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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments On January 4, 2022, an unannounced licensure survey and complaint investigation was conducted for this 73 bed Assisted Living Facility (ALF) with a census of 31. The following three (3) complaints were investigated during this survey: Intake ID: 20211025018 and Intake ID: 20211104001 were substantiated with deficiencies cited. Intake ID: 20211209006 was substantiated with no deficiencies cited. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities. The deficiencies cited pose a risk or potential risk of harm to the residents.	A 000		
A 301	420-5-4-.03 (1) (a) (b) (c) (d) Administration. The Assisted Living Facility Governing Authority. (a) An assisted living facility shall have an identified sole proprietorship, corporation, partnership, limited partnership, or other business entity that is its governing authority, or it shall have a designated individual or group of designated individuals who serve as its governing authority. A facility must give complete information to the Department identifying: 1. Each person who has an ownership interest of 10 percent or more of the governing authority. 2. Each person or entity who has an	A 301		

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A 301	Continued From page 1 ownership interest of 10 percent or more in the real property or building used by the assisted living facility to offer its services. 3. Each officer and each director of the corporation if the governing authority is a corporation. 4. Each partner, including any limited partners, if the governing authority is a partnership. (b) The governing authority shall submit any changes to the information listed above to the Department within 15 days of the change. (c) Responsibility of Staff to Governing Authority. The administrator, medical staff, facility personnel, and all auxiliary organizations shall be directly or indirectly responsible to the governing authority. For the purposes of these rules, auxiliary organizations include but are not limited to licensed or certified outside providers, consultants, management companies that are not the facility license holder. (d) The governing authority is responsible for appointing and supervising the administrator who is responsible for overall management and the day-to-day operation of the facility. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the governing authority failed to ensure the facility operated in compliance with the SBOH	A 301		

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rules for an assisted living facilities (ALF). The administrator failed to adequately perform her duties as administrator to ensure the facility was managed responsibly. This failure resulted in 21 deficiencies to include, four (4) in administration, three (3) in personnel, three (3) in records/reports, nine (9) in care of residents, one (1) in dietary service, and one (1) for fire safety. These widespread failures placed all 31 residents at significant risk for harm due to the administrator's failure to apply the rules for the day to day operations of the facility.

Findings:

The current administrator, Employee Identifier (EI#1) had been employed as the administrator at the facility about 7 months at the time of the survey. During a telephone interview on January 6, 2022, EI#2, Vice President of Operations/Governing Authority, reported he (EI#2) had become more involved with this facility in August 2021. Both EI#1 and EI#2 reported EI#2 usually visits the facility several times weekly. The surveyor asked EI#2 if he required quality reports to be submitted for his (EI#2) review and he said no because they have regular stand up meetings and he (EI#2) is kept informed of medication issues and complaints. EI#2 stated he (EI#2) was aware of the medication problems since receiving recent reports from the pharmacy (QMAR). EI#2 stated the pharmacy audit completed on December 30, 2021, was done at his (EI#2) request and he (EI#2) planned to continue the audits on an ongoing basis. The pharmacy documented evidence of non-compliance after auditing the Medication Storage Carts. The audit findings are as follows:

- The top of cart and drawers were not clean and

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well organized.
- External and internal medications were not stored separately.
- Syringes and other potentially hazardous devices were not stored properly.
- Discontinued and expired medications were present on the cart.
- Medication labels were not legible and did not contain all the required information.
- Controlled medication shift-to-shift change logs were not singed and completed.

EI#2 stated he (EI#2) was in contact with EI#1 daily. EI#2 stated EI#3, Corporate Nurse, was responsible for training the facility Resident Care Director (EI#4). EI#2 further stated he (EI#2) was based in Georgia and was still learning the SBOH rules for the State of Alabama, but was dedicated to operating the facility according to SBOH rules and planned to use this survey to help move the facility toward further compliance with those rules.

