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TRUEWOOD BY MERRILL, RIVERCHASE SCALF	1851 DATA DRIVE HOOVER, AL 35244

(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 October 28, 2025, an unannounced licensure survey was conducted for this 24-bed Specialty Care Assisted Living Facility (SCALF) with a census of 19. There was one (1) complaint investigated during this survey. LC#20250924006 was unsubstantiated. No 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 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practices resulted in the potential for harm to all residents and require a plan of correction.	A 000		
A 503	420-5-20-.05 (3) (a) (b) (c) Records and Reports. (3) Resident Records. (a) Records shall be current from the time of admission to the time of discharge or death and shall be retained in the facility for at least 3 years after a resident's death or discharge. (b) When an individual is admitted to a specialty care assisted living facility, records and information regarding the resident shall be protected from unauthorized disclosure. Employees and authorized agents of the Department shall be permitted to review all medical records and all other records to determine compliance with these rules. With the written consent of the resident, or with the written	A 503		

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A 503	Continued From page 1	A 503		

consent of the legal guardian of an incompetent resident, the local ombudsman shall be permitted access to all records regarding the resident. Records necessary to assess a resident's medical condition or to otherwise render good medical care shall be provided to the resident's treating physician or physicians or to the resident or to his or her legally authorized representative. A resident or his or her legal guardian may grant permission to any other individual to review the resident's confidential records by signing a standard release.

(c) In addition to all records required for the provision of resident care, for each resident the specialty care assisted living facility shall maintain on its premises the required documents listed below and any other documents required by the facility's policies and procedures:

1. Statement of resident rights signed by the resident.

2. Financial agreement.

3. Inventory of personal effects.

4. Admission record.

5. Incident investigations and reports involving the resident.

In addition to the above documents, the facility shall also maintain on its premises any Advance Directive or Portable Physician Do Not Attempt Resuscitation (DNAR) Order that has been executed by the resident. NOTE: Under no circumstances shall the facility require or refuse to allow a resident to execute an Advance

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A 503	Continued From page 2 Directive or Portable Physician DNAR Order. Advanced Directives shall be typewritten or legibly written in ink and may include the appointment of a health care proxy consistent with the specific language in the Natural Death Act (Code of Alabama 22-8A-1 et. seq). A Portable Physician DNAR Order shall follow the rule and form found in the Alabama Administrative Code 420-5-19 Appendix II. These records shall be protected from unauthorized disclosure. This Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain resident documentation of inventory of personal effects and acknowledgement of Resident's Rights. Findings: On the afternoon of October 28, 2025 during resident record review the surveyor observed. Resident Identifier (RI) #6 was admitted on January 9, 2025 with diagnoses that included dementia, chronic kidney disease, hypertension, and atrial fibrillation. RI#6's record did not have an inventory of personal effects and signed resident rights acknowledgement. Employee Identifier (EI)#2 was asked for the resident's inventory of personal effects and resident rights acknowledgement. These documents were not provided to the surveyor.	A 503		
A 507	420-5-20-.05 (3) (g) Records and Reports. (g) Admission Record. A permanent	A 507		

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A 507	Continued From page 3 record shall be developed for each resident upon his or her admission to the facility and updated as necessary to remain current. This record shall be typewritten or legibly written in ink. In addition to any information otherwise required by the facility's policies and procedures, it shall include the resident's: 1. Name. 2. Date of birth. 3. Sex. 4. Marital status. 5. Social security number. 6. Veteran status. 7. Name, address, and contact information of the resident's sponsor, responsible party, or closest living relative. 8. Name, address, and contact information of any person or agency providing assistance to the resident. 9. Name, address, and contact information of the resident's attending physician. 10. Preferred pharmacy or pharmacist. 11. Date of admission. 12. Date of discharge. 13. Facility, setting, or location to which discharged.	A 507		

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A 507	Continued From page 4 14. Date of death. 15. Cause of death, if known. 16. Religious preferences. 17. Information from insurance policies regarding funeral arrangements and burial provisions. 18. Written documentation that the facility has devised a plan to transfer the resident to a hospital, nursing home, or other appropriate setting if and when the facility becomes unable to meet the resident's needs. The resident's preference, if any, with respect to any particular hospital or nursing home shall be recorded. The facility shall keep written documentation that demonstrates the transfer plan has been thoroughly explained to the resident or sponsor, as appropriate, and that the resident or sponsor understands the transfer plan. 19. The written documentation of the procedure to follow in case of serious illness, accident, or death to the resident (including the name and telephone number of the physician to be called, the names and telephone numbers and addresses of family members or sponsor to be contacted, the resident's or, if appropriate, the sponsor's wishes with respect to disposition of personal effects, and the name and telephone number of the funeral home to be contacted). This Rule is not met as evidenced by: Based on observation and record review, the	A 507		

