

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D0804	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2021
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NAME OF PROVIDER OR SUPPLIER AUTUMN COVE	STREET ADDRESS, CITY, STATE, ZIP CODE 4425 GREENBRIER DEAR ROAD ANNISTON, AL 36207
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A 000	<p>Initial Comments</p> <p>Surveyor: 34502 On September 1, 2021, an unannounced licensure survey and complaint investigation was conducted for this 38 bed Assisted Living Facility (ALF) with a census of 22.</p> <p>There were two (2) complaints investigated during this survey. Intake ID: 20210316006 and Intake ID: 20210628011 were substantiated and deficiencies were cited as a result of these complaint investigations.</p> <p>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 pose a potential risk of harm to the residents and requires a plan of correction.</p>	A 000		
A 302	<p>420-5-4-.03 (1) (e) Administration. Policies.</p> <p>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:</p>	A 302		

Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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A 302	<p>Continued From page 1</p> <ul style="list-style-type: none"> (i) Facility responsibility to protect all residents from abuse, neglect, and exploitation. (ii) How allegations of abuse, neglect, and exploitation will be handled by the facility. (iii) Resident confidentiality. (iv) Admission and continued stay criteria. (v) Discharge criteria and notification procedures for residents and sponsors. (vi) Facility responsibility when a resident's personal belongings are lost. (vii) What services the facility is capable and not capable of providing. (viii) Medication management. (ix) Infection control. (x) Meal service, timing, menus and food preparation, storage, and handling. (xi) Fire safety and emergency plan, fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness. (xii) Staffing and conduct of staff while on duty. (xiii) Oxygen administration and storage if used in the facility. (xiv) Dietary Policies. The dietitian, 	A 302		

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A 302	<p>Continued From page 2</p> <p>with the approval of the administrator, shall develop written policies and procedures for the guidance of all personnel handling food as outlined by the most current Food and Drug Administration Food Code published by the U.S. Department of Health and Human Services. The facility shall develop and implement dietary policies and procedures to meet the needs of the residents in the facility. In addition to other matters deemed necessary by the facility, dietary policies shall address:</p> <p>(I) Sanitation of dishes, utensils, and service equipment, and sanitary food preparation and handling.</p> <p>(II) The attire and cleanliness of staff members who prepare, handle, or serve food.</p> <p>(III) A schedule of meals, which shall include between-meal nourishment or snacks, and fluids.</p> <p>(IV) Food substitutions or alternatives.</p> <p>(V) Method to ensure an adequate dietary plan is implemented for any resident with a therapeutic diet or special dietary needs.</p> <p>(VI) Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food.</p> <p>(VII) Provision of necessary services to any resident requiring adaptive devices to eat.</p> <p>(VIII) Procedure for the handling of potentially hazardous foods such as meat, milk, ice, and eggs.</p>	A 302		

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A 302	<p>Continued From page 3</p> <p>(IX) Storage of food.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Surveyor: 34502 Based on observations, record reviews and interviews, the facility failed to follow its own policies and procedures for infection control.</p> <p>THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON MARCH 7, 2019 AND NOVEMBER 30, 2017.</p> <p>Findings:</p> <p>According to the facility's Infection Control-General Policy and Procedure, "...All staff will be trained on facility infection control as part of initial training, annually, and as necessary...". According to the facility's Infection Control-Disease Outbreak Policy and Procedure, "...All staff will be trained in identifying and reporting changes in a resident's health status...". The facility failed to train all staff in isolation procedures when a disease outbreak occurred at the facility and failed to adequately monitor residents of the facility during a disease outbreak. Refer to deficiencies 405 and 504 for additional information.</p>	A 302		

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A 401 A 401	<p>Continued From page 4</p> <p>420-5-4-.04 (1) (2) Personnel.</p> <p>Personnel.</p> <p>(1) An assisted living facility shall ensure personnel are employed and on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week.</p> <p>(a) An assisted living facility shall be staffed at all times by at least one individual who has a current certification in cardiopulmonary resuscitation (CPR).</p> <p>(b) An assisted living facility must be staffed to ensure the safe evacuation of all residents in the event of a fire or emergency.</p> <p>(2) Employee Schedule. An assisted living facility shall post a schedule of employees indicating names and days and hours scheduled to work. This schedule shall be retained in the facility for 6 months after use.</p> <p>This Rule is not met as evidenced by: Surveyor: 34502 Based on interviews and record review, the facility failed to ensure personnel were on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week.</p> <p>THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.</p> <p>Findings:</p> <p>The Alabama Department of Public Health received a complaint on June 28, 2021, which</p>	A 401 A 401		

