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A 000	Initial Comments On September 1, 2021, an unannounced licensure survey and complaint investigation was conducted for this 27 bed Specialty Care Assisted Living Facility (SCALF) with a census of 25. There were two (2) complaints investigated during this survey. Intake ID 20210628010 was substantiated and deficiencies were cited as a result of the complaint investigation. Intake ID 20191203012 was unsubstantiated and 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 302	420-5-20-.03 (e) Administration. (e) Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). All residents shall be informed of new policies or changes in existing policies that may have bearing on the resident. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies	A 302		

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A 302	Continued From page 1 shall cover the following: (i) Facility responsibility to protect all residents from abuse, neglect, and exploitation. (ii) How allegations of abuse, neglect, and exploitation will be handled by the facility. (iii) Resident confidentiality. (iv) Admission and continued stay criteria. (v) Discharge criteria and notification procedures for residents and sponsors. (vi) Facility responsibility when a resident's personal belongings are lost. (vii) What services the facility is capable and not capable of providing. (viii) Medication management. (ix) Infection control. (x) Meal service, timing, menus and food preparation, storage, and handling. (xi) Fire safety and emergency plan, fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness. (xii) Staffing and conduct of staff while on duty. (xiii) Oxygen administration and storage if used in the facility.	A 302		

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

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A 302	Continued From page 3 ice, and eggs. (IX) Storage of food. (X) Procedure for food service in the event of a disaster. Disaster menus shall be developed. The policy shall address how food will be obtained and maintained at safe temperatures if electricity is not available. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to follow its own policies and procedures for infection control. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MARCH 7, 2019. Findings: 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 406 and 504 for additional information.	A 302		
A 401	420-5-20-.04 (1) (2) Personnel.	A 401		

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A 401	Continued From page 4 (1) A specialty care assisted living facility shall ensure adequate personnel are employed and on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. No specialty care assisted living facility shall have fewer staff on duty than specified in Table A below. Even if this minimum staffing ratio is met, the governing authority of a specialty care assisted living facility shall have additional staff on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. Facilities with resident bedroom wings separated from the remainder of the facility by a lockable door shall maintain dedicated staff to these areas adequate to meet all care and safety needs of the residents in these areas at all times.	A 401		

Table A

Staff Number	7 AM - 3 PM	3 PM - 11 PM	11 PM - 7 AM
2	1 -16 Residents	1 - 16 Residents	1 - 16 Residents
3	17 - 24 Residents	17 - 36 Residents	17 - 48 Residents
4	25 - 32 Resident	37 - 48 Residents	49 - 64 Residents
5	33 - 40 Residents	49 - 60 Residents	65 - 80 Residents
6	41 - 48 Residents	61 - 72 Residents	81 - 96 Residents
7	49 - 56 Residents	73 - 84 Residents	97 - 112 Residents
8	57 - 64 Residents	85 - 96 Residents	113 - 128 Residents
9	65 - 72 Residents	97 - 108 Residents	129 - 144 Residents
10	73 - 80 Residents	109 - 120	

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A 401	Continued From page 5 Residents 145 - 160 Residents 11 81 - 88 Residents 120 - 132 Residents 161 - 176 Residents 1 Additional For each 8 residents, For each 12 residents, For each 16 residents, Staff or any fraction thereof, or any fraction thereof, or any fraction thereof, by which the census by which the census by which the census exceeds 88 exceeds 132 exceeds 176 (a) A specialty care assisted living facility shall be staffed at all times by at least one individual who has a current certification in cardiopulmonary resuscitation (CPR). (b) A specialty care assisted living facility must be sufficiently staffed to ensure the safe evacuation of all residents in the event of a fire or emergency. (2) Employee Schedule. A specialty care 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. In the event of an unplanned staff shortage which would make it otherwise impossible to meet the staffing requirements imposed by these rules, a facility may employ a certified nurse aide who has not received the training specified in these rules. For the purposes of this subsection, a certified nurse aide is defined as an individual who has been deemed or determined to be competent by the Alabama Nurse Aide Registry maintained by the Alabama Department of Public	A 401		

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A 401	Continued From page 6	A 401		

Health. This individual may not work unless accompanied at all times by an individual who is appropriately trained in accordance with these rules. Such employment shall last only until the facility has employed staff trained in accordance with the above. In no event may the period during which such staff is employed in a facility exceed 120 consecutive hours.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility was not staffed to meet even the minimal requirements for a SCALF.

