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CARILLON OAKS MOBILE	5461 KOOIMAN ROAD THEODORE, AL 36582

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A 000	Initial Comments This is a 48 bed Specialty Care Assisted Living Facility (SCALF) with a census of 23 on October 19, 2021. There were two (2) complaints investigated during this unannounced licensure and complaint survey. LC#20210924007 and LC#20201103016 were both substantiated. There were deficiencies cited as a result of the complaint investigations. 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 potential for significant harm to the residents and requires a plan of correction.	A 000		
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	A 504		

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A 504	Continued From page 1 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. 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.	A 504		

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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.

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

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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.

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

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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 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

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A 504	Continued From page 5 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. 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 observation, record review, and interview, the facility failed to honor the residents' right for the confidential treatment of resident records and also failed to provide a safe and decent environment for all residents. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. Findings: On October 05, 2021, at approximately 10:30 AM,	A 504		

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the surveyor observed Resident Identifier (RI)#6 look through documentation that was sitting on top of the medication cart. The unsupervised medication cart was parked by the restroom in the common area with at least eight (8) other residents in the area.

On October 05, 2021, at approximately 11:30 AM, the surveyor with Employee Identifier (EI)#3, verified the documentation on top of the medication cart included a clipboard which contained the 24 hour nurses report sheets, along with medical and personal information about every resident in the facility. The narcotic count book was also on top of the cart which included detailed documentation for each resident in the facility including orders for controlled medications. EI#3 immediately removed the residents' information and placed it in a secured area.

On October 07, 2021, at approximately 11:00 AM, RI#2's record was reviewed with EI#1, EI#2, and EI#3.

RI#2 was admitted to the facility on June 02, 2020, with a diagnosis of dementia. RI#2's medications included Namenda 10 milligrams (mg) twice a day, Donepezil 10 mg daily, Seroquel 50 mg daily, and Tylenol 325 mg as needed for pain. RI#2's care plan (date unknown) documented RI#2 required assistance with all activities of daily living (ADL) and supervision during transfers and ambulation due to an unsteady gait and RI#2's tendancy to lean toward his/her right side. RI#2 suffered 11 falls between July 2020 and July 2021 with injuries that included various bruises and a hematoma to RI#2's head.

On October 28, 2020, RI#2's CRNP (Certified

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Registered Nurse Practitioner) documented RI#2 had a history of depression, had a calm, delusional but focused demeanor and ambulated with assistance. Staff reported RI#2 had "spells" of agitation especially in the evening hours. RI#2 was assessed by the CRNP for edema of RI#2's hands and found to have primary osteoarthritis. RI#2's medications were not changed at that time.

According to RI#2's record, RI#2's medications were adjusted approximately five (5) times for depression and behavior symptoms. RI#2's behavior screen assessments dated between February and August 2021 documented RI#2 exhibited behaviors including hollering for help during care, hitting during care, and seeing children in RI#2's room. On September 03, 2020, the CRNP added Atarax at bedtime as needed for insomnia. On October 16, 2020, the CRNP added Risperdal 0.5 mg twice a day. On January 05, 2021, the CRNP added Ativan 0.25 mg at bedtime "if restlessness persists". RI#2's care plan was updated to reflect the many medication changes, but had not been updated with new or revised interventions for RI#2's symptoms of insomnia, depression, or ongoing behaviors.

During review of the facility investigation and RI#2's records, RI#2's incident report and investigation dated August 16, 2021, documented EI#3 observed swelling and bruising of RI#2's wrist on August 15, 2021, at approximately 8:00 AM during the nurse's rounds. EI#3 documented on the incident report that RI#2's sponsor was notified at 8:15 AM on August 15, 2021, which contradicted what the surveyor was told during the interview with RI#2's sponsor on October 19, 2021 (see below). RI#2's incident report and investigation documented that RI#2's physician

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was notified at 8:20 AM on August 15, 2021. However, the surveyor noted the fax stamp on the fax notification to RI#2's physician was dated August 16, 2021, at 14:56 (2:56 PM). RI#2's physician's order for an X-ray of RI#2's left wrist was also not received by the facility until August 16, 2021, at approximately 3:59 PM, according to the fax stamp on the order.