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A 507	Continued From page 5 facility failed to have a written plan to transfer a resident to an appropriate setting in the event the facility became unable to meet the residents needs. Also, there was no written documentation of the procedure to follow in case of serious illness or death of a resident. Findings: On the afternoon of October 28, 2025 during resident record review the surveyor observed the following. RI#4 was admitted on July 11, 2014 with diagnoses that included Alzheimer's disease, depression, hyperlipidemia, panic disorder and gastroesophageal disorder. RI#4's record did not have a written resident plan for transferring the resident in the event the facility could no longer meet the residents needs or a written procedure for serious illness or death of the resident. EI#2 was asked if the plan was elsewhere in the records. EI#2 stated that it should be in the chart. The resident's written plan to transfer or procedure in case of serious illness was not provided to the surveyor for RI#4. RI#5 was admitted on January 22, 2020 with diagnoses that included memory loss, osteoarthritis, gastroesophageal reflux disease, hypertension, chronic kidney disease and dementia. RI#5's record did not contain the written plans for transfer or the procedure for serious illness or death of the resident. EI#2 was asked if the documentation was elsewhere in the records. EI#2 stated that it should be in the chart. Neither the resident's transfer plan nor written procedures in case of serious illness or death were provided to the surveyor for RI#5.	A 507		

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A 507	Continued From page 6 RI#6 was admitted on January 9, 2025 with diagnoses that included dementia, chronic kidney disease, hypertension, and atrial fibrillation. RI#6 record did not have a written plan to transfer the resident or written procedures in case of serious illness or death. EI#2 was asked for the written plans. The documentation was not provided to the surveyor for RI#6.	A 507		
A 602	420-5-20-.06 (2) (a) (b) (c) Care of Residents. (2) Medical Examination Record. (a) Initial Physical Examination. Not more than 30 days prior to admission of any resident to a specialty care assisted living facility, the resident or prospective resident shall be examined by a physician. For purposes of the initial physical examination, a physician currently licensed and in good standing with the Medical Licensure Commission of any state may complete this physical assessment. The physician shall report his or her findings in writing to the facility. This examination is not required for a resident of a facility dually licensed as an assisted living facility and as a specialty care assisted living facility in those cases when the resident is transferred from the assisted living unit to the specialty care assisted living unit in the same facility. In addition to any information otherwise required by the facility's policies and procedures and in addition to any other information the physician recommends or believes is pertinent, the initial physical examination record shall contain the following: 1. All of the physician's diagnoses and the resident's baseline weight and vital signs.	A 602		

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A 602	Continued From page 7 2. Medication presently prescribed (name, dosage, and strength of drug, frequency, and route of administration). 3. A statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident-to-resident contact. 4. Documentation of evaluation for tuberculosis within the previous 12 months. (b) Annual Physical Examination. In addition to the admission physical examination, each resident shall be examined annually by a physician, and findings from the annual physical examination shall be documented with a copy placed in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent or recommended by the resident's attending physician, the annual physical examination shall contain the following: 1. The resident's weight and vital signs. 2. Changes in diagnoses. 3. Changes in condition. 4. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration). 5. Changes in treatment. (c) Change of Condition Physical	A 602		

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A 602	Continued From page 8 Examinations. Changes in the resident's condition that require a physician examination and result in a change in diagnoses, condition, medications, or treatments shall be reported to the facility and documented in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent, or recommended by the resident's treating physician, this physical examination shall contain a listing of the following: 1. Changes in diagnoses. 2. Changes in condition. 3. Changes in medications prescribed (name, dosage and strength of drug, frequency, and route of administration). 4. Changes in treatment. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to obtain baseline vital signs prior to admission. In addition, a resident's Initial Physical Examination was incomplete and was a telehealth visit. Findings: RI#2 RI#2 was admitted to the facility on July 23, 2024 and had diagnoses which included atrial fibrillation, advanced dementia, arthritis,	A 602		

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A 602	Continued From page 9 depression, hypertension and stroke. RI#2's Initial Physical Examination, dated July 18, 2024, was documented as a telehealth visit and did not contain RI#2's vital signs and weight. EI#1 stated this occurred before he (EI#1) became administrator and agreed a telehealth visit was not acceptable. RI#4 On the afternoon of October 27, 2025 during resident record review it was observed by the surveyor that RI#4's initial medical examination for admission on July 11, 2024 did not contain required baseline vital signs of temperature and respirations. RI#4 was admitted on July 11, 2014 with diagnoses that included Alzheimer's disease, depression, hyperlipidemia, panic disorder and gastroesophageal disorder. RI#4's record did not have the baseline vital signs of temperature and respirations on the medical examination. EI#5 was asked who was responsible for obtaining admission baseline vital signs. EI#5 stated it was the admission person who was responsible to obtain all information for admission. EI#5 stated it was missed by the admission person.	A 602		
A 604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility RN or care coordinator shall screen prospective residents for eligibility for admission into the specialty care assisted living facility. The screening shall include a clinical history, a mental status examination to include aphasia screening, a geriatric depression	A 604		