The Alabama Department of Public Health received three (3) complaints which were investigated and substantiated during the onsite survey. The complaints involved residents not receiving medications as ordered placing them at risk for harm. Numerous deficient practices were identified during the onsite survey to include, not adhering to their infection control policy, allowing wound care to be performed by a family member, poorly developed resident care plans that were not current and did not address resident problem areas with appropriate care actions, failure to follow physicians' orders, inadequate health supervision of residents, fire drills and fire alarm/sprinkler inspections not completed, facility records were not made available to surveyors, medications not administered to residents, lack of

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A 301	Continued From page 4 staff training and incidents not reported and investigated as required. The surveyors reviewed the complaints and most of the deficiencies with EI#2 during the telephone interview. EI#2 reiterated to surveyors his (EI#2) commitment to bringing the facility to full compliance with the SBOH rules for ALF's and to maintaining that compliance. The following deficiencies were identified as a result of the administrators' failure to apply the State Board of Health's rules for the day to day operations of the facility. 302 - The policies and procedures for medication management were not followed. 303 - The administrator did not perform her duties as required. 305 - The State Board of Health was not notified of a change in administrator. 402 - Employees were not screened for abuse. 403 - Employee records were incomplete. 405 - The staff was not trained in special needs of residents. 503 - Resident records were not available for review. 504 - The residents were not always provided a safe environment. 508 - Incidents were not reported to ADPH as required.	A 301		

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A 301	Continued From page 5 601 - Physician orders were not followed. 602 - Medical examinations were not completed as required. 604 - Health supervision was not provided. 611 - Resident care plans were not current and appropriate. 615 - The application site of a patch was not documented. 616 - Controlled medications were not accounted for at every shift change. 618 - Oxygen administration was not documented on the medication administration record. 621 - Wound care was not being performed by a properly certified agency. 703 - There was an insufficient amount of potable water on hand in the event of an emergency situation. 1101 - Fire drills were not conducted monthly and semiannual inspections of the fire alarm and sprinkler system were not done.	A 301		
A 302	420-5-4-.03 (1) (e) Administration. Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and adherence to, procedures implementing those	A 302		

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A 302	Continued From page 6 policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). All residents shall be informed of new policies or changes in existing policies that may have bearing on the residents. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies shall cover the following: (i) Facility responsibility to protect all residents from abuse, neglect, and exploitation. (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	A 302		

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A 302	Continued From page 7 extinguisher checks, and disaster preparedness. (xii) Staffing and conduct of staff while on duty. (xiii) Oxygen administration and storage if used in the facility. (xiv) Dietary Policies. The dietitian, with the approval of the administrator, shall develop written policies and procedures for the guidance of all personnel handling food as 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	A 302		

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A 302	Continued From page 8 is nutritionally compromised or is not eating adequate quantities of food. (VII) Provision of necessary services to any resident requiring adaptive devices to eat. (VIII) Procedure for the handling of potentially hazardous foods such as meat, milk, ice, and eggs. (IX) Storage of food. (X) Procedure for food service in the event of a disaster. Disaster menus shall be developed. The policy shall address how food will be obtained and maintained at safe temperatures if electricity is not available. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to follow its own policy for infection control. Findings: According to the facility's Infection Control: Communicable Disease and Containment Policy, "...Staff will follow the Physician's Plan of Care and CDC guidelines related to: use of appropriate Personal Protective Equipment (PPE) and transmission-based precautions...The Executive Director will follow state guidelines for reporting communicable diseases to local or state authorities...The Resident Care Director will monitor infection control practices by observation on rounds...". The facility failed to use appropriate PPE for resident care and contact. Refer to deficiency 504 for additional information. The	A 302		

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A 302	Continued From page 9 facility failed to follow state guidelines for reporting a COVID-19 outbreak. Refer to deficiency 508 for additional information. The Resident Care Director (EI#4) failed to monitor infection control practices to ensure proper precautions were utilized to prevent the spread of infection. Refer to deficiency 504 for additional information.	A 302		
A 303	420-5-4-.03 (2) (a) Administration. The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an administrator shall meet all applicable statutory requirements. 4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences. 5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age. 6. The administrator and any individual authorized to act as a substitute shall be of	A 303		

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A 303	Continued From page 10 reputable and responsible character. 7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week. 8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment and adequate care being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement. 9. The facility administrator is responsible for ensuring that required training is provided to all staff. 10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting. 11. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when needed. 12. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan.	A 303		

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13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, EI#1, Administrator, failed to adequately perform her (EI#1's) duties to ensure the proper and safe management of the day to day operations of the facility. These failures placed all 31 residents of the facility at risk of harm.

Findings:

On January 4-6, 2022, surveyors with the ADPH conducted an onsite survey and complaint investigation at the facility. Three (3) complaints were investigated. The complaints contained allegations the residents were not receiving medications as ordered by the physician. Surveyors substantiated these complaints while onsite and identified other deficient practices as listed below:

EI#1 was aware of the COVID-19 outbreak in facility and did not ensure the staff was following their infection control policy or using the proper PPE for staff's protection and to prevent the spread of the virus to other residents. In addition, EI#1 had knowledge of a serious medication error, and yet it was not reported to ADPH within 24 hours, as required. Refer to deficiency 302, 504, and 508 for additional information.

