 16-17, 2023. The complainant reported that RI#1's sponsor had a camera installed in RI#1's room and the camera footage from RI#1's room revealed that RI#1 fell	A 303		

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in RI#1's room at 9:21 PM on January 16, 2023. The sponsor was contacted by the facility around 6:40 AM on January 17, 2023 when RI#1 was found by facility staff on the floor in RI#1's room.

RI#1 was admitted to the facility on September 13, 2022, with diagnoses which included chronic kidney disease stage 2, ischemic heart disease, essential hypertension, type 2 diabetes mellitus with diabetic polyneuropathy and hyperlipidemia.

On January 24, 2023, the surveyor conducted an onsite investigation at the facility and interviewed the following staff who worked at the facility from 10:00 PM on January 16, 2023 until 6:00 AM on January 17, 2023.

EI#9, Care Specialist (former employee), was employed by the facility from December 13, 2022 until January 19, 2023. EI#9's employment was terminated by the facility following an investigation of a fall sustained by RI#1 on the night of January 16-17, 2023. Review of the facility's incident investigation revealed EI#9 was assigned to care for RI#1 on the night of January 16-17, 2023. On January 17, 2023, EI#9 was asked by EI#2, why RI#1 was not checked on during the night shift of January 16-17, 2023. EI#9 replied she (EI#9) "checked on someone on 240 hall, I don't remember the room numbers".

However, after review of the facility's camera footage for January 16-17, 2023, (the night that RI#1's fall occurred), EI#9 was not observed to enter RI#1's room between the hours of 10:00 PM and 6:00 AM. In fact, no one entered RI#1's room or even opened RI#1's door during the entire eight hour night shift.

When EI#9 was interviewed by phone on January

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24, 2023, the surveyor explained that camera footage had been reviewed at the facility and no one entered RI#1's room during the night shift of January 16-17, 2023. EI#9 replied, "They say I didn't but I did. I check on my residents. I don't go in. I just stick my head in the door."

EI#5, Medication Technician, had been employed at the facility since January 5, 2022. EI#5 stated the Medication Technician was the person in charge on the night shift. The night shift usually consisted of one Medication Technician and two or three Care Specialists. EI#5 added that the residents were divided between the staff on duty, based on the hall where they resided. EI#5 carried a pager which received all of the resident calls through the call system. EI#5 also used a portable radio to call Care Specialists and to notify them when an assigned resident was in need of assistance.

The Care Specialist was required to "clear out" the resident call by entering the resident's room, which then notified EI#5 that the resident's call had been addressed. EI#5 stated she (EI#5) had worked with EI#9 previously and EI#9 would always "clear out" her calls. EI#5 stated she (EI#5) checked on assigned residents every two hours, but did not check on residents that were not assigned to (EI#5) prior to RI#1's fall on January 17, 2023. EI#5 added that she (EI#5) now tries to "lay eyes" on all the residents during her (EI#5's) shift, even the residents who are not assigned to her (EI#5). EI#5 stated "I had no idea she (EI#9) was not doing her job". When asked if staffing was adequate on the night shift, EI#5 staffed that staffing was adequate.

EI#7, Care Specialist, had been employed at the facility since October 4, 2022. EI#7 stated she

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(EI#7) was not assigned to care for RI#1 on the night of January 16-17, 2023 and added that EI#9 was assigned to RI#1 on that night. EI#7 was not aware that RI#1 had fallen until she (EI#7) received a call from the facility later in the morning on January 17, 2023. EI#7 stated she (EI#7) had worked with EI#9 two times previously but was not aware EI#9 was not checking on her (EI#9's) residents because they worked on different halls. EI#7 stated she (EI#7) was trained to check on residents every two hours. When asked about staffing on the night shift, EI#7 stated that staffing was adequate.