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

Findings:

The Alabama Department of Public Health received a complaint which alleged there were staffing concerns at the facility. The anonymous complainant reported, during a visit to a family member, there were only two (2) Resident Assistants (RAs) on duty 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. Surveyors were able to substantiate these complaints during the onsite survey.

At the time surveyors entered the facility, the resident census was 25. One resident was currently in the hospital. Review of the Resident Days report revealed the census had been 24 or 25 for the month of August 2021. Based on the

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A 401	Continued From page 7	A 401		

census, the facility was required to have at least three staff members on duty at all times. When the census was 25, four staff members were required on duty for the 7:00 AM until 3:00 PM shift.

During interviews on August 31 and September 1, 2021, three Resident Assistants (RAs), Employee Identifier (EI)#14, EI#15 and EI#19, reported they had worked with only two 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 Assisted Living Facility (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.

During interviews, RAs reported they (RAs) not only provided care to residents but were responsible for housekeeping and laundry services. There were three resident dining rooms in separate areas on the SCALF and EI#2 reported one staff member was needed to monitor each dining room during meals. One resident had a history of multiple choking episodes and another resident actually choked during the onsite survey. Two residents sustained falls during the onsite survey and had to be sent

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A 401	Continued From page 8 to the hospital for evaluation and treatment. At least eight residents required staff to provide toileting assistance and required assistance with transfers. Two residents were currently on isolation and required extra time for use of required isolation supplies. One of the two residents on isolation required total care and was unable to transfer or reposition self or propel wheelchair. The other resident on isolation was sent to the hospital during the onsite survey due to a sudden decline in condition. One resident wandered frequently and followed staff about the facility. At least eight elopements had occurred at the facility since the last onsite survey. The facility was not staffed with at least one individual who had current certification in cardiopulmonary resuscitation (CPR) at all times. Refer to deficiency 406 for additional information on employee CPR certification. The facility was not staffed to meet even the minimal requirements for a SCALF and was not staffed to meet the care and safety needs of all residents of the SCALF at all times. EI#2 reported a recent staffing deficit due to illnesses among staff and their family members. Surveyors were provided with an updated employee schedule which satisfied the minimum requirements for a SCALF prior to the end of the onsite survey.	A 401		
A 402	420-5-20-.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	A 402		

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A 402	Continued From page 9 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. Specialty care 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) A specialty care assisted living facility shall not hire an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure employees were properly screened prior to hire and prior to working at the facility. Findings: On September 1, 2021 at approximately 12:00 noon, the surveyor selected eight (8) employee	A 402		

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A 402	Continued From page 10	A 402		

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 provide the surveyor with some copies of the required documentation.

Review of employee files revealed the following deficient practices.

EI#2, Wellness Director, Registered Nurse (RN), date of hire was November 11, 2020, and 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 Alabama Department of Public Health Nurse Aide Abuse Registry prior to hire.

EI#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.

EI#12, RA, date of hire November 21, 2019, did not have a physical exam on file or evaluation of TB prior to hire date.

EI#13, RA, was hired April 29, 2019. There was not a physical exam or evaluation of TB on file.

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A 402	Continued From page 11 EI#9 agreed documentation on employee files was incomplete.	A 402		
A 406	420-5-20-.04 (9) Personnel. (9) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. An RN shall identify staff training needs and shall provide or arrange for needed training. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that, prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on specialty care assisted living facilities. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire. 5. Identifying and reporting abuse, neglect, and exploitation. 6. Basic first aid. 7. Advance directives.	A 406		