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A 401	<p>Continued From page 5</p> <p>alleged there were staffing concerns at the facility. The anonymous complainant reported during a visit with a family member on June 26, 2021, there were only two (2) resident assistants (RA) for the entire facility (ALF and SCALF). The complainant also expressed concern as to how the staff would evacuate all residents if there was a fire. A review of the August 2021 and September 2021 staffing schedule revealed one (1) Med Tech (MT) was scheduled to work 7 AM to 7 PM and one (1) MT worked 7 PM to 7 AM. Review of the "Resident Days" report revealed the census averaged 23 for the month of August 2021.</p> <p>On August 31, 2021 at 9:00 AM, the surveyor interviewed Employee Identifier (EI)#10, MT, regarding her (EI#10) duties on the 7 AM to 7 PM shift. EI#10 explained there was only one (1) staff person scheduled to work each 12 hour shift and they assisted with medications and provided resident care. EI#10 said her (EI#10) responsibilities included, medication assistance (scheduled and PRN), checking residents at least every two (2) hours, laundry, housekeeping, and showers. EI#10 stated; "I get the meds done on time and the rest I do the best I can." The surveyor reviewed the medication times that were scheduled on EI#10's 12 hour shift. EI#10 assisted residents with medications scheduled for the following times; Morning, Midday, Afternoon, Evening, and Bedtime. EI#10 went onto say the residents are behind on their showers and the cleaning was not done like it should be. EI#10 said EI#4, Activity Director, would help answer call lights on first shift if she (EI#10) couldn't get to it right away. EI#10 informed the surveyor the 7 PM to 7 AM RA (EI#13) had been out sick with COVID and one of the SCALF RAs had been filling in. EI#2 told the surveyor there was not a</p>	A 401		

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A 401	<p>Continued From page 6</p> <p>specific RA assigned to work second and third shifts on the ALF unit since EI#13 had been unable to work.</p> <p>The surveyor asked Resident Identifier (RI)#9 on September 1, 2021 at 8:00 AM, if she/he had any concerns with staffing. RI#9 said she/he would like to have her/his room vacuumed and bathroom cleaned more but, "the girl giving medicines can't do it all." RI#9 reported the call light was answered promptly and she/he was satisfied with the laundry. RI#5 reported he/she was scheduled for a shower on Monday (August 30, 2021) but he/she didn't get it.</p> <p>During interviews on August 31 and September 1, 2021, three (3) RA, EI#14, EI#15 and EI#19, reported they had worked with only two (2) staff members on duty during recent weeks. In addition, EI#19 reported she (EI#19) had worked on August 28, 2021 with one Licensed Practical Nurse (LPN), EI#6, to staff the entire building, including the ALF. EI#19 reported no staff were on duty in the ALF during this time. This was verified by review of Timecard Reports. From 8:28 AM until 1:15 PM on August 28, 2021, only EI#19 and EI#6 were left to staff both the ALF and the SCALF with a total of 47 residents in two separate facilities. EI#19 stated she (EI#19) and EI#6 remained on the SCALF and took turns going to the ALF to answer call lights. The only other staff member on duty in the building during these hours was EI#20, Food and Beverage Director, who was responsible for preparing meals for 47 residents, serving food and cleaning up after meals.</p> <p>EI#2, Wellness Director, reported a recent staffing deficit due to illnesses among staff and their family members.</p>	A 401		

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A 401	Continued From page 7 The facility was not staffed with at least with at least one individual who had current certification in CPR at all times. Refer to deficiency 405 for additional information of employee CPR certification.	A 401		
A 402	420-5-4-.04 (3) Personnel. (3) Employee Screening. (a) Prior to any resident contact, such as but not limited to assistance with activities of daily living, newly employed personnel shall have a physical examination certifying that the employee is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to residents through normal staff to resident contact. Employees who develop signs or symptoms of infectious skin lesions or diseases that would be capable of transmission to residents through normal staff to resident contact shall not be permitted to have resident contact until free from such signs and symptoms. (b) Not more than 30 days prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis. (c) Vaccines. Assisted living facilities shall immunize employees in accordance with current recommended Centers for Disease Control and Prevention (CDC) guidelines (www.cdc.gov/vaccines). Any particular vaccination requirement may be waived or delayed by the State Health Officer in the event of a vaccine shortage. (d) An assisted living facility shall not	A 402		