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A 604	Continued From page 10 screen, a physical self-maintenance screen, and a behavior screen. Appendix A herein, contains the Physical Self Maintenance Scale (PSMS) form and the Behavior Screening form. These forms shall be completed to screen physical functioning and behaviors. The PSMS and Behavior Screen assessments shall be completed by the RN or care coordinator upon admission, annually, and when there is a change in the resident's status. The facility RN shall perform a comprehensive assessment of each prospective resident for facility eligibility. This assessment shall document identified care needs and serve as a baseline for the RN plan of care and future assessments. (b) Monthly Assessments. The RN shall assess each resident monthly and more often when necessary to identify changes in the resident's health status. The monthly assessment shall include a review of monthly weights, falls, incidents, elopements, behavioral symptoms, medications, changes in resident status, and appropriateness of the resident's plan of care. (c) Comprehensive Assessment. The facility RN shall perform a comprehensive assessment and communicate with the resident's attending physician and with the resident's sponsor or responsible family member when a decline in health status or behavior occurs, or if the resident develops any of the following problems: 1. Weight loss:	A 604		

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A 604	Continued From page 11 (i) Each month, the facility shall accurately weigh and record the weight of each resident. (ii) A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half percent or greater weight loss in a period of 3 months or less, or a 10 percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician. 2. Falls (two or more falls within a 30 day period). 3. Elopement. 4. Any sign and symptom of adverse drug reaction, interaction or over sedation, or circumstances which contraindicate medications that have been prescribed for the resident. 5. Unmanageable, combative, or potentially harmful behavior(s). 6. Any accident with injury. (d) Focused Assessments. The RN or LPN shall conduct focused assessments when necessary to identify changes in resident status. (e) Any change in resident status requires immediate documentation and implementation of interventions or reassessment	A 604		

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A 604	Continued From page 12 of existing interventions. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to perform assessments of residents as required. Findings: RI#2 RI#2 had resided at the facility since July 23, 2024. Review of RI#2's facility record on October 28, 2025 revealed RI#2 had numerous falls at the facility including falls on September 25, 2025 and on October 17, 2025. No comprehensive assessment, PSMS and behavior screening were completed when RI#2 sustained these two falls within 30 days. Also, caregivers and nurses reported that RI#2 had recently declined in functional status and a meeting had been scheduled with RI#2's family to discuss discharge planning. EI#1 confirmed that a meeting had been scheduled with RI#2's family to issue a 30-day discharge notice. However, no comprehensive assessment, PSMS and behavior screening had been completed to document this decline in RI#2's status. At the request of the surveyor, a PSMS was completed for RI#2 on October 28, 2025 by EI#5. The total score of RI#2's PSMS was 27 with a score of 5 in Dressing, Grooming and Bathing and a score of 4 in Physical Ambulation. These scores were all above the level allowed in a SCALF. RI#2 had not been assessed timely to determine RI#2's functional status and ability to safely reside in a SCALF.	A 604		

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A 604	Continued From page 13 RI#3 RI#3 was admitted to the facility on August 4, 2025 and had diagnoses which included post-traumatic stress disorder, dementia, hypertension and bipolar disorder. No comprehensive assessment, PSMS, behavior screening, geriatric depression screen, aphasia screening and mental status examination had been completed for RI#3 prior to admission or since admission to the facility. EI#5, Registered Nurse, had only been employed at the facility for 3 weeks and was unable to provide the required assessments. On the afternoon of October 27, 2025 the surveyor observed during resident record review the that the resident records sampled did not contain complete monthly weights and assessments. RI#4 was admitted on July 11, 2014 with diagnoses that included Alzheimer's disease, depression, hyperlipidemia, panic disorder and gastroesophageal disorder. RI#4's record did not have monthly assessments and weights for January 2025, February 2025 and March 2025. EI#2 was asked if these were contained elsewhere in the records, EI#2 stated that it should be in the chart. The resident's assessments and weights for January, February and March 2025 were not provided to the surveyor for RI#4. RI#5 was admitted on January 22, 2020 with diagnoses that included memory loss, osteoarthritis, gastroesophageal reflux disease, hypertension, chronic kidney disease and	A 604		

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A 604	Continued From page 14 dementia. RI#5's record did not have monthly assessments completed for February 2025 and March 2025. EI#2 was asked if the assessments and weights for the resident were located somewhere else. EI#2 stated the documentation should be in the chart. The resident's assessments and weights for February and March 2025 were not provided to the surveyor for RI#5. RI#6 was admitted on January 9, 2025 with diagnoses that included dementia, chronic kidney disease, hypertension, and atrial fibrillation. RI#6's record did not include monthly assessments for February 2025 and March 2025. EI#2 was asked if the assessments and weights for the resident were located somewhere else, EI#2 did not provide the requested assessments and weights to the surveyor for RI#6.	A 604		
A 611	420-5-20-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. The RN shall develop written plans of care for each resident prior to or at the time of admission. The plans of care shall be based on resident's assessments, diagnoses, and recommendations of the resident's physician. The plan of care shall be developed in cooperation with the resident, if appropriate, and	A 611		