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A 406	Continued From page 12 8. Protecting resident confidentiality. 9. Resident fire and environmental safety. (b) Prior to providing any resident care, all staff shall complete The Dementia Education and Training Act (DETA) Care Series Training developed by the Alabama Department of Mental Health or equivalent training approved by the State Health Officer. All licensed staff shall complete DETA Brain Series Training, The Pharmacological Management of Dementia, and the Dementia Assessment Series provided by the DETA Program or equivalent training approved by the State Health Officer prior to resident contact. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained. (c) All staff who have resident contact shall be able to demonstrate diversional methods and redirection. All staff shall be able to demonstrate an understanding of the implications of caring for residents with agnosia, amnesia, aphasia, and apraxia. All staff shall be able to demonstrate an understanding of the facility's fire and evacuation plan and all other policies regarding safety, including policies for preventing elopements, responding to elopements, and fall prevention. (d) Cardiopulmonary Resuscitation. A specialty care 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 a specialty care assisted living facility who have contact with residents	A 406		

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A 406	Continued From page 13 must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within 90 days of hire. A specialty care 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 the American Red Cross in CPR or AED utilization. (e) 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. (f) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above. This Rule is not met as evidenced by: 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 CPR and failed to ensure all staff were certified in CPR within 90 days of hire.	A 406		

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A 406	Continued From page 14 Findings: Initial Required Training Prior to Resident Contact Review of employee files on September 1, 2021, revealed the following missing documentation for EI#6, LPN, (date of hire September 10, 2020): State law and rules on speciality care 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; Dementia Education and Training Act (DETA) Care Series; DETA Brain Series; Pharmacological Management of Dementia; Dementia Assessment Series. EI#9 agreed there was no documentation of EI#6's training to include attendance records or post-test evaluations. 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. Special Needs Training The facility had residents with special needs.	A 406		

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A 406	Continued From page 15 Three residents were currently receiving hospice care, three residents received oxygen and at least two residents had a diagnosis of diabetes mellitus. However, training had not been documented for these special needs. Of the eight (8) employees files reviewed three (3) employees (EI#2, 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. At the time of the onsite survey, two residents of the facility 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 an outbreak of COVID-19 occurred at the facility but no refresher training had been completed for this special need. 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 following dates when no staff currently certified in CPR were scheduled to work: 7:00 AM-3:00 PM shift - August 21, 28 and 29; 3:00 PM-11:00 PM shift - August 1, 6, 7, 8, 13, 14, 15, 20, 21, 22 and 28; 11:00 PM-7:00 AM shift - August 5, 18, 19, 23, 24, 27, 28 and 29. EI#9 confirmed this was the most current information she (EI#9) had on employees' CPR certification. CPR Certification Within 90 Days of Hire Review of the Employee CPR List on September	A 406		

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A 406	Continued From page 16 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#16, EI#17, EI#18, EI#19 and EI#20. EI#9 confirmed this was the most current information she (EI#9) had on employees' CPR certification.	A 406		
A 504	420-5-20-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission, of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate. 1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility. 2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints. 3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy.	A 504		

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A 504	Continued From page 17 4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time. 5. Every resident shall have freedom to participate in and benefit from social, religious, and community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. 6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the premises, an individual account record for each resident shall be maintained by the administrator and an up-to-date record shall be maintained for all transactions. 7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so. 8. Every resident shall have the right to a reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals. 9. Every resident shall have the right to 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.	A 504		

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A 504	Continued From page 18 10. Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to receive or reject medical care, dental care, or other health care services except those required to control communicable diseases. 11. Every resident shall have the right to at least 30 days prior written notice of involuntary relocation or termination of residence from the facility unless the resident is a patient in a facility providing a higher level of care and no longer meets the eligibility and continued stay requirements in these rules, or for medical reasons the resident is considered by a physician to require an emergency relocation to a facility providing a more skilled level of care, or unless the resident engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record. 12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person without restraint, interference, coercion, discrimination, or reprisal. 13. Every resident shall have the right to confidential treatment of personal and medical 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.	A 504		

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A 504	Continued From page 19 14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the facility, provided that: (i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care. (ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation. (iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time without recourse. 15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges. 16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities. 17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider	A 504		

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Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll-free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll-free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area.

18. All state inspection reports and any resulting corrective action plan from the past 24 months shall be posted in a prominent location. If there has been no inspection in the past 24 months, then the results of the most recent inspection and any resulting corrective action plan shall be posted.