Review of the Thrive Senior Living Job Title: Care Specialist on January 24, 2023 revealed the following Duties and Responsibilities:

Verify individualized service plan (ISP) and ensure appropriate care is being provided to the correct resident

Recognize and respond to the needs of residents

Assure that Staff Call System is within easy reach at all times and answered promptly

Follow established safety precautions and observe, monitor and intervene or report unsafe conditions in the facility

Review of the Thrive Senior Living Job Title: Experience Coordinator-Med Tech on January 24, 2023 revealed the following Essential Responsibilities:

Recognize and respond to the needs of residents and team members

Ensure all assigned tasks are handled in accordance with Community policies and procedures as instructed by supervisor

During an interview on January 25, 2023, RI#1's sponsor informed the surveyor that he/she had

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reported two times that RI#1's call pendant was missing. The first time was January 15, 2023 and the report was made to a staff member on duty at the time (name and title unknown). The second time was January 16, 2023 and the report was made to the administrator, EI#1. When interviewed on January 26, 2023, EI#1 stated RI#1's sponsor had paid for RI#1 to have a pendant in addition to the pull cords already in place in RI#1's bedroom and bathroom. EI#1 also stated RI#1's sponsor had reported to her (EI#1), on January 16, 2023, that RI#1's pendant was missing. EI#1 stated she (EI#1) had a new pendant created that same day for RI#1 and it was given to the Medication Technician to deliver to RI#1. The Medication Technician delivered the pendant to the wrong resident. EI#1 stated RI#1 did not receive the new pendant until after the fall occurred on January 17, 2023.

During an interview with EI#4, Licensed Practical Nurse (LPN), on January 24, 2023, EI#4 stated she (EI#4) assessed RI#1 following the fall on January 17, 2023. After assisting RI#1 to the chair, EI#4 then asked RI#1 if he/she (RI#1) had the call pendant. RI#1 held up the purple string which had previously been attached to the call pendant to allow RI#1 to wear the pendant around the neck. The pendant was missing. EI#4 stated she (EI#4) reported the missing pendant to management and a new one was provided that same day.

When interviewed on January 24, 2023, EI#1, Administrator, informed the surveyor EI#9 had been trained on facility policies as well as State Rules for Assisted Living Facilities. Documentation of the training was provided. However, oversight of EI#9 was not provided to ensure EI#9 utilized the training provided and

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A 303	Continued From page 11 performed the essential duties of her (EI#9's) job. The administrator failed to manage staff activities in a manner that resulted in a safe environment and adequate care being provided at all times for RI#1. A functional call system was not available to RI#1 even though RI#1's sponsor had purchased an additional method of utilizing the system for RI#1 (pendant) and had notified the administrator when the additional system (pendant) was no longer available. These failures resulted in actual harm to RI#1 and placed all residents of the facility at significant risk of harm.	A 303		
A 504	420-5-4-.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 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.	A 504		

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A 504	Continued From page 12 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 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	A 504		

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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 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

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A 504	Continued From page 14	A 504		

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; and

(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

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A 504	Continued From page 15 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. 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, 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.	A 504		

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A 504	Continued From page 16 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 and to freely come and go from the home. 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 record reviews and interviews, community standards of care were not followed for one resident's care by failure to perform periodic checks on the resident during an entire eight hour shift. 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 fall and was left alone on the floor of their room for approximately nine hours on the night of January 16-17, 2023. An incident investigation of the alleged fall was received by the Alabama Department of Public	A 504		

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Health, from the facility, prior to the onsite survey. The investigation conducted by the facility and interviews with facility staff during the onsite survey revealed the following timeline of events.

January 16, 2023

10:36 PM - EI#9 was seen on the camera passing down the 240 Hall. No residents' rooms were entered.

11:00 PM - EI#9 entered Resident Room 247 (not RI#1's room).

January 17, 2023

12:25 AM - EI#9 was observed on the camera in the hallway. No resident rooms were entered.

12:37 AM - EI#9 was observed pulling laundry from the 260 Hall.