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A 611	Continued From page 15 the sponsor. The RN shall identify resident care problem areas and formulate written interventions to address those problems. The RN shall evaluate the implementation of the interventions and the resident's response to the interventions and modify the plan of care as necessary. 1. The plan shall at all times reflect the current condition of the resident. All entries on the plan of care shall be accurately dated. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following: 2. A listing of the resident's individual needs or problems that require intervention by the facility. 3. A listing of interventions provided by the facility to address the resident's identified needs or problems. 4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider. 5. Activities of Daily Living. Residents of a specialty care assisted living facility shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident. (i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested.	A 611		

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A 611	Continued From page 16 (ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips. (iii) Hair. Residents' hair shall be kept clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be provided assistance with personal safety. 6. As changes in medication and 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 Registered Nurse (RN) failed to maintain updated care plans for residents which addressed the residents' current care issues with appropriate interventions to meet the care needs of the residents. In addition, the facility failed to meet the care needs of at least one resident. Findings: RI#1	A 611		

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A 611	Continued From page 17 RI#1 was admitted to the facility on November 18, 2024 and had diagnoses which included diabetes mellitus type 2, hypertension, advancing dementia, major depressive disorder and cerebral atrophy. RI#1 sustained significant weight loss at the facility on the following dates: May 9, 2025 weight loss of 5.1 per cent for 1 month (154 pounds on April 3, 2025 and 146 pounds on May 9, 2025); May 9, 2025 weight loss of 8.1 per cent for 3 months (159 pounds on February 6, 2025 and 146 pounds on May 9, 2025); August 16, 2025 weight loss of 11.6 per cent for 6 months (159 pounds on February 6, 2025 and 140.5 pounds on August 16, 2025). The most recent Service Plan provided to the surveyor was dated June 19, 2025. RI#1's repeated significant weight loss was not addressed on RI#1's facility care plan with appropriate interventions to prevent continued weight loss. RI#2 RI#2 had resided at the facility since July 23, 2024. On October 27 and 28, 2025, the surveyor observed personal care provided to RI#2 by EI#10 and EI#11. RI#2 required a minimum of 2-person assistance for transferring and ambulating due to RI#2 resisting the assistance of caregivers and pulling against caregivers when standing. EI#10 and EI#11 also reported that RI#2 would hit caregivers at times during care assistance. These behaviors and requirement of at least two caregivers to assist RI#2 were not addressed on RI#2's facility care plan dated October 17, 2025. In fact, RI#2's Service Plan read "...Bathing Minimal: Resident can bathe without physical assistance but may require reminding or standby assistance...Toileting Moderate: Resident requires standby assistance	A 611		

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A 611	Continued From page 18 for toileting tasks...". RI#2's facility record contained documentation of at least 8 falls sustained by RI#2 since October 12, 2024, including recent falls on September 25, 2025, on October 16, 2025 and on October 17, 2025. RI#2's facility Service Plan did not address each fall with appropriate interventions to prevent a recurrence. RI#2's facility record also contained documentation that RI#2 would hold food and medicines in his/her cheek. This behavior was not addressed on RI#2's facility care plan with appropriate interventions to prevent choking or aspiration. RI#2's facility Service Plan, dated October 17, 2025, read "...Resident requires cutting up of food, opening cartons/packages; may need encouragement to select menu items...". On October 28, 2025, the surveyor and EI#7 observed that RI#2's fingernails were long and had a dark brown substance underneath the nails. EI#7 agreed RI#2's fingernails were in need of trimming and cleaning. RI#2's facility Service Plan read "...Grooming/Personal Hygiene Minimal: Resident may manage grooming/personal hygiene but requires verbal reminders/prompts/cues...". RI#2 was cognitively unable to provide adequate personal grooming. RI#2's need for assistance with nail care had not been addressed on RI#2's facility care plan and had not been provided by facility staff. RI#3 RI#3 had resided at the facility since August 4, 2025. RI#3 had diagnoses of post traumatic stress disorder, dementia and bipolar disorder. On the morning of October 28, 2025, the surveyors observed an episode of agitation and yelling demonstrated by RI#3 in the hallway of the	A 611		

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A 611	Continued From page 19 facility. RI#3 was redirected by staff with minimal difficulty. During interviews, staff reported that RI#3 had unpredictable and disruptive behaviors. RI#3's facility Service Plan, dated October 16, 2025, read "...Resident does not have current or history of disruptive, aggressive, anxious, depressive, verbal or socially inappropriate behaviors..." and had not been updated to address RI#3's behaviors. On October 27, 2025, EI#5, Registered Nurse, stated she (EI#5) had been employed at the facility for only three weeks and had not completed training on resident assessments and developing care plans. EI#5 added that the regional nurse had been responsible for resident assessments and care plans prior to her (EI#5's) employment.	A 611		
A 616	420-5-20-.06 (5) (i) (j) (k) (l) (m) Care of Residents. (i) Medications kept under the control or custody of a specialty care assisted living facility shall be packaged by the pharmacy and shall be maintained by the facility in unit dose packaging. Medications kept under the control or custody of the specialty care assisted living facility that are not available in unit dose packaging must be packaged by the pharmacy and administered by a physician, RN, or LPN. (j) Unless a resident can and does self-manage his or her own medications, a specialty care assisted living facility shall require each resident to use a single pharmacy. This does not apply to emergency pharmacy services. All residents need not use the same pharmacy that is used by other residents unless express	A 616		