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A 402	<p>Continued From page 8</p> <p>hire an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry.</p> <p>This Rule is not met as evidenced by: Surveyor: 34502 Based on record reviews and interview, the facility failed to ensure employees were properly screened prior to working at the facility.</p> <p>Findings:</p> <p>On September 1, 2021 at approximately 12:00 noon, the surveyor selected eight (8) employee files for review. EI# 9, told the surveyors she (EI#9) was hired as the Business Office Manager in April 2021, and she (EI#9) had been updating the employee files. EI#9 provided the requested employee files and told the surveyor this was the "state file." However, the surveyor found the files to be incomplete. The surveyor discussed the missing documentation with EI#9. EI#9 said she (EI#9) would be able to provide some of the documentation. At the conclusion of the survey, EI#9 did give the surveyor some copies of the required documentation.</p> <p>Review of employee files revealed the following deficient practices.</p> <p>EI#2, Wellness Director, RN, date of hire was November 11, 2020. The "Employee New-Hire Physical" was signed the same day. However, the question on the form, "Employee is free of signs and symptoms of infections, skin lesions and diseases?" was not answered Yes or No by the physician. In addition, there was no documentation EI#2 was screened through the</p>	A 402		

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A 402	<p>Continued From page 9</p> <p>Alabama Department of Public Health Nurse Aide Abuse Registry prior to hire.</p> <p>El#3, Community Engagement Director, was hired at the facility on June 9, 2021. Documentation in the employee file showed a skin test was administered for tuberculosis (TB), but it was greater than 30 days prior to hire.</p> <p>El#12, Resident Assistant (RA), date of hire November 21, 2019, did not have a physical exam on file or evaluation of TB prior to hire date.</p> <p>El#13, RA, was hired April 29, 2019. There was not a physical exam on file or evaluation for TB had been done.</p> <p>El#9 agreed documentation in the employee files was incomplete.</p>	A 402		
A 405	<p>420-5-4-.04 (6) Personnel.</p> <p>(6) Training.</p> <p>(a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained in the facility. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that prior to resident contact, all staff members receive training on the subject matter listed below:</p> <p>1. State law and rules on assisted living facilities.</p>	A 405		

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A 405	<p>Continued From page 10</p> <ol style="list-style-type: none"> 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire. 5. Identifying and reporting abuse, neglect, and exploitation. 6. Basic first aid. 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environment safety. 10. Special needs of the elderly, mentally ill, and mentally retarded. 11. Safety and nutritional needs of the elderly. 12. Identifying signs and symptoms of dementia. <p>(b) Cardiopulmonary Resuscitation. An assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of an assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must</p>	A 405		

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A 405	<p>Continued From page 11</p> <p>obtain certification in CPR within 90 days of hire. An assisted living facility equipped with an automated external defibrillator (AED) shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or American Red Cross in CPR or AED utilization.</p> <p>(c) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training.</p> <p>(d) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above.</p> <p>This Rule is not met as evidenced by: Surveyor: 34502 Based on record reviews and interviews, the facility failed to provide initial required employee training prior to resident contact, special needs training and refresher training as needed for employees. The facility also failed to ensure staffing at all times included at least one individual currently certified in Cardiopulmonary Resuscitation (CPR) and failed to ensure all staff were certified in CPR within 90 days of hire.</p> <p>THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON MARCH 7, 2019 and NOVEMBER 30, 2017.</p>	A 405		