2:57 AM - EI#9 was observed passing down the hallway. No resident rooms were entered.

4:57 AM - EI#9 was observed on the 240 Hall. No resident rooms were entered.

6:45 AM - EI#6 entered RI#1's room and found RI#1 on the floor. EI#6 called EI#8 for assistance.

6:45 AM - EI#4 was called to RI#1's room by EI#6 and EI#8. EI#4 assessed RI#1 and found a dime size skin tear to the right lower leg and bruising to the right arm. EI#4 administered Tylenol to RI#1 and did not feel it was necessary to transport RI#1 to the hospital. EI#4 observed RI#1 did not have a call pendant and was unable to recall what happened.

7:07 AM - EI#4 left a message for RI#1's sponsor notified the sponsor of RI#1's fall.

8:00 AM - RI#1's physician was notified of the fall.

8:00 AM - EI#3, RN, was notified of RI#1's fall by EI#4.

9:30 AM - RI#1's sponsor contacted EI#1,

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Administrator, to report RI#1 had actually fallen at 9:21 PM on January 16, 2023 and no one came to check on RI#1 throughout the night. The sponsor reported RI#1 was on the floor the entire night and unable to get up alone. This information was reported based on camera footage from a camera in RI#1's room which was observed by RI#1's sponsor.

9:40 AM - A comprehensive assessment of RI#1 was completed by EI#3. EI#3 found no new injuries and RI#1 had no pain in the lower right leg. RI#1's blood pressure was low (94/78), blood sugar was elevated (233) and RI#1 was confused. Due to the low blood pressure, EI#3 elevated RI#1's feet and provided caffeine. EI#3 did not feel it was necessary to transport RI#1 to the hospital at that time.

11:15 AM - A follow-up comprehensive assessment of RI#1 was completed by EI#3. At the time of the assessment, EI#3 identified a developing hematoma on the top of RI#1's head as well as increased confusion. EI#3 and EI#1 sent RI#1 to the hospital for evaluation and treatment.

RI#1 was not checked on by any facility staff during the hours of 10:00 PM on January 16, 2023 and 6:00 AM on January 17, 2023. As noted in deficiencies 303 and 1203, RI#1 did not have available the call pendant that had been paid for by RI#1's sponsor. RI#1 was unable to get up or to reach the emergency pull chords in the bathroom and bedroom to call for assistance. RI#1 was evaluated and treated at the hospital for a scalp contusion and a urinary tract infection on January 17, 2023.

During interviews with facility staff on January 24, 2023, six staff members (EI#4, EI#5, EI#6, EI#7, EI#8 and EI#9) all stated they knew residents

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A 504	Continued From page 19 should be checked on at least every two hours. Several staff members stated they had not been trained at the facility to perform every two hour resident checks but they just knew it to be an acceptable standard of care and the right thing to do. EI#9 failed to monitor RI#1's status at least every two hours and to ensure RI#1 had access to the call system, placing RI#1 in an unsafe environment which resulted in actual harm to RI#1. In spite of the facility's camera footage which confirmed EI#9 did not enter RI#1's room on the night of January 11-12 and 16-17, 2023, EI#9 stated she (EI#9) checked on her residents. EI#9 offered no explanation for her (EI#9's) failure to monitor RI#1 on the nights of January 11-12 and 16-17, 2023.	A 504		
A 611	420-5-4-.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. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall be based on the initial medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be reviewed and updated based on the annual examination, and all other physician examinations, diagnoses, and recommendations of the resident's treating physician, and the	A 611		

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A 611	Continued From page 20	A 611		

resident's monthly assessments. The plan of care shall be developed and updated in cooperation with the resident and, if appropriate, the sponsor. All entries on the plan of care shall be accurately dated.

1. The plan shall at all times reflect the current condition of the resident and document the personal care and services required from the facility by the resident. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following:

2. A listing of the resident's individual needs or problems that require intervention by the facility.

3. A listing of interventions provided by the facility to address the resident's identified needs or problems.

4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider.