EI#1 was managing the employees files and did not ensure the personnel files were complete and employees were screened for abuse in a timely

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manner. Refer to deficiencies 402 and 403 for additional information.

EI#1 was aware a hospice resident was near the end life and did not provide the proper training for staff to make sure the dying resident's special needs were met. Refer to deficiencies 405 and 611 for additional information.

EI#1 was aware the Medication Administration Record (MAR) for a discharged resident was not available through the electronic system but did not make attempts to obtain the missing MAR to make sure the record was complete. In addition, the MAR was not available for the surveyor's review to determine if a complaint could be substantiated. Refer to deficiency 503 for additional information.

EI#1 was aware of medication issues as brought to her (EI#1) attention through complaints received from families and a recent pharmacy audit which revealed non-compliance. However, some of the same medication issues continued through the survey. Also, EI#1 had knowledge the medical director was not responding to the staff's request for medication refills for several months but failed to correct the problem. Refer to deficiencies 504, 601, and 616 for additional information.

EI#1 did not ensure two (2) residents had completed medical exams by the physician or the residents were properly screened for tuberculosis (TB) prior to admission, therefore, placing the other residents at risk for exposure to TB. Refer to deficiency 602 for additional information.

EI#1 did not oversee the resident's overall physical and mental well being that should have

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been completed on a monthly basis. EI#1 did not ensure the residents were assessed for significant changes for two (2) months in a row. EI#1 was not aware the resident's ability to safely self administer medications with assistance was not being assessed. EI#1 was not monitoring the residents weights to ensure they were done or were accurate. EI#1 was aware some of the residents were refusing to be weighed monthly, yet did not put a plan into action. EI#1 did not manage and direct staff to ensure EI#4 was allowed adequate time to complete her monthly assessments. EI#4 was expected to provide health supervision for 31 ALF residents, as well as 16 residents in the SCALF. Refer to deficiency 604 for additional information.

EI#1 did not ensure there was an acceptable written plan of care developed for each resident at the time of admission nor were the plans of care updated as the residents conditions changed. The surveyor found seven (7) residents had inadequate care plans that were not individualized and did not reflect the residents' current conditions. As noted above, EI#1 did not ensure EI#4 had sufficient time to develop appropriate plans of care to properly care for the residents. Refer to deficiency 611 for additional information.

EI#1 was aware a resident was being retained with unmanageable behaviors for approximately seven (7) months and had not issued a discharge notice. EI#1 also allowed a family member to perform dressing changes to a leg wound for one (1) resident knowing wound care should only be performed by a properly licensed agency staff. Refer to deficiency 621 for additional information.

EI#1 did not oversee the fire safety procedures

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A 303	Continued From page 14	A 303		

and documentation to ensure fire drills were performed correctly every month. Refer to deficiency 1101 for additional information.

On the morning of February 3, 2022, the surveyors conducted a telephone interview with EI#1 to discuss her (EI#1) role as the administrator. EI#1 said she (EI#1) was hired as the Associate Executive Director (AED) on March 1, 2021. As the AED she (EI#1) coordinates and manages the financial operations for the facility. In June 2021, EI#1 told the surveyors she (EI#1) agreed to place her administrator license on the wall because the Executive Director (EI#2) did not have one. EI#1 explained she (EI#1) had been serving as the acting administrator, as well as the AED, for the last seven (7) months. EI#1 said she (EI#1) was not given the opportunity or time to function as the administrator. EI#1 said she (EI#1) was not surprised of the survey findings and was expecting to see some problems because of the changes.

EI#1 was asked to explain how she (EI#1) oversees the facility as the administrator. EI#1 said she (EI#1) makes daily rounds and communicates with the staff and residents. EI#1 said she (EI#1) reports her findings to EI#2 by telephone or in stand up meetings every other day.