19. Every resident shall have the right to 30 days prior written notice to both resident and sponsor of any increase of fees or charges.

20. Every resident shall have the right to 30 days prior written notice of any involuntary change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents.

21. Every resident shall have the right to wear his or her own clothes, and to keep and use his or her own personal possessions, including toilet articles, except for personal possessions too large to be stored in the resident's room.

22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings.

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A 504	Continued From page 21 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file. This Rule is not met as evidenced by: Based on 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; (2) performing infection surveillance by monitoring residents for fever, respiratory illness, or other signs/symptoms of COVID-19; (3) posting appropriate signage on the use of PPE and isolation precautions for staff in an appropriate location. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: 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 COVID-19 disease outbreak in December 2020. The facility had 12 residents and six (6) employees in the SCALF with confirmed	A 504		

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cases of COVID-19. A second outbreak was reported in the SCALF the end of August 2021, with two (2) residents and three (3) employees testing positive for 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.

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 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 staff 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

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stated staff just started wearing a mask again after the last COVID-19 outbreak on August 26, 2021.

Staff Education:
The facility did not have evidence education was provided 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.

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.

Resident Screening:
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 when the staff stopped checking the residents' temperatures. 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.

The facility was not actively conducting infection surveillance by tracking and monitoring residents during a COVID outbreak. The facility was not monitoring the residents' vital signs daily or assessing for signs of respiratory illness, or other signs/symptoms of COVID-19. Staff had not been properly trained to recognize signs and symptoms

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A 504	Continued From page 24 of respiratory illness and to properly perform isolation procedures. Proper signage was not present to alert staff and visitors of the need for special precautions.	A 504		
A 508	420-5-20-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in a specialty care assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review. 1. Incidents which require investigation are: (i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as extensive bruising, pain, or injury that is not consistent with actions necessary in providing day-to-day care to a resident or for which medical treatment was sought. (ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid including but not limited to a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office. (iii) The onset of wandering behavior by any resident who is not fully cognitively intact.	A 508		

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A 508	Continued From page 25 (iv) Elopement by a resident. (v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. (vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules. (vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules. (viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or Staphylococcus aureus). (ix) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (xi) An unplanned occurrence that results in media attention.	A 508		

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A 508	Continued From page 26 (xii) A medication error, overdose, or over sedation. (xiii) Ingestion by a resident of a toxic substance that requires medical attention. (xiv) Any indication of malfunction of the sprinkler system, or fire alarm system. 2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following: (i) Names of all residents involved. (ii) Names of all staff involved including person in charge at the time of the incident. (iii) When the administrator was notified (date and time). (iv) Circumstances under which the incident occurred. (v) When the incident occurred (date and time). (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken. (viii) The extent and description of injury, if any, to the affected resident or residents. (ix) Immediate treatment rendered. (x) Symptoms, pain, or injury discussed	A 508		

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with the physician, and the date and time the physician was notified.

(xi) Names, telephone numbers, and addresses of witnesses.

(xii) Date and time relatives or sponsor were notified.

(xiii) Out-of-facility treatment.

(xiv) Follow-up care.

(xv) Outcome resolution.

(xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future.

(xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation.

(xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request.

(xix) The entire investigative file and documentation of all corrective action taken shall be retained for a period of not less than 3 years after the resident is discharged or dies.

(xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff.

3. In addition, the following incidents

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A 508	Continued From page 28 shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident: (i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention. (ii) Elopement by a resident. (iii) Suspected, alleged, confessed, witnessed, or actual abuse, neglect, or exploitation of a resident or residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file. (iv) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (vi) An unplanned occurrence that results in media attention. (vii) Any medication error, overdose, or over sedation. The incident shall be immediately	A 508		