The X-ray order was received/acknowledged by the portable X-ray company on August 17, 2021, at approximately 10:30 AM, two (2) days after RI#2's swollen and bruised wrist was identified by EI#3. RI#2's X-ray report results were not received by the facility until August 18, 2021, at approximately 8:06 PM according to the fax stamp on the report. RI#2 was discharged at an unknown time on August 18, 2021, with his/her sponsor to a skilled nursing facility without knowledge of RI#2's X-ray results. RI#2's X-ray report from August 17, 2021, documented RI#2 had an acute impacted fracture of the distal radius and ulnar styloid.

The facility's investigation regarding RI#2's fractured wrist of unknown origin was found to be incomplete and did not include employee statements from EI#3, EI#7, EI#8, or EI#10, who also worked shifts on August 14 and August 15, 2021, when RI#2's left wrist was noted to be injured. The facility investigation also did not include a statement from the sitter who sat with RI#2 on August 14, 2021.

RI#2's records did not document that any first aid or care had been provided for RI#2's fractured wrist between August 15 at 8:00 AM and August 18, 2021, except for August 16, 2021, instructions to support RI#2's left hand on a pillow, the X-ray on August 17, 2021, and a single dose of Tylenol

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on August 18, 2021. EI#1, EI#2 and EI#10 all documented between August 15, and August 17, 2021, that RI#2 didn't have any "voiced complaints of pain" or signs and symptoms of pain, which contradicted what RI#2's sponsor told the surveyor below.

On October 07, 2021, at approximately 11:00 AM, EI#3 told the surveyor that EI#3 observed that RI#2 had swelling and bruising of RI#2's left wrist area on August 15, 2021, at approximately 8:00 AM. EI#3 told the surveyor that EI#3 called RI#2's sponsor to report the bruising and swelling, and RI#2's sponsor did not want RI#2 to go to the emergency room for evaluation due to Covid concerns. EI#3 also told the surveyor that EI#3 had spoken with the private sitter supervisor who reported that there had not been any incidents reported to the supervisor. EI#3 told the surveyor that EI#3 had written a statement about RI#2's fractured wrist of unknown origin, but EI#3 didn't know what happened to their written statement. EI#1 also told the surveyor that EI#3 had written a statement about the incident but couldn't find EI#3's written statement at the time of the survey.

On October 19, 2021, at approximately 12:00 PM, RI#2's sponsor told the surveyor that RI#2's sponsor was contacted around mid-day and told that RI#2 had bruising and swelling of the left hand. RI#2's sponsor visited RI#2 on August 15, 2021, at 5:00 PM, and stayed for three (3) hours. RI#2's sponsor told the surveyor that he/she was pretty sure that RI#2's left wrist was painful because RI#2 became vocal when the left wrist was moved during the changing of the linens on RI#2's bed after an incontinence episode. RI#2's sponsor told the surveyor RI#2 had a planned discharge to a local skilled nursing facility on

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A 504	Continued From page 10 August 18, 2021. RI#2's sponsor told the surveyor RI#2's sponsor requested RI#2 not be sent to the local hospital for evaluation of the left wrist swelling and bruising, fearful of RI#2 contracting Covid and would not be able to complete RI#2's transfer to the skilled nursing facility. RI#2's sponsor told the surveyor RI#2 had trouble verbalizing any care needs due to RI#2's advanced dementia. RI#2's sponsor requested a portable X-ray of RI#2's left wrist on August 15, 2021, but was never contacted by the facility regarding RI#2's X-ray results and fractured left wrist. After RI#2's discharge from the facility, RI#2's sponsor took RI#2 to an orthopedic physician (date unknown), who performed additional X-rays and applied a cast to treat RI#2's fractured left wrist.	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	A 508		

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providing day-to-day care to a resident or for which medical treatment was sought.

(ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid including but not limited to a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office.

(iii) The onset of wandering behavior by any resident who is not fully cognitively intact.

(iv) Elopement by a resident.

(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).

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A 508	Continued From page 12 (ix) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (xi) An unplanned occurrence that results in media attention. (xii) A medication error, overdose, or over 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	A 508		

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A 508	Continued From page 13 and time). (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken. (viii) The extent and description of injury, if any, to the affected resident or residents. (ix) Immediate treatment rendered. (x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified. (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	A 508		

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be made available for inspection and copying by representatives of the Department upon request.

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

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

3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the 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

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gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility.

(v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident.