The surveyor asked if EI#4 was given sufficient time to perform her (EI#4) duties. EI#1 said EI#4 was hired as the Memory Care Coordinator in August 2021, and transitioned to the Resident Care Coordinator position in October 2021. The facility hired someone to help EI#4 but they didn't stay. EI#1 said they (EI#1 and EI#4) have been looking through applications trying to find someone to help EI#4. EI#1 said EI#4 was

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A 303	Continued From page 15 implementing and updating the care plans and assessments for both the ALF and SCALF, and had been doing the best she (EI#4) could to catch up. EI#1 told the surveyors EI#4 was supposed to be trained on how to do care plans, monthly assessments and medication awareness testing by the corporate nurse (EI#3). However, EI#1 said she didn't believe EI#4 received the training she (EI#4) needed. EI#1 stated she (EI#1) was not aware resident monthly assessments were not documented in June 2021, and July 2021. EI#1 said she thought those had been done by EI#3. EI#1 told the surveyor they (EI#1 and EI#4) had walked into a mess and they were trying to clean it up and move forward.	A 303		
A 305	420-5-4-.03 (2) (c) Administration. (c) Department Notification. 1. The licensee of an assisted living facility shall provide written notification of voluntary closure of the facility to the State Board of Health at least 30 days prior to the expected closure date. 2. The State Board of Health shall be provided written notification not later than 15 days after any change in administrator. 3. The State Board of Health shall be provided written notification not later than 15 days after any change in management company. This Rule is not met as evidenced by:	A 305		

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A 305	Continued From page 16 Based on record review and interview, the facility failed to provide written notification of change in administrator to the State Board of Health (SBOH). Findings: On January 4, 2022, EI#1 informed surveyors she (EI#1) was the current administrator at the facility and had been administrator since June 1, 2021. On January 6, 2022, EI#2, Vice President of Operations, confirmed EI#1 was the current administrator at the facility. Discussion with SBOH staff and review of SBOH records revealed no written notification of change in administrator had been received by the SBOH. EI#1 stated he (EI#1) became more involved with the facility in August 2021 and was unsure why there was no written notification to the SBOH when the administrator change occurred.	A 305		
A 402	420-5-4-.04 (3) Personnel. (3) Employee Screening. (a) Prior to any resident contact, such as but not limited to assistance with activities of daily living, newly employed personnel shall have a physical examination certifying that the employee is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to residents through normal staff to resident contact. Employees who develop signs or symptoms of infectious skin lesions or diseases that would be capable of transmission to residents through normal staff to resident contact shall not be permitted to have resident contact until free from such signs and symptoms.	A 402		

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A 402	Continued From page 17 (b) Not more than 30 days prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis. (c) Vaccines. Assisted living facilities shall immunize employees in accordance with current recommended Centers for Disease Control and Prevention (CDC) guidelines (www.cdc.gov/vaccines). Any particular vaccination requirement may be waived or delayed by the State Health Officer in the event of a vaccine shortage. (d) An assisted living facility shall not 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, potential employees were not screened for abuse as required. Findings: Review of employee files on January 5, 2022 revealed EI#1 and EI#4 were not screened through the Alabama Department of Public Health Nurse Aide Abuse Registry prior to hire as required. EI#1 was hired on March 1, 2021 and was screened for abuse on March 4, 2021. EI#4 was hired on August 6, 2021 and was not screened for abuse until August 18, 2021. EI#1 was unable to provide documentation of timely abuse screenings for these employees.	A 402		

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A 403	Continued From page 18	A 403		
A 403	420-5-4-.04 (4) Personnel. (4) Personnel Records. An assisted living facility shall maintain a personnel record for each employee. This record shall contain: (a) An application for employment which contains information regarding the employee's education, training, and experience. (b) Verification of current certification or licensure, if applicable. (c) Record of required physical examinations and vaccinations. (d) Verification the facility has not hired an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry. (e) Date of hire. (f) Date of initial resident contact. (g) Date employment ceased. This Rule is not met as evidenced by: Based on record review and interview, employees' personnel records did not contain required information to include date of initial resident contact. Findings: Review of employee files on January 5, 2022 revealed three of three files (EI#1, EI#4 and EI#15) did not contain the date of the employee's	A 403		

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A 403	Continued From page 19 initial resident contact. EI#1 agreed the required information had not been documented in the files.	A 403		
A 405	420-5-4-.04 (6) Personnel. (6) 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. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained in the facility. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on 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 405		

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A 405	Continued From page 20 8. Protecting resident confidentiality. 9. Resident fire and environment safety. 10. Special needs of the elderly, mentally ill, and mentally retarded. 11. Safety and nutritional needs of the elderly. 12. Identifying signs and symptoms of dementia. (b) Cardiopulmonary Resuscitation. An assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of an assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within 90 days of hire. An assisted living facility equipped with an automated external defibrillator (AED) shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or American Red Cross in CPR or AED utilization. (c) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training.	A 405		