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A 616	Continued From page 20	A 616		

policy of the specialty care assisted living facility provides otherwise and all residents are informed of such policy and provided a copy of such policy prior to or at the time of admission. The specialty care assisted living facility shall require pharmacies used for medication supply for residents not self-managing their medications to review all ordered medication regimens for possible errors or adverse drug interactions and to advise the facility and the prescribing health care provider when these are detected.

(k) If controlled substances prescribed for residents of any specialty care assisted living facility are kept in the custody of the specialty care assisted living facility, they shall be stored in a manner that is compliant with state and federal laws, the requirements of the Alabama State Board of Pharmacy, and any requirements prescribed by the Alabama State Board of Health. At a minimum, controlled substances in the custody of the facility shall be stored using a double lock system, under proper temperature and humidity controls and permit only authorized personnel access. The facility shall maintain a system to account for all controlled substances in its possession. All other medications in the custody of the facility shall be stored using at least a single lock, under proper temperature and humidity controls and permit only authorized personnel access. This shall include medications stored in a resident's room when the staff and not the resident have access to the medications. Medications may be kept in the custody of an individual resident who can safely manage his or her medications. Such medications may be stored in a locked container accessible only to the resident and staff, or may be stored and secured in the resident's living quarters, if the room is

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A 616	Continued From page 21 single occupancy and has a locking entrance. (l) Medication administration records and written physician orders for all over-the-counter drugs, legend drugs, and controlled substances shall be retained for a period of not less than 3 years. They shall be available for inspection and copying on demand by agents of the State Board of Health. They shall be made available for inspection at reasonable times by residents, anyone authorized by the resident, and by the sponsors of residents. (m) Labeling of Drugs and Medicines. All containers of prescribed medicines and drugs shall be labeled in accordance with the rules of the Alabama State Board of Pharmacy and shall include appropriate cautionary labels, such as, "Shake Well," or "For External Use Only." This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to maintain a proper system to account for all controlled substances in its possession. Findings On the afternoon of October 27, 2025, the surveyor and EI#9 counted controlled substances stored in the facility's medication cart. EI#9 provided to the surveyor a copy of the Narcotic Shift Count from September 30, 2025 through October 27, 2025. Most 10:00 PM narcotic counts on the forms contained a single signature followed by a slash (/) and initials. Most 6:00 AM	A 616		

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A 616	Continued From page 22 narcotic counts on the forms contained a single signature. EI#9 explained that, since there was not a nurse on duty from 10:00 PM until 6:00 AM, a caregiver observed the nurse count narcotics at 10:00 PM then initialed beside the nurse's signature The nurse counted alone and signed upon arriving at the facility at 6:00 AM. The narcotic keys were stored in a locked box from 10:00 PM until 6:00 AM. There were no witnesses to the narcotics counts at 6:00 AM. EI#1 agreed this was not an appropriate system to account for the narcotics and added that a new system would be put in place and he (EI#1) also planned to hire a nurse for the 10:00 PM-6:00 AM shift.	A 616		
A 617	420-5-20-.06 (6) Care of Residents. (6) Disposal of Medications. (a) Controlled substances and legend drugs dispensed to residents, that are expired or unused because the medication is discontinued or because the resident dies, shall be destroyed within 30 days. Unused legend drugs that are not expired may be donated to a charitable clinic pursuant to Alabama Administrative Code Chapter 420-11-11, et. seq. Under no circumstances shall expired, discontinued, or unused medications be stored or housed in the facility beyond 30 days. (b) Medications of residents who are discharged or transferred to another facility shall be returned to the residents. The responsible party will sign a statement that these medications have been received. The statement shall list the pharmacy, prescription number, date, resident's name, and strength of the medication and the amount. This statement shall be maintained in a	A 617		

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A 617	Continued From page 23 file for at least three years. (c) When medications are destroyed on the premises of the specialty care assisted living facility, a record shall be made and retained for at least three years. This record shall include: the name of the specialty care assisted living facility, the method of disposal, the pharmacy, the prescription number, the name of the resident, the name, strength, and dosage of the medication, and the amount and the reason for the disposal. This record shall be signed and dated by the individual performing the destruction and by at least one witness. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to properly document disposition of a resident's medications upon discharge of the resident from the facility. Findings: Review of RI#7's facility record on October 28, 2025 revealed the following information. RI#7 was admitted to the facility on September 18, 2023 and had diagnoses which included atrial fibrillation, diabetes mellitus, chronic kidney disease, hypertension, history of cerebrovascular accident and dementia. RI#7 was discharged from the facility to another facility on September 26, 2025. RI#7's family member signed the Release or Destruction of Medications form indicating acceptance of RI#7's medications on September 26, 2025. The form did not contain the prescription numbers and name of the pharmacy. EI#1 agreed the required information	A 617		