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A 405	<p>Continued From page 12</p> <p>Findings:</p> <p>Initial Training Required Prior to Resident Contact: Review of employee files on September 1, 2021, revealed the following missing documentation for EI#6, License Practical Nurse (date of hire September 10, 2020):</p> <p>State law and rules on assisted living facilities Facility policies and procedures Resident rights Identifying and reporting abuse, neglect, and exploitation Basic first aid Advance directives Protecting resident confidentiality Resident fire and environmental safety Special needs of the elderly, mentally ill, and mentally retarded Safety and nutritional needs of the elderly Identifying signs and symptoms of dementia</p> <p>EI#9 agreed there was no documentation of EI#6's training to include attendance records or post-test evaluations.</p> <p>Special Needs Training: The facility had residents with special needs. RI#1 was under hospice care and receiving oxygen as needed (PRN)and RI#5 was a diabetic. However the training had not been documented. Of the eight (8) employees files reviewed three (3) employees (EI#1, EI#12, and EI#13) did not have training documented for oxygen therapy. None (0) of the eight (8) employee files had documented training for hospice or diabetes.</p>	A 405		

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A 405	<p>Continued From page 13</p> <p>At the time of the onsite survey, two (2) residents in the memory care were currently on isolation after testing positive for COVID-19. On September 1, 2021, the surveyor asked both EI#2 and EI#9 if staff had been trained in proper isolation procedure. Both EI#2 and EI#9 replied current staff had not been trained. EI#2 added some staff may have been trained during 2020 when the an outbreak of COVID-19 occurred at the facility but no refresher training had been completed. Refer to deficiency 302 for additional information.</p> <p>Fire Drill Refresher Training: Review of fire drill documentation on August 31, 2021 revealed the following comment on the fire drill record, dated July 28, 2021, "need refresher training". When questioned about the training on August 31, 2021, EI#8 stated he (EI#8) conducted the monthly fire drills but the administrator was responsible for completing any training when the need was identified. The facility administrator had resigned the week prior to the survey. On September 1, 2021, EI#9, Business Office Manager, stated she (EI#9) maintained copies of training for employees and she (EI#9) was sure refresher training in fire safety had not been completed.</p> <p>Staffing at All Times With at Least One Individual Currently Certified in CPR: Review of the employee schedule for the month of August 2021, as well as, the Employee CPR List on September 1, 2021 revealed the 7:00 AM - 7:00 PM Med Techs (EI#10 and EI#11) did not have CPR certification. EI#13, RA, was current in CPR until September 1, 2021, but had been unable to work since August 27, 2021. The RAs used for back up in the ALF unit EI#16 and EI#21 did not have CPR certification. The ALF unit was</p>	A 405		

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A 405	<p>Continued From page 14</p> <p>not staff with anyone certified in CPR on August 31, 2021, 7:00 PM - 7:00 AM. EI#9 confirmed this was the most current information she (EI#9) had on employee's CPR certification. EI#9, informed the surveyor a CPR renewal class would be scheduled as soon as possible. To ensure the facility was covered until a CPR class could be scheduled, EI#2 said she would arrange for the oncoming uncertified staff to complete the online course (2020 ECC and AHA guidelines) prior to their shift on September 1, 2021.</p> <p>CPR Certification Within 90 Days of Hire: Review of the Employee CPR List on September 1, 2021 revealed the following employees had worked at the facility greater than 90 days and currently were not certified in CPR: EI#4, EI#6, EI#7, EI#9, EI#10, EI#11, EI#14, EI#16, EI#17, EI#18, EI#19 and EI#20. EI#9 confirmed this was the most current information she (EI#9) had on employee's CPR certification.</p>	A 405		
A 504	<p>420-5-4-.05 (3) (d) Records and Reports.</p> <p>(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.</p> <p>1. No resident shall be deprived of any civil or legal rights, benefits, or privileges</p>	A 504		

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A 504	<p>Continued From page 15</p> <p>guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>7. Every resident shall have the right to</p>	A 504		

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A 504	<p>Continued From page 16</p> <p>share a room with his spouse if both are residents of the facility and agree to do so.</p> <p>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.</p> <p>9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident.</p> <p>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.</p> <p>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.</p> <p>12. Every resident shall have the right to</p>	A 504		

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A 504	<p>Continued From page 17</p> <p>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.</p> <p>13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file.</p> <p>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:</p> <p>(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.</p> <p>(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</p> <p>(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.</p>	A 504		

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A 504	<p>Continued From page 18</p> <p>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.</p> <p>16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	A 504		

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A 504	<p>Continued From page 19</p> <p>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.</p> <p>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.</p> <p>22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings.</p> <p>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.</p> <p>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.</p> <p>This Rule is not met as evidenced by: Surveyor: 34502 Based on observations, record reviews, and interviews, the facility failed to adhere to standards and recommendations as established by the Centers for Disease Control (CDC) to help prevent the transmission of COVID-19 by; (1) providing appropriate education and screening of staff, and (2) performing infection surveillance by monitoring residents for fever, respiratory illness, or other signs/symptoms of COVID.</p>	A 504		