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A 405	Continued From page 21 (d) 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 review and interview, staff were not trained in special needs of residents with diabetes and hospice. Findings: Review of employee files on January 5, 2022 revealed three of three employees (EI#1, EI#4 and EI#15) did not receive training in diabetes and hospice. The facility had at least (2) residents with a diagnosis of diabetes mellitus and one (1) resident who was receiving hospice services. EI#1 agreed diabetic and hospice training had not been completed as required.	A 405		
A 503	420-5-4-.05 (3) (a) (b) (c) Records and Reports. (3) Resident Records. (a) Records shall be current from the time of admission to the time of discharge or death and shall be retained in the facility for at least three years after a resident's death or discharge. (b) When an individual is admitted to an assisted living facility, records and information regarding the resident shall be protected from unauthorized disclosure. Employees and authorized agents of the Department shall be	A 503		

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

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

1. Statement of resident rights signed by the resident.

2. Financial agreement.

3. Inventory of personal effects.

4. Admission record.

5. Incident investigations and reports involving the resident.

In addition to the above documents, the facility shall also maintain on its premises any Advance Directive or Portable Physician Do Not Attempt Resuscitation (DNAR) Order that has been

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A 503	Continued From page 23 executed by the resident. NOTE: Under no circumstances shall the facility require or refuse to allow a resident to execute an Advance Directive or Portable Physician DNAR Order. Advance Directives shall be typewritten or legibly written in ink and may include the appointment of a health care proxy consistent with the specific language in the Natural Death Act (Code of Alabama 22-8A-1 et. seq). A Portable Physician DNAR Order shall follow the rule and form found in the Alabama Administrative Code 420-5-19 Appendix II. These records shall be protected from unauthorized disclosure. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to produce a complete record for a discharged resident. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: On January 6, 2022, the surveyor reviewed Resident Identifier (RI)#10's record to investigate a complaint reported to ADPH on November 4, 2021. RI#10 was admitted on October 1, 2021 and discharged to another facility on November 16, 2021. The family member alleged RI#10 had gone without his/her memory and anxiety medications during his/her stay at the facility. The record presented to the surveyor did not contain the Medication Administration Records (MAR). EI#4, RN, informed the surveyor she (EI#4) was unable to retrieve the MAR once a resident was discharged because the electronic MAR system (QMAR) does not give the option to print. The	A 503		

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A 503	Continued From page 24 surveyor informed EI#1 and EI#4 this was needed to determine compliance with the rules. Both verbalized understanding.	A 503		
A 504	420-5-4-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate. 1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility. 2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints. 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	A 504		

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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.

10. Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within

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A 504	Continued From page 26 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. 14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform	A 504		

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A 504	Continued From page 27 such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the facility, provided that: (i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care. (ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation; and (iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time without recourse. 15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges. 16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing 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	A 504		

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A 504	Continued From page 28 Complaint Hotline and the Department of Human Resources toll-free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area. 18. All state inspection reports and any resulting corrective action plan from the past 24 months shall be posted in a prominent location. If there has been no inspection in the past 24 months, then the results of the most recent inspection and any resulting corrective action plan shall be posted. 19. Every resident shall have the right to 30 days prior written notice to both resident and sponsor of any increase of fees or charges. 20. Every resident shall have the right to 30 days prior written notice of any involuntary change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. 21. Every resident shall have the right to wear his or her own clothes, to keep and use his or her own personal possessions including toilet articles except for personal possessions too large to be stored in the resident's room. 22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings. 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours and to freely come and go from the home.	A 504		

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A 504	Continued From page 29 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, interviews and record reviews, the facility failed to provide a safe environment for residents at all times. The facility also failed to follow recommended community standards of care for residents by failure to follow Centers for Disease Control (CDC) guidelines for use of personal protective equipment (PPE) when a resident had a confirmed COVID-19 infection, and by failure to consistently provide medications to residents. Findings: Safe and Decent Environment/Community Standards of Care/Medication Administration Review of residents' MARs on January 5, 2022, revealed medications had not been administered to residents due to refusal of the medications by the resident or medications not available from the pharmacy. The omitted doses included, antihypertensive medications, nerve pain medications, and gastric reflux medications. In addition, two (2) residents were receiving oxygen without confirmation of the correct flow rate. EI#4 verbalized understanding of the importance of blood pressure medication being given daily as ordered. This deficient practice placed the	A 504		

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A 504	Continued From page 30	A 504		

residents at risk of harm due to not consistently receiving medications necessary to treat and control their medical conditions. Refer to deficiency 601 for additional information on these omitted medication doses.