(vi) An unplanned occurrence that results in media attention.

(vii) Any medication error, overdose, or over sedation. The incident shall be immediately reported to the attending physician, facility 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

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A 508	Continued From page 16 number. (ii) Time and date of the report. (iii) Reporter's name. (iv) Name of resident(s), staff, or visitor(s) involved in the incident. (v) Names of staff on duty at the time of the incident. (vi) Date and time of the incident. (vii) A brief description of the incident. (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.	A 508		

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that a thorough investigation was completed for a fractured wrist of unknown origin. This deficient practice placed all 23 residents at significant risk for harm related to possible unidentified abuse.

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

Findings:

On October 07, 2021, at approximately 11:00 AM, the surveyor reviewed RI#2's record with EI#1, EI#2, and EI#3.

RI#2 was admitted to the facility on June 02, 2020, with a diagnoses of dementia. RI#2's care plan (date unknown) documented that RI#2 required assistance with all ADL'S and supervision with transfers and ambulation due to an unsteady gait and RI#2's tendency to lean to his/her right side. RI#2 suffered 11 falls between July 2020 and July 2021 with injuries which included various bruises and a hematoma to RI#2's head.

During review of the facility investigation and RI#2's records, the incident report and investigation dated August 16, 2021, documented that EI#3 observed swelling and bruising of RI#2's wrist on August 15, 2021 at approximately 8:00 AM during the nurse's rounds. The incident report documented that RI#2's sponsor was notified at 8:15 AM on August 15, 2021 which contradicted what the surveyor was told during the interview with RI#2's sponsor on October 19,

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2021 (see below). RI#2's incident report documented that RI#2's physician was notified at 8:20 AM on August 15, 2021. However, the surveyor noted that the faxed notification to RI#2's physician was dated August 16, 2021, at 14:56 (2:56 PM) according to the fax stamp. This contradicted the handwritten date of August 15, 2021, on the faxed physician notification form. RI#2's physician's order for an X-ray of RI#2's left wrist was received by the facility on August 16, 2021, at approximately 3:59 PM, according to the fax stamp and handwritten date by the physician on the physician's order.

The surveyor also noted that the following employees worked on August 14 and August 15, 2021, but the investigation presented to the surveyor for RI#2's fractured wrist of unknown origin did not include employee statements from EI#3, EI#7, EI#8, or EI#10. The facility investigation also did not include a a statement from the sitter who sat with RI#2 on August 14, 2021.

On October 07, 2021, at approximately 11:00 AM, EI#3 told the surveyor that EI#3 observed that RI#2 had swelling and bruising of RI#2's left wrist area on August 15, 2021, at approximately 8:00 AM. EI#3 told the surveyor she (EI#3) called RI#2's sponsor to report the bruising and swelling, but RI#2's sponsor did not want RI#2 to go to the emergency room for evaluation due to Covid. EI#3 also told the surveyor she (EI#3) had spoken with the private sitter's supervisor who told EI#3 that there had not been any incidents for RI#2 reported to the sitter's supervisor. EI#3 told the surveyor that EI#3 had written a statement about the discovery of RI#2's left wrist swelling and bruising but didn't know where EI#3's statement went. EI#1 also told the surveyor that

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A 508	Continued From page 19 EI#1 had seen a written statement by EI#3 but couldn't find the written statement at the time of the survey. On October 07, 2021, at approximately 11:00 AM, EI#1 verified the date of May 15, 2021, was incorrectly documented as the date RI#2's injury was identified on RI#2's fractured wrist investigation summary. The actual date that RI#2's wrist injury was identified was August 15, 2021. EI#1's investigative summary documented that the facility didn't find RI#2's wrist swelling suspicious because RI#2 had experienced previous hand swelling according to a CRNP note for RI#2 dated October 28, 2020. However, RI#2's previous hand swelling noted by the CRNP was not of the wrist area and was not accompanied by any documented bruising. On October 19, 2021, at approximately 12:00 PM, RI#2's sponsor told the surveyor that RI#2's sponsor was contacted around mid-day on August 15, 2021 and told that RI#2 had bruising and swelling of the left hand. RI#2's sponsor visited RI#2 on August 15, 2021, at 5:00 PM, and stayed for three (3) hours. RI#2's sponsor took photos of RI#2's wrist swelling and bruising during that visit. RI#2's X-ray report dated August 17, 2021, documented that RI#2 had an acute impacted fracture of the distal radius and ulnar styloid. RI#2's sponsor told the surveyor that after RI#2's discharge from the facility (on August 18, 2021) RI#2's sponsor took RI#2 to an orthopedic physician, who performed additional x-rays and applied a cast to RI#2's fractured left wrist.	A 508		
A 604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents.	A 604		