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A 504	<p>Continued From page 20</p> <p>THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.</p> <p>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MARCH 7, 2019.</p> <p>Findings:</p> <p>The ADPH received complaints which alleged proper precautions were not taken to prevent the spread of COVID-19 within the facility. The facility reported a disease outbreak in December 2020. There were 12 residents and six (6) employees in the memory care (SCALF) with confirmed cases of COVID-19. In the ALF unit there was two (2) residents and five (5) employees. A second outbreak was reported in the memory care the end of August 2021 with two (2) residents and three (3) employees with COVID-19. The surveyors substantiated the facility was not in compliance with following infection prevention and control practices to prevent the development and transmission of COVID-19.</p> <p>Upon arrival to the facility the morning of August 31, 2021, the surveyors entered the facility and were in the processing of performing self screenings for COVID-19, as two (2) employees came into the facility. EI#10, Med Tech (MT) and EI#17, RA, did not screen themselves although there was signage posted at the front entrance that read "Employee Screening Required Prior to entry into community." The surveyor reviewed the binder with the screening questionnaires and noted the last employee to complete a COVID screening was EI#2, RN, on August 26, 2021. The afternoon of August 31, 2021, the surveyors requested copies of COVID-19 screening forms and temperatures taken for all the employees</p>	A 504		

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A 504	<p>Continued From page 21</p> <p>working on day shift (August 31, 2021). Shortly thereafter, EI#3, Community Director, and EI#9, Business Office Manager, informed the surveyor only two (2) employees (EI#2 and EI#4) had screened prior to the start of their shift. EI#3 also informed the surveyor the screening questionnaires had just been placed in the front entrance on August 26, 2021, by the former administrator on her way out the door. During interviews with staff the surveyors learned they had not been screening for COVID-19 for several months. EI#10 told the surveyor, "We quit screening a long time ago." EI#14, EI#15, EI#17 and EI#19, also stated staff had not been screening for COVID-19 for several months. EI#10, EI#14, EI#15, EI#17, EI#18 and EI#19 all stated staff just started wearing a mask again after the last COVID-19 outbreak on August 26, 2021.</p> <p>Staff Education: The facility did not have evidence they provided education to staff regarding COVID-19 symptoms and how it is transmitted. The facility also did not have documentation of education to staff regarding isolation procedures.</p> <p>Staff Screening: The facility was not screening staff at the beginning of their shifts for fever or sign/symptoms of illness. The facility was not actively taking the staff's temperatures and documenting the absence of illness prior to their shifts during a current outbreak.</p> <p>On September 1, 2021 at 7:40 AM, the surveyor asked EI#10 if she (EI#10) monitored the residents daily for COVID-19. EI#10 replied, "We used to take their temperatures", but not anymore. EI#10 said she (EI#10) could not recall</p>	A 504		

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A 504	<p>Continued From page 22</p> <p>when the staff stopped checking the residents temperatures. RI#9 told the surveyor the resident's temperatures are only checked if they go out of the facility. During an interview with EI#2, Wellness Director, on September 1, 2021, the surveyor inquired how the facility was identifying and screening residents for COVID-19. EI#2 explained we have discussed checking resident's temperature but we are not doing it.</p> <p>Resident Screening: The facility was not actively conducting infection surveillance by tracking and monitoring residents during a COVID outbreak. The facility was not monitoring the resident's vital signs daily or assessing for signs of respiratory illness, or other signs/symptoms of COVID-19.</p>	A 504		
A 604	<p>420-5-4-.06 (3) (a) (b) Care of Residents.</p> <p>(3) Health Supervision.</p> <p>(a) Initial Assessment. No more than 30 days prior to admission, the facility shall assess prospective residents for facility eligibility. This assessment shall document identified care needs and serve as a baseline for future assessments.</p> <p>(b) Monthly Assessments. The facility shall assess each resident monthly and more often when necessary to identify changes in resident's status. In addition to other items that may be required by the facility's own policies and procedures, the monthly assessment shall:</p> <p>1. Assess the resident's ability to safely self-manage medications or safely self-administer medications with assistance.</p>	A 604		