Safe and Decent Environment/Community Standards of Care/Isolation Procedures

CDC recommendations for the use of PPE when a resident has a confirmed COVID-19 infection include use of a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves and eye protection such as goggles or a face shield that covers the front and sides of the face. On the morning of January 4, 2022, the surveyor observed EI#7, Licensed Practical Nurse (LPN), entering a resident's room (RI#5) wearing an N95 mask, disposable gown, and gloves, but did not wear eye protection. EI#7 informed the surveyor the facility had two (2) residents (RI#5 and RI#6) isolating within their rooms after recently testing positive for COVID-19. However, there was no signage posted to alert staff to wear the appropriate PPE prior to entering the resident's rooms nor were there bio hazardous bins for disposal of contaminated PPE when leaving the room. EI#7 informed the surveyor the PPE was stored on the unit at the desk. The PPE was not immediately available outside the residents rooms. On January 4, 2022, EI#4 was interviewed about the positive COVID-19 cases and stated all staff had been trained to use PPE and should be using the PPE that was placed on the unit. EI#4 told the surveyor she (EI#4) had already ordered carts and bins and was waiting for them to be delivered. The afternoon of January 5, 2022, the surveyor observed signage, isolation carts stocked with PPE, and bio hazardous bins in the immediate area of the two (2) residents infected

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A 504	Continued From page 31 with COVID-19. The failure to use proper precautions at the earliest onset to prevent the spread of COVID-19 created an unsafe environment for all residents, staff and visitors at the facility.	A 504		
A 508	420.5.4-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in an 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 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	A 508		

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A 508	Continued From page 32 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 of 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	A 508		

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A 508	Continued From page 33 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 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.	A 508		

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A 508	Continued From page 34 (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 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.	A 508		

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A 508	Continued From page 35 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 as defined in these rules. (ii) Elopement by a resident. (iii) Suspected, alleged, confessed, or witnessed abuse, neglect, or exploitation 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. 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.	A 508		

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A 508	Continued From page 36 (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 of the Alabama Administrative Code Sec. 420-4-1-.04. shall 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 3 years. (x) Any indication of malfunction of the sprinkler system, or fire alarm system. 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.	A 508		

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A 508	Continued From page 37 (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. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to report an outbreak of a contagious disease to the Department's Online Incident Reporting System (OIRS) within 24 hours of the diagnosis (Code 420-4-1-.04). In addition, the facility failed to report a medication error to the OIRS within 24 hours of the incident Findings: Incidents Not Reported/COVID-19 Outbreak A review of the OIRS on January 3, 2022, by surveyors revealed no positive cases of COVID-19 had been reported by the facility. However, upon arrival to the facility on January 4, 2022, the surveyors observed a sign posted "No Visitors" for the next 10 days (January 1-11, 2022) posted at the front entrance. The concierge informed the surveyors that visitors were being restricted due to multiple cases of COVID-19 in the building. Upon arrival to the ALF unit, the surveyor was informed by EI#7, LPN, there were two (2) residents (RI#5 and RI#6) currently in	A 508		

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A 508	Continued From page 38 isolation and one (1) resident (RI#2) in the hospital with a COVID diagnosis. Later during the survey, EI#4, RN, provided the surveyor with a list of residents in the ALF who had tested positive for COVID-19. The first positive case was RI#2 on December 31, 2021. EI#4 explained to the surveyors she (EI#4) was working with the state infection control division to get the positive cases reported but admitted she (EI#4) was not aware she (EI#4) was supposed to report the positive cases to the ALF OIRS. Incident Reported Late/RI#8 On October 24, 2021, EI#4, RN, reported a medication error to ADPH (Intake ID: 20211024007), which had occurred four (4) days earlier. On October, 20, 2021, RI#8 became over-sedated when two (2) Fentanyl patches had inadvertently been applied by a med tech. The Emergency Medical Service (EMS) system was activated and RI#8 was taken to the emergency department for treatment. During an interview on January 5, 2022, EI#4 stated the medication error was reported late because she (EI#4) waited until she (EI#4) returned to work to submit the incident report. The surveyors reinforced the importance of reporting any incident within the 24 hour timeframe with EI#1 and EI#4. Both agreed to comply in the future.	A 508		
A 601	420-5-4-.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	A 601		

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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 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 another emergency call).