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A 508	Continued From page 29 reported to the attending physician, facility medical director, or back-up physician. (viii) Ingestion by a resident of a toxic substance that requires medical attention. (ix) Notifiable diseases and health conditions listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04. shall also be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1-.04. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than three years. (x) Any indication of a malfunction of the sprinkler system, fire alarm system, or a door locking device. 4. The report to the Department's Online Incident Reporting System shall include the following: (i) Facility name and direct phone number. (ii) Time and date of the report. (iii) Reporter's name. (iv) Name of resident(s), staff, or visitor(s) involved in the incident. (v) Names of staff on duty at the time of the incident. (vi) Date and time of the incident.	A 508		

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A 508	Continued From page 30 (vii) A brief description of the incident. (viii) Any injury or injuries to resident(s). (ix) Action taken by the facility in response to the incident. (i) Vital Statistics Reports. A record shall be kept of all births, deaths, and stillbirths that occur within the specialty care assisted living facility. By the fifth day of each month, the administrator shall make a report of such births, deaths, and stillbirths for the preceding month on such forms as the State Board of Health shall provide to the county health officer, or in counties without a county health officer, to the State Registrar. This report shall be in addition to the official birth, death, and stillbirth certificates. If there are no births, deaths, or stillbirths in any month, a report shall be made stating that fact to the county health officer. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report an incident to the Department's Online Incident Reporting System and failed to investigate the incident as required. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MARCH 7, 2019. Findings: Resident Identifier (RI)#8 was admitted to the	A 508		

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A 508	Continued From page 31 facility on March 4, 2021 and had diagnoses which included moderate protein calorie malnutrition, cerebrovascular disease, Alzheimer's disease, vascular dementia, chronic kidney disease stage 3, chronic obstructive pulmonary disease and cardiomegaly. RI#8 was discharged from the facility to a skilled nursing facility on July 7, 2021. Review of RI#8's facility file on September 1, 2021 revealed the following care plan entry "... Elopement: Resident exited C-hall door and was brought back in facility by staff...". The entry was not dated but the care plan entry by "Updated" was "3/26/21". EI#2 stated RI#8 did elope and she (EI#2) thought the incident had been reported to the state but was unable to locate the incident report and investigation of this incident. EI#2 stated she (EI#2) thought the incident occurred in February 2021. Interventions were implemented on RI#8's facility care plan to address this elopement. The surveyor was unable to locate an incident report of this incident in the Department's Online Incident Reporting System.	A 508		
A 601	420-5-20-.06 (1) Care of Residents. (1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician. (a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her choice. If the resident is unable to designate an attending physician, or does not wish to designate an attending physician, the facility shall assist the resident in identifying an attending physician who will serve the resident. A resident	A 601		

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A 601	Continued From page 32	A 601		

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

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

(c) All physician orders shall be written in accordance with community standards. If verbal orders are used, they are to be used infrequently. A physician verbal order shall only be accepted by an RN or LPN employed by the facility and authorized to do so by facility policy and procedures and state law. All verbal orders shall be reduced to writing on the physicians' order sheet by a licensed facility nurse and shall be dated and signed by the nurse receiving the order. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, or another practitioner who is responsible for the care of the resident and authorized to write orders by facility policy. All verbal orders must be authenticated within such time period as provided by facility policy, but in no case shall exceed 30 days following entry of the order.

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This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to follow physician's orders timely for one resident's treatment.

Findings:

RI#5 was admitted to the facility on October 23, 2015 and had diagnoses which included dementia with behavioral disturbances, anemia and constipation. RI#5 had a documented history of choking episodes on September 9, 2020, on October 22, 2020 and on May 18, 2021. RI#5 was currently receiving a regular diet with no meat which, according to EI#2, was due to RI#5's history of choking and difficulty chewing and swallowing meats. A chest x-ray was performed for RI#5 on May 19, 2021 following a choking episode. The "Conclusion" read "Small opacities are present in the left lung base. This may be due to atelectasis, or, in the proper clinical context, pneumonia...". An entry on RI#5's facility care plan, dated September 9, 2020, read "Starting to choke at meals...Barriam swallow". EI#4 reported she (EI#4) took RI#5 to have this test done and it was normal but no test results were found on RI#5's facility record. RI#5 sustained a gradual weight loss of nine pounds in 3 months in May 2021 and a dietary consult was completed and Med Pass supplement started.