5. Activities of Daily Living. Residents of assisted living facilities 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.

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A 611	Continued From page 21 (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. Resident's hair shall be kept clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be provided assistance with personal safety. 6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to maintain a care plan for a resident which addressed the resident's current care needs with appropriate interventions to meet the care and safety needs of the resident. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings:	A 611		

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A 611	Continued From page 22 The Alabama Department of Public Health received a complaint which alleged a resident of the facility fell and remained on the floor for approximately nine hours without being checked on by facility staff. Review of facility records for RI#1 on January 24, 2023, revealed the following information. RI#1 had resided at the facility since September 13, 2022. A 30-day discharge notice was issued to RI#1 on January 10, 2023 due to "severely cognitively impaired", "not able to identify his/her medications, is a possible elopement risk or is not able to make good safety decisions". RI#1 sustained numerous falls at the facility on the following dates: September 22, 2022, found on the floor, no injury; September 29, 2022, found on the floor, hit head and sent to emergency department; October 5, 2022, found on floor, no injury; November 1, 2022, resident reported a fall, no injury; November 3, 2022, found on floor, skin tear to arm; November 20, 2022, found on floor, small cut to finger; December 24, 2022, slid out of lift chair, no injury, was confused at time of fall; December 25, 2022, found on floor in bathroom, no injury; January 17, 2023, found on floor, hematoma to head. RI#1's facility Care Service Plan was dated September 9, 2022. An initial entry on RI#1's Care Service Plan under Fall Precautions read "Educate resident to call for assistance". The Care Service Plan documented updates after the following falls under Fall Precautions: "9/22/22-slid off sofa. Extra cushions removed for safety; 9/30/22-unwitnessed fall in suite. Resident stated...hit...head. Sent to er for evaluation; 10/5/22-unwitnessed fall. Lost balance opening door. Reminded to call for assistance with daily	A 611		

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tasks; 11/1/22-resident self reported fall in suite. Resident teaching to use call pendent when incidents occur; 11/3/22-Unwitnessed fall in suite. Slid from lift recliner chair. Skin tear to left arm. Education provided on use of lift recliner chairs; 11/21/22-lost balance in hallway attempting to unlock door. Team to ensure resident has room key...when out of suite; 12/24/22-slid from lift chair. Education on proper use of lift chair for safety; 12/25/22-unwitnessed fall in bathroom. Education for team to ensure resident has personal items close at hand; 1/17/23-fall in suite. Unwitnessed. Sent to er later the same day due to complaint of pain in neck and low B/P. Resident unable to recall how fall occurred". The interventions on October 5, 2022, November 1, 2022 and December 24, 2022 were repetitive. No new interventions were developed at the time of these falls to prevent recurrence.

When RI#1 was found on the floor January 17, 2023, RI#1's sponsor reported RI#1 had been on the floor for approximately nine hours and no facility staff had entered the room during the nine hours to assist RI#1. Although RI#1's facility care plan instructed staff to teach RI#1 to call for assistance, the staff failed to ensure RI#1 had a functional call system in place. In fact, at the time of the fall on January 17, 2023, RI#1 did not have a call pendant which had been paid for by RI#1's sponsor and had been reported missing two days before the fall. Following RI#1's fall on January 17, 2023, no additional interventions were documented on RI#1's Care Service Plan to prevent additional falls and to keep RI#1 safe.

RI#1 had sustained nine falls during the four months he/she resided at the facility and RI#1 had confusion which limited RI#1's ability to make safe decisions. The facility staff had not

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A 611	Continued From page 24 implemented necessary measures to prevent additional falls for RI#1. On January 24, 2023, the surveyor requested a plan of action from EI#1 to keep RI#1 safe until discharged from the facility. EI#1 provided the plan which implemented 24-hour sitters for RI#1 until discharge.	A 611		
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. 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	A 621		

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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 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

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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.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to provide all care needs and maintain a safe environment for a resident who was cognitively impaired and had been issued a 30-day discharge notice.