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A 617	Continued From page 24 was missing.	A 617		
A 619	420-5-20-.06 (8) Care of Residents. (8) Storage of Medical Supplies. (a) First Aid Supplies. First aid supplies shall be maintained in a place readily accessible to persons providing personal care and services in the specialty care assisted living facility. These supplies will be inspected at least annually to ensure their usability. This Rule is not met as evidenced by: Based on interview and observation the facility failed to annually inspect first aid supplies to ensure usability. Findings: On the afternoon of October 28, 2025 the surveyor observed that the facility first aid kit had expired September 30, 2022. EI#4 was asked if he was aware that the first aid kit had expired. EI#4 responded he did not know the first aid kit had expired. EI#4 stated he would order a new one immediately. On the afternoon of October 28, 2025, the administrator, EI#1, stated to the surveyor that a new first aid kit had been ordered as replacement.	A 619		
A 703	420-5-20-.07 (3) Food Service. (3) Dietary Service.	A 703		

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A 703	Continued From page 25 (a) Number of Meals. No fewer than three meals shall be provided each 24 hours. Food service shall be provided in a resident's room during temporary illness if necessary. The diet shall be well-balanced, palatable, properly prepared, and sufficient in quantity and quality to meet the nutritional needs of the residents in accordance with Dietary Reference Intakes of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The food must be adapted in type and preparation to the habits, preferences, and physical abilities of the residents. (b) Timing of Meals. A time schedule for serving meals to residents and personnel shall be established. Meals shall be served approximately five hours apart with no more than 14 hours between the evening meal and breakfast. The time schedule of meals shall be posted with the menu. The facility shall make evening snacks available after service of the evening meal. The facility shall provide fluids throughout the day and shall make between-meal nourishment (snacks) available. (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.	A 703		

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A 703	Continued From page 26 (e) A facility shall not obtain food from charitable organizations. A facility shall not avoid serving a meal by sending or transporting residents to missions, soup kitchens, or other charitable facilities for meals. (f) The amount of food on hand shall be sufficient to serve three meals per day to all residents for 3 days. Non-perishable food and potable water shall be maintained in the facility in sufficient quantity to serve three meals per day to all residents for 3 days. This Rule is not met as evidenced by: Based on observation and interview, the facility meal time schedule did not meet the requirements for a SCALF. Findings: On the morning of October 28, 2025, the surveyor noted that the posted meal times were as follows: Breakfast 7:30 AM, Lunch 12:00 noon and Dinner 5:00 PM, leaving 14 1/2 hours between the evening meal and breakfast. EI#1 and EI#4 stated the meal times would be adjusted.	A 703		
A1101	420-5-20-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All specialty care assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an	A1101		

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A1101	Continued From page 27	A1101		

evacuation floor plan shall be appropriately posted in a conspicuous place.

(b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, 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.

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A1101	Continued From page 28 3. Complies with the requirements of the currently adopted Life Safety Code. (f) Fire Alarm and Sprinkler System. 1. Fire Alarm System. Where fire alarm systems are required, a corridor smoke detection system shall be installed on each floor, including areas open to the exit access corridor, to comply with NFPA 72, connected to the facility's fire alarm system. In lieu of corridor smoke detection, smoke detectors connected to the building fire alarm system may be installed in each resident's room, open areas, and at smoke doors (except that corridor smoke detection shall not be deleted when its use is dictated by other requirements). 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, interview and record	A1101		

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A1101	Continued From page 29 review the facility failed to document fire drills and have fire safety systems inspected as required. Findings: On the morning of October 27, 2025 during fire safety record review, the surveyor observed that fire alarm system inspection for April 2023 was not done. It was noted that documentation for fire drills was not made available to the surveyor by the facility for the following times. February, October, November and December of 2023. March-August and November and December of 2024.	A1101		
A1203	420-5-20-.12 (5) Physical Environment. (5) General Building Requirements - Group and Congregate. (a) Structural Soundness and Repair. The building shall be structurally sound, free from leaks and excessive moisture, in good repair, and painted with sufficient frequency to be reasonably attractive inside and out. The interior and exterior of the building shall be kept clean and orderly. (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	A1203		

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shall have sufficient artificial lighting to prevent accidents and promote efficiency of service. Night lights shall be provided in all hallways, stairways, and bathrooms.

(d) Screens. All screen doors and operable windows shall be equipped with tight-fitting, full-length 16 mesh screens. Screen doors shall be equipped with self-closing devices.

(e) Emergency Lighting.

1. All specialty care assisted living facilities shall provide an emergency artificial lighting system to adequately illuminate halls, corridors, and stairwells in case of electrical power failure. As a minimum, dry cell battery-operated lighting shall be provided to light such spaces.