(b) Back-up Physician Support. Each 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 an 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

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A 601	Continued From page 40 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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure all residents received medications and oxygen as prescribed by the physician. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received two (2) anonymous complaints which alleged residents had gone without their medications (November 4, 2021) and medications were not administered correctly (October 25, 2021). The complainants also reported the facility informed them (complainants) the problems had occurred due to the attending physician or the pharmacy's failure to respond to their request for medication refills. On January 5, 2022, the surveyors interviewed EI#4 regarding the complainants allegations. EI#4 said she (EI#4) was aware medications were not being given as ordered.. EI#4 stated, when residents were out of medications, she (EI#4) or the staff would request refills from the physician. However, the medications could not be obtained from the pharmacy until a new order was obtained from the physician. EI#4 said she (EI#4) has made repeated attempts to obtain refills by calling and	A 601		

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faxing the physician which sometimes takes several days before the physician responded to a request for a new prescription. Faxed request for refills to the physician were noted in some residents' records. EI#4 verbalized understanding it is unsafe for residents to go without their medications. The surveyors brought EI#4's concerns to the attention of EI#2 on January 6, 2022, during a telephone interview. EI#2 concurred this has been an ongoing concern with the attending physician and he (EI#2) was looking for a solution.

The following deficiencies were found during the record review.

RI#1 was admitted to the facility on July, 12, 2021, with diagnosis to include, arthritis and neuropathy due to Lyme disease, macular degeneration, depression, hypertension, cervicalgia and urge incontinence. RI#1 was a recent admit to hospice and was in the later stages of brain and lung cancer. R#1 was observed receiving oxygen at 3 liters per minute (LPM), however, there was not a physician's order on file. EI#4 informed the surveyor RI#1 was receiving comfort measures and the oxygen was started by hospice, but did not provide the oxygen order during the survey. Refer to deficiency 618 for additional information. Review of the December 2021 MAR, revealed ten (10) doses of amlodipine besylate (Norvasc) 5 mg daily for hypertension was not administered due to "AWAITING PHARMACY TO DELIVER" (Dec. 13 and 14), "PHYSICALLY UNABLE TO TAKE" (Dec. 15) and "REFUSED TO TAKE" (Dec. 20, 24, 26, 27, 28, 29, and 30). On January 6, 2022, when asked if the physician was notified when residents refused medications, EI#4 stated the nurse would usually notify the physician if the

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A 601	Continued From page 42	A 601		

medications was refused for several doses. No documentation was present to indicate RI#1's physician was notified of the multiple doses of Norvasc not being given.

RI#3 had been a resident since October, 20, 2021, and had been diagnosed with the following conditions, hypertension (HTN), osteoarthritis, hyperlipidemia, benign prostatic hyperplasia (BPH), and gastroesophageal reflux disease (GERD). The surveyor observed medication assistance the morning of January 4, 2022 with EI#7, LPN. During medication reconciliation on January 6, 2022, the surveyor found medications were not given as ordered during the month of December 2021, because the medications had not been delivered by the pharmacy ("AWAITING PHARMACY DELIVERY"). RI#3 did not receive Gabapentin 400 mg capsule three times a day (8 AM, 1 PM, and 6 PM) on December 1, 2, and 3 for nerve pain. Terazosin 5 mg at bedtime (9 PM) on December 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10, for treatment of HTN and BPH. In addition, RI#3 did not receive five (5) vitamins or supplements from December 2, 3. 4. 5, 6, and 7. On January 6, 2022, EI#4, acknowledged the Gabapentin was not given because they could not get in touch with the primary care provider (PCP). EI#4 informed the surveyor a seven (7) day supply was provided by the pharmacy until a refill could be obtained from the physician.