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A 604	<p>Continued From page 23</p> <p>2. Accurately weigh and record the weight of each resident. A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half or greater weight loss in a period of three months or less, or a ten percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician.</p> <p>3. Document identified changes in resident status.</p> <p>4. Assess the appropriateness of each resident's plan of care. Any decline in resident status requires immediate implementation and documentation of interventions or reassessment of existing interventions.</p> <p>This Rule is not met as evidenced by: Surveyor: 34502 Based on record reviews and interviews, the facility failed to complete monthly assessments for all residents.</p> <p>Findings:</p> <p>During record reviews on September 1, 2021, the surveyor found the monthly assessments had not been completed for the following residents:</p> <p>- RI#1 did not have documentation for August</p>	A 604		

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A 604	<p>Continued From page 24</p> <p>2020 and December 2020.</p> <p>- RI#2 did not have documentation from January 2020 to August 2020 and December 2020.</p> <p>- RI#3 did not have documentation for August 2020 and December 2020.</p> <p>- RI#5 did not have documentation for December 2020.</p> <p>- RI#7 did not have documentation for December 2020.</p> <p>The surveyor discussed the missing documentation with EI#2, Wellness Director. EI#2 told the surveyor she (EI#2)thought the charts may have been thinned and the documentation removed. However the missing monthly assessments were not provided during the survey.</p>	A 604		
A 617	<p>420-5-4-.06 (8) Care of Residents.</p> <p>(8) Disposal of Medications.</p> <p>1. 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. Under no circumstances should expired, discontinued, or unused medications be stored or housed in the facility beyond 30 days.</p> <p>2. Medications of residents who are</p>	A 617		

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A 617	<p>Continued From page 25</p> <p>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 file for at least three years.</p> <p>3. When medications are destroyed on the premises of the assisted living facility, a record shall be made and retained for at least 3 years. This record shall include: the name of the 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.</p> <p>This Rule is not met as evidenced by: Surveyor: 34502 Based on record review and interview, the facility failed to properly document medication disposition upon discharge of residents from the facility.</p> <p>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON NOVEMBER 30, 2017.</p> <p>Findings:</p> <p>RI#6 was admitted to the facility on February 2, 2021, and had diagnoses which included diabetes mellitus II, Parkinson's disease and</p>	A 617		

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A 617	Continued From page 26 hyperlipidemia. RI#6 was sent to the hospital on July 15, 2021, due to a wound infection and later discharged to a skilled nursing facility. A Medication Destruction Form was documented for RI#6 on August 19, 2021. The destruction form did not include the dosage of the medication, the method of destruction and the reason for disposal of the medications. EI#2 agreed the form was incomplete.	A 617		
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	A 621		

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A 621	<p>Continued From page 27</p> <p>(ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity BUT the individual has sufficient cognitive ability to direct his or her own care AND the individual is able to direct others and does direct others to provide the physical assistance needed to complete such tasks, AND the facility staff is capable of providing such assistance and does provide such assistance. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff.</p> <p>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.</p> <p>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.</p>	A 621		

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A 621	<p>Continued From page 28</p> <p>6. All skilled services provided in the facility, such as but not limited to wound care or insertion of a urinary catheter, shall be provided by the staff of properly licensed or certified agencies. Skilled services shall not be delegated to facility staff.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This Rule is not met as evidenced by: Surveyor: 34502 Based on record reviews and interviews, the facility retained a resident who required skilled nursing care which exceeded 90 days.</p> <p>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON NOVEMBER 30, 2017.</p> <p>Findings:</p> <p>RI#6 was admitted to the facility on February 2,</p>	A 621		