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

Findings:

RI#1 had resided at the facility since September 13, 2022. RI#1 sustained nine falls during the four months of residency at the facility. RI#1's Monthly Wellness Reviews contained documentation of

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	D4548	A. BUILDING: _____ B. WING _____	C 01/26/2023

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THRIVE AT JONES FARM	2238 CECIL ASHBURN DR. SE HUNTSVILLE, AL 35802

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A 621	Continued From page 27	A 621		

the following changes. In September 2022, RI#1 refused activities of daily living and getting up from bed. In October 2022, physical therapy and occupational therapy were ordered for RI#1 but the therapy was refused by RI#1's sponsor. In November 2022, RI#1's cognitive status declined and behavioral health was ordered due to signs and symptoms of depression. In December 2022, RI#1 was unable to recognize his/her name on the medication packages and failed the medication awareness test. The December 2022 monthly review also documented RI#1's cognitive status had declined and RI#1 refused community activities. On January 10, 2023 a 30-day discharge notice was issued to RI#1 and sponsor due to RI#1 being "severely cognitively impaired...not able to identify his/her medications, is a possible elopement risk or is not able to make good safety decisions".

On the morning of January 24, 2023, the surveyor observed RI#1 ambulate a short distance in his/her room using a walker. RI#1's gait was slow and unsteady and RI#1 had some difficulty maneuvering the walker causing the walker to catch on furniture. RI#1 was wearing a call pendant on a string around the neck but did not remember the pendant was available until asked by the surveyor. On the afternoon of January 24, 2023, the surveyor observed medication awareness testing of RI#1 by EI#2. RI#1 was presented with two medication packets and asked if the packets contained his/her name. RI#1 quickly responded that he/she was unable to read the packets. Glasses and a magnifier were offered to RI#1 but RI#1 stated it "won't help". RI#1 added "I always just tell them to give them to me". When questioned about insulin injections RI#1 was unable to state how often insulin injections were given. RI#1 became very

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A 621	Continued From page 28 suspicious and agitated during the medication testing and asked why he/she was being questioned since the doctor had ordered his/her medications. During interviews on January 24, 2023, multiple staff members reported RI#1 was frequently confused and was not safe to be alone. Staff reported RI#1 may not remember to call for assistance if needed. Staff also reported RI#1 had a history of hallucinations and had wandered into the wrong room at times when attempting to find his/her own room. Following issuance of the 30-day discharge notice, no additional interventions were added to RI#1's facility care plan until a fall occurred on January 17, 2023. Refer to deficiency 611 for additional information on RI#1's care plan. Following RI#1's fall, a complaint was received by the Alabama Department of Public Health which alleged RI#1 had actually fallen on the night of January 16, 2023 and remained on the floor about nine hours without any staff entering RI#1's room or assisting RI#1 until the morning of January 17, 2023. Interviews with staff also revealed RI#1 did not have in his/her possession, at the time of the fall, the call pendant which had been paid for by RI#1's sponsor and had been reported missing by RI#1's sponsor two days before the fall. Refer to deficiency 1203 for additional information on RI#1's call pendant. The facility failed to take necessary steps to ensure that care needed by RI#1 was provided to keep RI#1 safe until discharge from the facility. At the request of the surveyor, a written plan of action was received from EI#1 during the onsite survey and 24 hour sitters were placed with RI#1 until discharge.	A 621		

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A1203	Continued From page 29	A1203		
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. (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.	A1203		

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A1203	Continued From page 30 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. 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	A1203		

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A1203	Continued From page 31 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 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	A1203		

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A1203	Continued From page 32 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. 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.	A1203		

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A1203	Continued From page 33 (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 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	A1203		