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A 604	Continued From page 20 (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 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	A 604		

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A 604	Continued From page 21 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 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).	A 604		

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A 604	Continued From page 22 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 review and interview, the facility failed to ensure a resident's fractured wrist was properly evaluated and care provided in a timely manner. This deficient practice placed all 23 residents at a significant risk for harm THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. Findings: On October 07, 2021, at approximately 11:00 AM, the surveyor reviewed RI#2's record with EI#1, EI#2, and EI#3. RI#2 was admitted to the facility on June 02, 2020, with a diagnoses of dementia. RI#2's care plan (date unknown) documented that RI#2 required assistance with all ADL'S and supervision with transfers and ambulation due to an unsteady gait and leaning to the right. RI#2 suffered 11 falls between July 2020 and July 2021 with injuries which included various bruises and a hematoma to RI#2's head.	A 604		

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A 604	Continued From page 23 On October 28, 2020, the CRNP progress note documented that RI#2 had increased agitation and swelling in hands (no bruising was documented). The CRNP diagnosed RI#2 with osteoarthritis and recommended the use of PRN Tylenol for pain management. On August 16, 2021, an incident report completed for RI#2, documented the nurse (later identified as EI#3) was doing rounds on August 15, 2021, and noticed RI#2's left hand was swollen. (RI#2) has had previous hand swelling in the past. Documentation of the injury was left wrist swollen bruised. Immediate treatment rendered was documented as X-ray ordered on August 16, 2021, X-ray completed on August 17, 2021. EI#2, EI#3, and EI#10, documented RI#2 had no pain on August 15, 16, and 17, 2021. According to RI#2's MAR, RI#2 did not receive any pain medication on August 14, 15, 16, or 17, 2021, but received Atarax 25 mg and Ativan 0.5 mg together on August 14, 2021, at 9:18 PM, and August 15, 2021, at 7:53 PM, for restlessness and anxiety, which are well known signs and symptoms of pain in residents with a dementia diagnosis who have difficulty verbalizing their care needs. On August 18, 2021, RI#2's care plan documented that RI#2 had swelling of the left wrist and RI#2's X-ray report documented an acute impacted distal radius fracture and acute ulnar styloid fracture. However, there were no interventions for care or monitoring for complications. The only documented care was instruction by EI#2 for pillow support on August 16, 2021, and a single Tylenol tablet that had been given on August 18, 2021.	A 604		

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A 604	Continued From page 24 On October 07, 2021, at approximately 11:00 AM, EI#3 told the surveyor that EI#3 observed that RI#2 had swelling and bruising of RI#2's left wrist area on August 15, 2021, at approximately 8:00 AM. EI#3 told the surveyor she called RI#2's sponsor to report the bruising and swelling, and RI#2's sponsor did not want RI#2 to go to the emergency room for evaluation due to Covid concerns. On October 07, 2021, at approximately 11:00 AM, EI#1, EI#2, and EI#3, all agreed that there was no documentation that the facility provided any type of first aid, or care to RI#2's fractured wrist. On October 19, 2021, at approximately 12:00 PM, RI#2's sponsor told the surveyor that RI#2's sponsor visited RI#2 on August 15, 2021, at 5:00 PM, and stayed for three (3) hours. RI#2's sponsor told the surveyor that he/she was pretty sure that RI#2's left wrist was painful because RI#2 became vocal when the left wrist was moved during the changing of the linens on RI#2's bed due to an incontinence episode on August 15, 2021. RI#2's sponsor told the surveyor that RI#2 had a planned discharge to a local skilled nursing facility on August 18, 2021, which was why RI#2's sponsor requested that RI#2 not be sent to the local hospital for evaluation of the left wrist swelling and bruising, fearful that RI#2 could contract Covid and would not be able to complete RI#2's transfer to the skilled nursing facility. RI#2's sponsor also told the surveyor that RI#2 had trouble verbalizing any pain or care needs due to RI#2's advanced dementia. RI#2's sponsor also told the surveyor that RI#2's sponsor had requested a portable X-ray of RI#2's	A 604		