On August 23, 2021, a Physician's Notification Form was completed by EI#5 which read, "Resident is having a difficult time chewing/swallowing and coughing when eating. Attempting to chew but spits out food onto plate. Suggestions?". The physician's response on

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A 601	Continued From page 34 August 23, 2021 was "Try speech tx eval [if (RI#8) cooperates]. There was no follow-up documentation regarding this physician's order but EI#2 stated the speech therapy consult had not been completed on September 1, 2021, nine days after the order was obtained. EI#2 added home health could not complete the speech therapy consult until RI#5 had a face-to-face visit with the physician and the physician was not available until September 8, 2021, sixteen days after the order was obtained. EI#5 continued to have coughing spells while eating during the survey and remained at significant risk of choking and aspiration. Physician's orders had not been followed to properly assess RI#5 to determine the cause of the choking spells and implement the best treatment to keep RI#5 safe.	A 601		
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	A 602		

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A 602	Continued From page 35 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. 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.	A 602		

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A 602	Continued From page 36 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 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 record review and interview, the Initial Physical Examination for one resident did not contain required information.	A 602		

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A 602	Continued From page 37 Findings: RI#8 was admitted to the facility on March 4, 2021. Refer to deficiency 508 for additional information on RI#8. RI#8's Initial Medical Exam/Plan of Care, dated February 11, 2021, did not contain a statement by the physician that the resident was free of signs and symptoms of infectious skin lesions and diseases that were capable of transmission to other residents through normal resident-to-resident contact. EI#2 was unable to locate the required documentation.	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 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	A 604		

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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:

(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

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A 604	Continued From page 39 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 of existing interventions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility Registered Nurse (RN) failed to perform required assessments of prospective residents for facility eligibility and failed to properly assess a resident when a decline in health status occurred. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MARCH 7, 2019.	A 604		

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A 604	Continued From page 40 Findings: Assessment for Facility Eligibility RI#1 RI#1 was admitted to the facility on January 25, 2020 and had diagnoses which included Alzheimer's disease, hypertension, diabetes mellitus II, depression and chronic leg pain. No comprehensive assessment of RI#1 was documented to determine facility eligibility for admission. RI#3 RI#3 was admitted to the facility on December 11, 2019 and had diagnoses which included dementia, anxiety, osteoarthritis, anemia and depression. No comprehensive assessment of RI#3 was documented to determine facility eligibility for admission. EI#2 stated she (EI#2) thought these comprehensive assessments had been completed but was unable to locate the documentation. Assessment for Decline in Health Status RI#3 was admitted to the facility on December 11, 2019 and had diagnoses which included dementia, anxiety, osteoarthritis, anemia and depression. During interviews with staff on August 31 and September 1, 2021, the surveyor was informed RI#3 had declined over the past several weeks, could not propel a wheelchair and required total care at the time of the onsite survey. On August 31, 2021, the surveyor observed EI#17 and EI#18 toilet RI#3. Upon	A 604		

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entering RI#3's room, RI#3 was seated in a recliner and had to be physically lifted from the recliner by EI#18. RI#3 did not assist at all with the transfer, was unable to stand or ambulate and was unable to propel the wheelchair once seated in it. RI#3 was taken to the bathroom and lifted onto the toilet. One RA had to hold RI#3 up to allow the other RA to clean RI#3 properly. RI#3's feet were contracted and pointed toward the floor while RI#3 was being held in a standing position. RI#3 was incontinent of bowel and bladder. After personal care was completed RI#3 was transferred from the toilet to the wheelchair, requiring a total lift, and was pushed in the wheelchair back to the recliner where RI#3 was again lifted and placed back in the recliner. RI#3 talked briefly during the process and would scream out in pain at times but was totally unable to assist with any care provided.

RI#3 was currently on isolation precautions for COVID-19 after testing positive on August 26, 2021. No comprehensive assessment, PSMS and Behavior Screening were completed when this significant change in RI#3's condition occurred. RI#3 required the use of oxygen and had a rattling cough. EI#2 reported RI#3 normally had a sitter for 12 hours daily but the sitter had been out since RI#3 tested positive for COVID-19. Although RI#3 was currently ill, all staff interviewed reported RI#3 had declined prior to RI#3's current illness and had been unable to propel the wheelchair or assist with transfers for some time.