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A 621	<p>Continued From page 29</p> <p>2021. Refer to deficiency 617 for additional information on RI#6. The Pre-Admission Questionnaire for RI#6 was completed on January 22, 2021, and did not document any wounds. The Initial Medical Exam was completed for RI#6 on February 1, 2021, and also did not document any wounds. However, two days after RI#6's admission to the facility, a facility Registered Nurse (RN) notified the physician of a "large diabetic ulcer" to RI#6's left heel and home health services were ordered for skilled wound care. RI#6 began receiving home health services on February 8, 2021, with a diagnosis of chronic ulcer to the left heel. The home health nurses notes on February 8, 2021, also documented a diabetic ulcer to the left fifth toe. This ulcer was documented as healed on March 24, 2021. Diabetic ulcers were documented by home health to the left great toe and to the left second toe on March 5, 2021. These ulcers were also documented as healed on March 24, 2021.</p> <p>On April 5, 2021 and again on June 16, 2021, RI#6 developed infections to the heel wound and was treated with antibiotics. On July 15, 2021, RI#6 was sent to the hospital due to chest pain and a temperature of 102.1 degrees. EI#2 informed the surveyor RI#6 was again diagnosed with a wound infection of the left heel at the hospital and was later admitted to a skilled nursing facility.</p> <p>Review of the Home Health Certification and Plan of Care for RI#6 revealed RI#6 received home health nursing services for skilled wound care from February 8, 2021 until RI#6's admission to the hospital on July 15, 2021. Although RI#6 required skilled care which could not be provided by the facility for more than five months, RI#6 was retained at the facility. EI#2 reported no 30</p>	A 621		

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A 621	Continued From page 30 day discharge notice had been issued to RI#6's sponsor and RI#6's sponsor made the decision to move RI#6 to a skilled nursing facility. EI#2 agreed RI#6 should have been discharged to a higher level of care.	A 621		
A 703	420-5-4-.07 (3) Food Service. (3) Dietary Service. (a) Number of Meals. No fewer than three meals shall be provided each 24 hours. Food service shall be provided in a resident's room during temporary illness if necessary. The diet shall be well-balanced, palatable, properly prepared, and sufficient in quantity and quality to meet the nutritional needs of the residents in accordance with Dietary Reference Intakes of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The food must be adapted in type and preparation to the habits, preferences, and physical abilities of the residents. (b) Timing of Meals. A time schedule for serving meals to residents and personnel shall be 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	A 703		

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A 703	<p>Continued From page 31</p> <p>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.</p> <p>(d) Alternate food selections or substitutes shall be made available to all residents.</p> <p>(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.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Surveyor: 34502 Based on observation and interview, the facility failed to post the time meals were to be served to the residents.</p> <p>Findings:</p> <p>During the initial tour on the morning of August 31, 2021, the surveyor observed the meal times were not posted. The surveyor brought this to the attention of EI#4, Activities Director and she (EI#4) acknowledged it was not posted in the</p>	A 703		

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A 703	Continued From page 32 designated location. EI#4 immediately printed a schedule of the times breakfast, lunch, and dinner were to be served and posted alongside the menu.	A 703		
A1101	420-5-4-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift of Group and Congregate facilities. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the currently adopted Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be	A1101		

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A1101	<p>Continued From page 33</p> <p>conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs.</p> <p>(d) Roller latches are prohibited on doors separating corridors from adjacent spaces.</p> <p>(e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that:</p> <ol style="list-style-type: none"> 1. Minimizes leaks and spills. 2. Adequately protects against inappropriate access. 3. Complies with the requirements of the currently adopted Life Safety Code. <p>(f) Fire Alarm and Sprinkler System.</p> <ol style="list-style-type: none"> 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 	A1101		

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A1101	<p>Continued From page 34</p> <p>documentation shall be reported to the Department within 12 hours or no later than the next duty day, and shall be corrected expeditiously.</p> <p>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.</p> <p>This Rule is not met as evidenced by: Surveyor: 34502 Based on record reviews and interviews, the facility failed to properly document monthly fire drills.</p> <p>THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON MARCH 7, 2019 AND NOVEMBER 30, 2017.</p> <p>Findings:</p> <p>Review of the facility's monthly fire drill reports on August 31, 2021 revealed one fire drill was performed and documented jointly each month for the ALF and the SCALF which were housed in the same building. There was no consistent written documentation of the observations for each individual facility (ALF and SCALF) to include the effectiveness of the fire drill plan. When interviewed on the afternoon of August 31, 2021, EI#8 stated he (EI#8) only performed one fire drill each month which included both the ALF and the SCALF but would start evaluating and</p>	A1101		

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A1101	Continued From page 35 documenting the fire drills separately for each facility. EI#8 added the building which housed the ALF and SCALF was unique because the ALF and SCALF shared a smoke compartment. CONNIE CHERRY, REGISTERED NURSE DEBRA FREEMAN, REGISTERED NURSE	A1101		