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A 604	Continued From page 25 left wrist on August 15, 2021, and was never told by the facility that RI#2's wrist was X-rayed or fractured. RI#2's sponsor told the surveyor that he/she did not see any care provided to RI#2's fractured wrist during the three hours that RI#2's sponsor sat with RI#2 on August 15, 2021, between 5:00 PM and 8:00 PM. RI#2's sponsor told the surveyor that he/she had left some Advil tablets for RI#2's painful wrist if needed. RI#2's record did not reflect that the facility nurses even tried to get an order from the physician to give the Advil if RI#2 needed it for pain. After RI#2's August 18, 2021, discharge from the facility RI#2's sponsor took RI#2 to an orthopedic physician, who performed additional X-rays and applied a cast to RI#2's fractured left wrist.	A 604		
A 608	420-5-20-.06 (3) (j) Care of Residents (j) Mechanical Restraint and Seclusion. No form of physical restraint or seclusion shall be applied to residents of a specialty care assisted living facility except in extreme emergency situations when the resident presents a danger of harm to himself or herself or to other residents. In such an event, the facility shall use the least restrictive intervention that will be effective to protect residents, immediately notify the resident's physician and sponsor, and appropriate treatment, transfer to an appropriate health care facility, or both shall be provided without any avoidable delay. In no event shall emergency behavioral symptoms of residents be treated with sedative medications, anti-psychotic medications, anti-anxiety medications, or other psychoactive medications in a specialty care assisted living facility.	A 608		

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A 608	Continued From page 26 This Rule is not met as evidenced by: Based on record review and interview, the facility obtained physician orders for the use of a chemical restraint. This deficient practice affected at least one (1) resident and had the potential to affect the remaining 22 residents living in the facilty. Findings: On October 07, 2021, at approximately 11:00 AM the surveyor reviewed RI#4's record with EI#1, EI#2, and EI#3. RI#4 was admitted to the facility on June 09, 2020, with diagnoses including dementia and diabetes. On August 09, 2021, RI#4's physician wrote an order for Ativan 01 mg (0.5ml) intramuscularly (IM) every 6 hours as needed for anxiety/agitation. RI#4's care plan documented the following behaviors "yelling help me", "says (RI#4) is dying", "asks wher am I", and complains of right side pain. The only interventions for RI#4's behaviors were Ativan pills or injection, "reassure (RI#2) that they are alright", and "reassure that the medication will help with pain". On October 07, 2021, at approximately 11:00 AM, EI#2 told the surveyor RI#4 was never given the IM Ativan medication however, RI#4's care plan dated August 16, 2021, documented that the IM Ativan was "ordered - medication effective". EI#2 agreed that the only care plan intervention updates/revisions for RI#4's behavior were medication/dosage changes.	A 608		

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CARILLON OAKS MOBILE	5461 KOOIMAN ROAD THEODORE, AL 36582

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 611	Continued From page 27	A 611		
A 611	420-5-20-.06 (4) (a) (b) Care of Residents.	A 611		

(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 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

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A 611	Continued From page 28 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 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	A 611		

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A 611	Continued From page 29 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 review and interview, the facility failed to update the resident's care plan when there was a significant change in the residents health status or behaviors. This deficient practice had the potential for significant harm to all 23 residents. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. Findings: On October 07, 2021, at approximately 11:00 AM, the records for RI#2 and RI#4 were reviewed with EI#1, EI#2, and EI#3. RI#2 was admitted to the facility on June 02, 2020, with a diagnosis of dementia. RI#2's medications included Namenda 10 milligrams (mg) twice a day, Donepezil 10 mg daily, Seroquel 50 mg daily and Tylenol 325 mg as needed for pain. RI#2's care plan (date unknown) documented that RI#2 required assistance with all ADLs. On September 17, 2020, RI#2's care plan documented that RI#2 complained of knee pain. The only intervention documented for RI#2's knee pain was an X-ray with negative results. No other interventions for RI#2's knee pain were documented.	A 611		