The most recent PSMS completed for RI#3 was on August 6, 2021 and revealed a total score of 18 with a 3 in Physical Ambulation (Ambulates with assistance of another person, railing, cane, walker or wheelchair), indicating RI#3 could either

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A 604	Continued From page 42 ambulate or propel self in wheelchair. RI#3 was unable to ambulate or propel the wheelchair, even with the assistance of another person. The most recently documented PSMS score for RI#3 did not accurately reflect RI#3's current functional status. RI#3 had not been properly assessed when RI#3's health and physical status declined to determine the need for care which could not be provided in a SCALF.	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 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	A 611		

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A 611	Continued From page 43 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. (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	A 611		

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A 611	Continued From page 44 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 record reviews and interviews, the facility RN failed to update a resident's care plan with appropriate interventions to address changes in the resident's condition. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MARCH 7, 2019. Findings: RI#3 was admitted to the facility on December 11, 2019. Refer to deficiency 604 for additional information on RI#3. On August 26, 2021, RI#3 developed symptoms and tested positive for COVID-19. RI#3 was placed on appropriate isolation and was started on oxygen. RI#3's facility care plan was not updated to include the isolation precautions and oxygen precautions. EI#2 agreed the care plan had not been appropriately updated.	A 611		

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A 617	Continued From page 45	A 617		
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 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.	A 617		

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A 617	Continued From page 46 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to properly document release of medications upon discharge of a resident. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MARCH 7, 2019. Findings: RI#8 was admitted to the facility on March 4, 2021. Refer to deficiencies 508 and 602 for additional information on RI#8. RI#8 was discharged from the facility on July 7, 2021 to a skilled nursing facility. A Medication Release Form, dated July 7, 2021, documented release of RI#8's medications to RI#8's sponsor. However, the form did not contain prescription numbers for each medication. EI#2 agreed the required information was not documented.	A 617		
A 618	420-5-20-.06 (7) Care of Residents. (7) Oxygen Therapy. (a) A resident of a specialty care assisted living facility that requires oxygen therapy shall have oxygen administered only by a physician, RN, or LPN. (b) Oxygen use including date, time, rate, and proper function of the equipment shall be documented on the medication administration or medication assistance record at least once per shift. 1. If a resident receives oxygen therapy	A 618		

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A 618	Continued From page 47 in a facility: 2. All oxygen equipment, such as tubing, masks, and nasal cannula shall be maintained in a safe and sanitary condition. 3. All oxygen tanks shall be safely maintained and stored. 4. The facility shall require safe use of oxygen therapy. No smoking and appropriate precautionary signs shall be posted. 5. The facility shall ensure that each resident using oxygen therapy maintains an adequate supply of oxygen. Refer to National Fire Protection Association (NFPA) 99 for Oxygen Storage Requirements. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to properly document residents' oxygen use and failed to ensure each resident using oxygen therapy maintained an adequate supply of oxygen. Findings: Documentation of Oxygen Use RI#1, RI#3 and RI#6 all had oxygen available for use at the facility. The oxygen use for these three residents was not documented on each resident's Medication Administration Record (MAR) to include date, time, rate and proper function of the equipment at least once per shift. EI#5 stated residents' oxygen use was not documented as required.	A 618		

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A 618	Continued From page 48 Adequate Supply of Oxygen RI#3 and RI#6 both used oxygen concentrators. No portable oxygen tanks were found in these residents' rooms for use during power outage. On September 1, 2021, EI#2 stated she (EI#2) did not think there was portable oxygen available for these two residents in the facility.	A 618		
A 621	420-5-20-.06 (9) (b) Care of Residents. (b) Retention. 1. A specialty care assisted living facility shall not allow any resident to return to the specialty care assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the specialty care assisted living facility is licensed to provide or the facility is capable of providing. 2. A specialty care assisted living facility shall not retain a resident that has a PSMS score greater than 23 or a score of five in feeding, dressing, grooming, bathing or a score of four or five in physical ambulation. 3. A specialty care assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility. 4. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in a specialty care assisted living facility. 5. A specialty care assisted living facility	A 621		