2. Emergency lighting must provide illumination in accordance with the currently adopted Life Safety Code for at least 90 minutes.

(f) Floors.

1. All floors shall be level, smooth and free of cracks, and finished so as to be easily kept clean. The basic requirement for floor 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

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acceptable surface and shall be kept clean and in good repair.

(h) Windows. Operable windows shall be so constructed and maintained so that they fit snugly, and are capable of being opened and closed easily. Windows in specialty care facilities may have devices which prevent full opening of the window.

(i) Ceiling Height. Each room occupied by residents shall have a ceiling height of eight feet or more. Existing facilities with ceiling heights less than eight feet shall be acceptable when the height complies with the codes.

(j) Handrails. If handrails are installed in halls or corridors, the handrails shall be mounted at
30 - 36 inches above the floor and returned to the wall at each end.

(k) Stairways. Stairways shall be well lighted, kept in good repair, and have handrails. Open space under stairs shall not be used for storage purposes. All walls and doors under stairs shall meet the same fire rating as the stairwell.

(l) Doors.

1. In each new specialty care assisted living facility, doors of resident bathrooms connected to resident bedroom shall swing into the bedroom.

2. Bedroom and bathroom doors may be equipped with hardware that will permit a resident to lock himself within the room, provided

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a master key is readily accessible for the staff at a central location.

3. Resident bedroom and other exit access doors in specialty care assisted living facility shall be at least three feet wide.

4. Exterior egress doors except the main entry/exit door, may be equipped with a delayed egress locking system installed in accordance with NFPA 101. Other exterior egress doors may be arranged to prevent free and unhindered egress from specialty care assisted living facilities, in accordance with the Special Requirements portion of this section.

5. Exit doors swinging outward shall swing out over a landing having a minimum length and width equal to the door's width at the same level as the floor level, except existing doors shall not have more than a four inch step down.

(m) Ventilation. The building shall be well ventilated at all times to prevent accumulation of objectionable odors. Kitchens, laundries, service rooms, toilets, and bathrooms shall be ventilated by windows, gravity vents, or mechanical means as necessary to prevent 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

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

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

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

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

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

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

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A1203	Continued From page 34 (s) Heating, Lighting, and other Service Equipment. 1. Central or individual room gas heating systems shall be of the enclosed flame type equipped with automatic flame shut-off control and shall be vented directly to the outside. Heating units of any type shall be located to avoid direct contact with any combustible material and shall be maintained in accordance with manufacturer's recommendation. 2. Open flame and portable heaters are prohibited in specialty care assisted living facilities. This does not apply to a fire place with gas logs protected as noted elsewhere in these rules. 3. Lighting shall be restricted to electricity. Electric wiring, motors, and other electrical equipment in all specialty care assisted living facilities shall be in accordance with local electrical codes and the NFPA National Electrical Code. This Rule is not met as evidenced by: Based on observation and interview the facility failed to to keep walls clean and in good repair in the laundry room. The facility also failed to conduct a monthly visual inspections of the fire extinguisher in the laundry room. Findings: On the morning of October 28, 2025 during inspection tour of facility it was observed by the surveyor that the 2.4 pound ABC fire extinguisher located in the laundry room was last inspected	A1203		

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A1203	Continued From page 35 7/2025 and had not been inspected for the months of August and September 2025. EI#3 was asked if fire extinguishers were routinely inspected by a staff member. EI#3 responded that fire extinguishers were checked monthly by staff. EI#3 stated that this laundry extinguisher might of been missed by the designated employee who checks extinguishers. The walls behind and adjacent to the washer and dryer in the laundry room were observed to be peeling, blistered paint, water damaged sheet rock along the length of the wall from the baseboard to approximately 24 inches up the wall behind and next to the washer. EI#11 was asked how long the walls been in this condition. EI#11 stated they did not know. During the tour of facility the surveyor observed that the restroom door closer was damaged, broken and partially hanging down from the door. The door closer had caused a two inch diameter hole in the wall behind the door when opened. EI#3 was informed of this and immediately began repair on the door closer and wall.	A1203		
A1205	420-5-20-.12 (7) Physical Environment (7) Building Requirements - Congregate Specialty Care Assisted Living Facility. (a) General. Congregate specialty care assisted living facilities licensed, constructed, or renovated under the currently adopted codes shall comply with the building code and the requirements for limited care facilities in the "New Health Care Occupancies" Chapter of the Life Safety Code (excluding NFPA 101A Alternative Approaches to Life Safety). Facilities or portions of facilities, built under previously adopted	A1205		

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editions of the codes shall comply with the currently adopted requirements for limited care facilities in the "Existing Health Care Occupancies" Chapter of the Life Safety Code (excluding NFPA 101A Alternative Approaches to Life Safety).

(b) Exit doors. Panic hardware shall be installed on all exit doors, except where electrically controlled door hardware is used in accordance with other provisions of these rules.