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A 611	Continued From page 30 On October 28, 2020, RI#2's CRNP documented RI#2 had a history of depression, was ambulatory with calm delusional but focused demeanor, ambulated with assistance, and staff reported RI#2 had "spells" of agitation especially in the evening hours. RI#2 was assessed by the CRNP for swelling of RI#2's hands and found to have primary osteoarthritis. The CRNP made no medication adjustments at this time but recommended the use of PRN Tylenol for pain management. According to RI#2's record RI#2's medications were adjusted approximately five (5) times for depression and behavior symptoms. RI#2's behavior screen assessments dated between February and August 2021 documented RI#2's behaviors included hollering for help during care, hitting during care, and seeing children in RI#2's room. On September 03, 2020, the CRNP added Atarax at bedtime as needed for insomnia. There were no other interventions for insomnia on RI#2's care plan. On October 16, 2020, the CRNP added Risperdal 0.5 mg twice a day. RI#2's care plan was revised to reflect the order for Risperdal. There were no other intervention updates to RI#2's care plan for behaviors except the medication change. On January 05, 2021, the CRNP added Ativan 0.25 mg at bedtime "if restlessness persists". There were no interventions added to RI#2's care plan for restlessness and RI#2's MAR documetned the use of Ativan five (5) to seven (7) days a week. On October 05, 2021, at 10:45 AM, EI#3 told the	A 611		

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A 611	Continued From page 31	A 611		

surveyor she helped to update the care plans and that the original care plan was developed on admission by the RN (registered nurse). Additional care plan interventions/updates were added to the original care plan along with the date the updates/revisions were added.

On October 07, 2021, EI#2 agreed that RI#2's care plan had no interventions for restlessness and no revised interventions for behaviors except the orders for Ativan and the medication dosage changes.

RI#4 was admitted to the facility on June 09, 2020, with diagnoses including dementia and diabetes. RI#4's care plan (date unknown) documented RI#4 required assistance with all activities of daily living (ADL). RI#4's care plan documented the following behaviors "yelling help me", "says (RI#4) is dying", "asks where am I", and complains of right side pain. The only interventions for RI#4's pain and "behaviors" were Ativan pills or Ativan injection, "reassure (RI#4) that they are alright", and "reassure (RI#4) that the medication will help with pain".

According to RI#4's controlled count sheets for July through August 2021 and RI#4's MAR for October 2021, RI#4 routinely received PRN Ativan by mouth twice a day seven (7) days a week.

On August 09, 2021, RI#4's physician wrote an order for Ativan 01 mg (0.5ml) intramuscularly (IM) every 6 hours as needed for anxiety/agitation.

On October 07, 2021, at approximately 11:00 AM, EI#2 told the surveyor that RI#4 was never given the IM Ativan medication however, RI#4's care

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A 611	Continued From page 32 plan dated August 16, 2021, documented the IM Ativan was "ordered - medication effective". EI#2 agreed the only care plan intervention updates/revisions for RI#4's behavior were medication/dosage changes.	A 611		
A 615	420-5-20-.06 (5) (h) Care of Residents. (5) Medications. (h) All medications administered to residents in a specialty care assisted living facility, shall be contemporaneously recorded on a standard medication administration record. "Contemporaneously recorded" means recorded at the same time or immediately after medications are administered. The medication administration record shall include at least the following: 1. The name of the resident to whom the medication was administered. 2. The name of the medication administered. 3. The dosage of the medication administered. 4. The method of administration. 5. The site of injection or application, if the medication was injected or applied. 6. The date and time of the medication administration or assisted. 7. Any adverse reaction to the	A 615		

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A 615	Continued From page 33 medication. 8. The printed name, initials, and written signature of the individual administering the medication or assisting the resident with self-administration of the medication. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the nurses documented at the time when medications were administered. Findings: On October 07, 2021, at approximately 11:00 AM, the surveyor reviewed the medication administration records (MAR's) for RI#1, RI#3, and RI#4 with EI#1, EI#2, and EI#3. RI#1's MAR for the month of October 2021, had two medications (Gabapentin and Melatonin) that were scheduled for 9:00 PM that were not signed as given for October 01, 2021. RI#3's MAR for October 2021, had the following medications that had not been signed as given for the scheduled dates and times. Norvasc for blood pressure control - scheduled for 8:00 AM on October 03, 2021; Breo inhaler - scheduled for 8:00 AM on October 03, 2021; Pepcid - scheduled for 9:00 PM on October 01, 2021; Premixed nebulizer breathing treatment with Ipratropium /Albuterol - scheduled for 8:00 AM on October 03, 2021; nutritional supplement shakes scheduled for 8:00 AM and 12:00 PM on October 03, 2021; Miralax scheduled for 8:00 AM on October 03, 3021; and Vitamin D3 scheduled for	A 615		