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A1203	Continued From page 34 and the NFPA National Electrical Code. This Rule is not met as evidenced by: Based on observations and interviews, the facility allowed a portable heater in the room of a resident who was cognitively impaired. In addition, the facility failed to maintain a functional call system at all times for this resident. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: Portable Heater On the morning of January 24, 2023, the surveyor entered RI#1's room at the facility. The room was very warm. RI#1 was seated in a chair in the living area of the room. A portable heater was in use in the room and was placed approximately 8-10 feet from RI#1. That same morning the surveyor discussed RI#1's use of the portable heater with EI#1 and the heater was removed. Call System The Alabama Department of Public Health received a complaint which alleged a resident fell and remained on the floor for about nine hours without staff entering the room or assisting the resident. During the investigation of this complaint, the surveyor found an additional deficient practice affecting the resident's call system. RI#1 had resided at the facility since September 13, 2022 and had been issued a 30-day	A1203		

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discharge notice due to cognitive decline and inability to protect self from a medication error. In addition, RI#1 sustained nine falls while residing at the facility.

On January 24, 2023 EI#1 explained to the surveyor that all residents were provided with emergency pull cords located in the bedroom and bathroom of each apartment which the residents were instructed to pull if immediate assistance was needed. In addition, a call pendant could be purchased by the resident. The pendant was placed on a cord which could be worn around the neck and was available for the resident to push as needed wherever the resident was in the facility. Once the call system was activated by a resident, the calls were received by the person in charge on that shift via a pager. The person in charge was then responsible for notifying that resident's assigned caregiver to check on the resident. Once the caregiver went to the resident, the call system (pull cord or pendant) was reset by the caregiver to notify the person in charge that the call had been answered. EI#1 stated RI#1's sponsor had purchased a call pendant for RI#1 and the pendant had not been provided to RI#1.

During an interview with RI#1's sponsor on January 25, 2023, the sponsor stated that he/she had visited RI#1 on January 15 and was unable to locate the pendant at the time of the visit. RI#1's sponsor stated he/she notified a staff member on duty at the time (name unknown) of the need for a replacement pendant for RI#1. RI#1's sponsor also stated he/she met with EI#1 on the afternoon of January 16, 2023 and notified EI#1 of the need for a new pendant at that time. When interviewed, EI#1 acknowledged she (EI#1) had been informed the pendant was

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missing and had immediately requested a new pendant be created. EI#1 stated the new pendant was given to the Medication Technician to deliver to RI#1 on January 16, 2023. However, the Medication Technician had delivered the call pendant to the wrong resident. RI#1's sponsor reported RI#1 had a camera in his/her room which could be monitored at the sponsor's home. The sponsor stated RI#1 had fallen around 9:20 PM on the night of January 16, 2023 and remained on the floor until around 6:40 AM on January 17, 2023 before anyone entered the room to check on RI#1. Surveyor review of the video footage from the facility's camera system confirmed no facility staff had entered RI#1's room on the night of January 16-17, 2023, between 10:00 PM and 6:00 AM.

During an interview on January 24, 2023, EI#4 reported she (EI#4) was notified of RI#1's fall by Care Specialists on the morning of January 17, 2023. EI#4 and Care Specialists assisted RI#1 from the floor to a chair. At that time, EI#4 asked RI#1 about the call pendant and RI#1 picked up the cord for the pendant from the table beside the chair but no pendant was on the cord. A pendant could not be located. EI#4 added a new pendant was provided to RI#1 on the morning of January 17, 2023, following RI#1's fall.

Although an additional device had been purchased to ensure RI#1 had a method of calling for assistance, the facility failed to ensure this device was available to the resident at all times. As a result, RI#1 had no way to call for assistance on the night of January 17, 2023. The surveyor and EI#2 checked RI#1's pendant as well as the two emergency pull cords on January 24, 2023 and ensured all were functional at that time.

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