(c) Corridors and Passageways. Corridors and passageways shall be unobstructed and shall not lead through any room or space used for a purpose that may obstruct free passage.

(d) In new construction, the temperature of hot water accessible to residents shall be automatically regulated by tempering valves and a circulating pump system, unless the water heater is dedicated to resident use.

(e) Utility rooms shall be provided for each floor of Congregate specialty care assisted living facilities. The following equipment shall be provided:

1. Paper towel holder with an adequate supply of paper towels.

2. Wall cabinet or shelves.

3. Table or counter.

4. Soap dispenser with soap.

5. Sink - counter top, wall or floor

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A1205	Continued From page 37 mounted. 6. Space and facilities for cleaning equipment and supplies. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to have proper working smoke barrier doors. Findings: On the afternoon of October 27, 2025 it was observed by the surveyor that the smoke doors had excessive clearance under the door, greater than 1/4 inch. EI#1 was asked if the smoke doors had been worked on recently. EI#1 stated that maintenance director would know and she would address this with the maintenance director.	A1205		
A1206	420-5-20-.12 (8) Physical Environment (8) Additional Requirements for Specialty Care Assisted Living Facilities. (a) Facilities shall be certified and licensed for housing residents with dementia, and must comply with these special requirements for the physical plant. Facilities should confirm local code requirements, which may vary from those indicated below. (b) Additional Smoke Detection. Smoke detectors (electrical or system type) shall be provided in the sleeping rooms and any bedroom suite sitting areas, which house dementia residents. These detectors shall initiate at least a	A1206		

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A1206	Continued From page 38 local alarm or supervisory signal, through the fire alarm system or call system. (c) Windows in specialty care facilities may have devices which prevent opening of the window. (d) Areas to Wander and Secure Perimeter. 1. Each facility shall have a secure boundary or perimeter to safely accommodate residents in all aspects of its physical plant. Exterior building walls and doors, and walled or fenced outdoor areas may form this boundary. Such walls or fences shall be at least six feet high. 2. Each walled or fenced area shall have at least one gate, located along the discharge path of travel from the building egress doors to the public way. Gates shall be readily unlockable from either side by the staff or by automatic means. "Automatic means" shall be in the same manner as locked or delayed-egress exit doors. 3. If the facility's emergency plan utilizes fenced or walled outdoor spaces as refuge areas for containment of residents, each refuge area shall be of sufficient size to accommodate all occupants at a distance of not less than 50 feet from the building while providing a net area of 15 square feet per person. A gate shall be located within this refuge area. 4. If the facility's emergency plan uses the fenced or walled outdoor spaces merely as areas that are immediately passed through and	A1206		

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exited, not as refuge areas for containment of residents, there is no size or area requirement for the fenced or walled spaces.

5. An outdoor courtyard, which is completely surrounded by the building, must have at least two separate doorways, located remotely from each other, leading into separate smoke compartments of the building.

(e) Locking of Exit Doors. Locks on exit doors of each specialty care assisted living facility, if installed, shall be electrical locked or electrical delayed-egress locking devices. Buildings shall be protected throughout by an approved supervised automatic sprinkler system connected to the fire alarm system.

1. Delayed-egress locks must comply with the requirements for "Special Locking Arrangements" found in NFPA 101 Life Safety Code.

2. Electrically locked doors shall comply with the following:

(i) A control panel shall be provided at one or more stations with the capability to remotely unlock all exit doors, simultaneously. Locks may be arranged to unlock in Specialty Care compartments based on a zoning concept, where each zone is a rated fire or smoke compartment and the locks on all egress doors unlock within the alarmed zone or compartment. This zoning concept is permitted to apply to automatic functions required by the Life Safety Code.

(ii) A key, code, or card release switch

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A1206	Continued From page 40 shall be provided inside the facility at each locked door, which shall override the locking system to allow exiting from the compartment or building. (iii) All locks shall release automatically upon activation of the facility fire detection, or fire sprinkler system, or upon disablement of the fire alarm system. (iv) Locks shall release automatically upon loss of electric power controlling the lock. (v) The facility shall provide the residents sponsors with adequate information about the facility's door locking arrangements. (vi) The facility shall assure, at least monthly, that locked or delayed-egress exit doors function properly, in accordance with required fire safety provisions. This Rule is not met as evidenced by: Based on observation and interview, an outside gate was not readily unlockable from either side by staff or by automatic means. Findings: During activation of the fire alarm system on the afternoon of October 27, 2025, the surveyor observed an exterior gate outside the common area of the facility. The gate was secured by two separate locks, requiring a key to unlock the gate and allow exit from the enclosed area. The gate did not release automatically and remained locked during activation of the fire alarm system. When interviewed, EI#1 stated that he (EI#1) and	A1206		

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A1206	Continued From page 41 EI#3, Maintenance, were the only two staff members who had keys to unlock the gate. EI#1 agreed the gate could not be released by all staff at the facility in case of a fire. CONNIE CHERRY, REGISTERED NURSE GREGORY ZEITLIN, REGISTERED NURSE	A1206		