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A 615	Continued From page 34 8:00 AM on October 03, 2021. RI#4's MAR for the month of October 2021, had the following medications that had not been signed as given for the scheduled dates and times. Lipitor scheduled for 9:00 PM on October 01, 2021; nutritional supplement shake scheduled for 12:00 PM on October 03, and 05, 2021; Nystatin powder scheduled for 5:00 PM on October 02, 2021; Lyrica scheduled for 12:00 PM on October 03 and 05, 2021; Lyrica scheduled for 9:00 PM on October 01, 2021; and Trazodone scheduled for 9:00 PM on October 01, 2021. EI#2 told the surveyor that the nurses probably just forgot to sign the MAR when they gave the residents' medications.	A 615		
A1204	420-5-20-.12 (6) Physical Environment. (6) Building Requirements - Group Specialty Care Assisted Living Facilities. (a) General. Group specialty care assisted living facilities licensed, constructed, or renovated shall be limited to one story buildings and shall comply with the currently adopted building code and National Fire Protection Association, Life Safety Code. Facilities, or portions of facilities, built under the currently adopted codes shall comply with the Life Safety Code Chapter for New Residential Board and Care Occupancies (excluding NFPA 101A Alternative Approaches to Life Safety). Facilities, or portions of facilities, built under previously adopted editions of the codes shall comply with the currently adopted Life Safety Code Chapter for Existing Residential Board and Care Occupancies (excluding NFPA 101A Alternative	A1204		

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A1204	Continued From page 35 Approaches to Life Safety). (b) Required Fire Exits. 1. At least two exits, remote from each other and so located that there will be no dead-end corridors in excess of 20 feet, shall be provided. 2. Exits shall be so located that the distance of travel from the corridor door of any occupied room to an exit shall not exceed 100 feet. 3. Each bedroom or suite shall have at least one doorway opening directly to the outside, or to an exit corridor leading directly to the outside. 4. Exit doors shall swing to the exterior. 5. Panic hardware shall be installed on all exit doors, except where electrically controlled door hardware is used in accordance with other provisions of these rules. (c) Corridors and Passageways. Corridors and passageways used as a means of exit, or part of a means of exit, shall be at least 36 inches wide, shall be unobstructed, and shall not lead through any room or space used for a purpose that may obstruct free passage. (d) Smoke Barrier Separations. 1. Buildings exceeding 3,000 square feet in area shall be divided into separate areas by smoke barriers so located as to provide ample space on each side for approximately one-half	A1204		

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A1204	Continued From page 36 the beds. Smoke barriers shall have a fire-resistive rating of not less than one hour or minimum one-half hour for existing sprinkled facilities. 2. Doors provided in smoke barriers shall be smoke-resistive, so installed that they may normally be kept in the open position, but will close automatically upon fire alarm activation. 3. Duct penetrations in smoke barriers shall be properly protected with smoke dampers. 4. Penetrations of smoke barriers with wiring, conduits, pipes, etc., shall be sealed to maintain the fire and smoke rating. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain proper functioning of a back porch gate/door to a public way and also failed to maintain smoke doors to ensure that latching hardware functioned properly when the fire alarm was activated. Findings: On October 06, 2021, at approximately 2:10 PM, the surveyor requested the facility demonstrate a fire drill. The surveyor with EI#1 observed the fire alarm was activated by a pull station and a smoke door by rooms #24 and #25 failed to close and latch securely. The surveyor and EI#1 also observed that the back porch gate/door did not open freely due to a physical obstruction created by the gate/door frame and the magnetic locking plate. The back porch gate/door was located	A1204		

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A1204	Continued From page 37 between the dining room designated EXIT door and the path to a public way. EI#1 agreed that the smoke door hardware probably needed to be adjusted and fixed the smoke door closer that same day. EI#1 also told the surveyor that he/she would have someone out to fix the back porch gate/door that same day. TONYA AVENATTI, REGISTERED NURSE	A1204		