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A 621	Continued From page 49 shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless: (i) The individual is capable of performing and does perform all tasks related to his or her own care; OR (ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity but the individual has sufficient cognitive ability to direct his or her own care and the individual is able to direct facility staff and does direct facility staff to provide the physical assistance needed to complete such tasks, and the facility staff is capable of providing such assistance and does provide such assistance. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. 6. If a resident of a specialty care assisted living facility is diagnosed with a terminal illness and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90 days. If the facility is unable or becomes unable to meet the needs of a resident receiving hospice care, or if a resident receiving hospice care requires care beyond what the facility may lawfully provide pursuant to this section, then the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for specialty care assisted living facilities.	A 621		

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A 621	Continued From page 50 The facility would in all cases remain responsible for ensuring the appropriate delivery of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility retained a resident whose physical self maintenance ability was below the level allowed in a SCALF. Findings: RI#3 was admitted to the facility on December 11, 2019 and had recently declined in health and mobility status as reported by facility staff. Refer to deficiencies 604, 611 and 618 for additional information on RI#3. As reported in deficiency 604, RI#3 had not been properly assessed by the facility RN when changes in physical status occurred. Even though the most recent PSMS score, on August 6, 2021, documented a total score of 18 and a 3 in Physical Ambulation, RI#3 was currently unable to ambulate or self propel a wheelchair. RI#3 did not meet the criteria for continued stay in a SCALF due to mobility limitations. At the time of the survey, no 30-day discharge notice had been issued to RI#3's sponsor. EI#2 agreed the most recent assessment did not reflect RI#3's current functional status. RI#3 was retained at the facility in need of a higher level of care.	A 621		

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A 703	Continued From page 51	A 703		
A 703	420-5-20-.07 (3) Food Service. (3) Dietary Service. (a) Number of Meals. No fewer than three meals shall be provided each 24 hours. Food service shall be provided in a resident's room during temporary illness if necessary. The diet shall be well-balanced, palatable, properly prepared, and sufficient in quantity and quality to meet the nutritional needs of the residents in accordance with Dietary Reference Intakes of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The food must be adapted in type and preparation to the habits, preferences, and physical abilities of the residents. (b) Timing of Meals. A time schedule for serving meals to residents and personnel shall be established. Meals shall be served approximately five hours apart with no more than 14 hours between the evening meal and breakfast. The time schedule of meals shall be posted with the menu. The facility shall make evening snacks available after service of the evening meal. The facility shall provide fluids throughout the day and shall make between-meal nourishment (snacks) available. (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	A 703		

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A 703	Continued From page 52 accommodate the resident's needs. (d) Alternate food selections or substitutes shall be made available to all residents. (e) A facility shall not obtain food from charitable organizations. A facility shall not avoid serving a meal by sending or transporting residents to missions, soup kitchens, or other charitable facilities for meals. (f) The amount of food on hand shall be sufficient to serve three meals per day to all residents for 3 days. Non-perishable food and potable water shall be maintained in the facility in sufficient quantity to serve three meals per day to all residents for 3 days. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to post a time schedule for serving meals to residents. Findings: During an initial tour of the facility on August 31, 2021, no posting was found for meal times. A menu was posted on the wall near the main entrance. However, the time schedule of meals was not posted with the menu. The surveyor brought this to the attention of EI#4, Activities Director and she (EI#4) acknowledged it was not posted in the designated location. The following day, the surveyor noted mealtime postings outside the main entrance door to the facility. The mealtimes were still not posted in the food service area with the menu.	A 703		

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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 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	A1101		

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A1101	Continued From page 54	A1101		

are used in the facility, the dispensers must be installed in a manner that:

1. Minimizes leaks and spills.

2. Adequately protects against inappropriate access.

3. Complies with the requirements of the currently adopted Life Safety Code.

(f) Fire Alarm and Sprinkler System.

1. Fire Alarm System. Where fire alarm 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

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A1101	Continued From page 55 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 record reviews and interviews, the facility failed to properly document monthly fire drills. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MARCH 7, 2019. Findings: 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 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		