RI#8 was admitted on May 17, 2021 with the following diagnoses; chronic obstructive pulmonary disease (COPD), asthma, neuropathy, osteoarthritis, fibromyalgia, hypothyroidism, depression, anxiety, restless leg syndrome, insomnia, hypertension, and GERD. The surveyor and EI#7 visited with RI#8 on the morning of January 4, 2022 in her/his room. RI#8 was up in

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A 601	Continued From page 43 room and receiving oxygen at 2.5 LPM via nasal cannula. During the visit EI#7 and RI#8 did not know what the oxygen flow rate was to be set on the concentrator. The record was reviewed on January 5, 2022, but there was not a physician's order for oxygen. This was also confirmed by EI#4 on January 6, 2022. Refer to deficiency 618 for additional information. During pre-survey preparation the surveyor reviewed a serious medication error (Intake ID: 20211024007) reported to ADPH on October 24, 2021. Refer to deficiency 508 for additional information. EI#4, RN, reported a medication error occurred when EI#11, MT, applied a new Fentanyl 75 MCG patch without removing the older Fentanyl 75 MCG patch, which resulted in over sedation. RI#8 had to be transported by EMS to the hospital due to unresponsiveness and abnormal vital signs. On January 5, 2022, in an interview regarding the incident EI#11 explained she (EI#11) was not aware there was another patch on RI#8's back. RI#8's GERD was being treated by the physician with sucralfate 1 GM/10 ML suspension four (4) times daily before meals and at bedtime, however, it was only given as ordered on December 1, 2, and 31. The sucralfate was documented as not given on the MAR for the other days of the December due to, "AWAITING PHARMACY DELIVERY" or "RESIDENT REFUSED." There was no documentation the physician had been notified of the extended unavailability or refusal of medication..	A 601		
A 602	420-5-4-.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	A 602		

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A 602	Continued From page 44	A 602		

resident to an assisted living facility, the resident or prospective resident shall be examined by a physician. For purposes of the initial physical examination only, a currently licensed physician 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. In addition to any information otherwise required by the facility's policies and procedures, and in addition to any other information the physician recommends or believes is pertinent, the initial physical examination record shall contain the following:

1. All of the physician's diagnoses, and the resident's baseline weight and vital signs.

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

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A 602	Continued From page 45 addition to any information deemed necessary, pertinent, or recommended by the resident's attending physician, the annual physical examination shall contain the following: 1. The resident's weight and vital signs. 2. Changes in diagnoses. 3. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration). 4. Changes in treatment. (c) Change of Condition Physician Examinations. Changes in the resident's condition that require a physician examination and result in a change in diagnoses, 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. New 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.	A 602		

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This Rule is not met as evidenced by:
Based on record reviews and interview, the residents' Initial Medical Examinations did not contain all the required information.

Findings:

RI#1 was admitted to the facility on July 12, 2021 and the initial Medical Exam/Plan of Care was completed by the physician on July 8, 2021. The baseline weight had not been recorded nor was there supporting documentation RI#1 had been evaluated for tuberculosis (TB) within the previous 12 months.

RI#2 had a documented admission date of June 30, 2021, however, the initial Medical Exam/ Plan of Care was not dated until the next day on July 1, 2021. The physician failed to sign the medical exam, provide a statement RI#2 was free from infectious diseases, record the baseline weight, or specify a diet order. The chest x-ray to screen for pulmonary tuberculosis was completed the day after admission on July 1, 2021.

RI#4 was admitted the facility on March 24, 2021. The initial Medical Exam received by fax on March 23, 2021, did not include a baseline weight..

RI#5 was admitted on March 28, 2021, and the initial Medical Exam was dated the same. A baseline weight had not been recorded.

RI#8 had a documented admission date of May 17, 2021. The chest x-ray to evaluate for the presence of TB was not done until a day after

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A 602	Continued From page 47 admission on May 18, 2021. On January 6, 2022, the surveyor discussed the above deficiencies with EI#4. EI#4 agreed the required information was not documented or available in the medical records.	A 602		
A 604	420-5-4-.06 (3) (a) (b) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility shall assess prospective residents for facility eligibility. This assessment shall document identified care needs and serve as a baseline for future assessments. (b) Monthly Assessments. The facility shall assess each resident monthly and more often when necessary to identify changes in resident's status. In addition to other items that may be required by the facility's own policies and procedures, the monthly assessment shall: 1. Assess the resident's ability to safely self-manage medications or safely self-administer medications with assistance. 2. Accurately weigh and record the weight of each resident. A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half or greater weight loss in a period of three months or less, or a ten percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight,	A 604		

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A 604	Continued From page 48 and such diet has been approved by the resident's attending physician. 3. Document identified changes in resident status. 4. Assess the appropriateness of each resident's plan of care. Any decline in resident status requires immediate implementation and documentation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to complete monthly assessments for all residents, assess the resident's ability to safely self administer medications with assistance, weigh and record the weight of each resident monthly. Findings: Monthly Assessments: During record reviews on January 6, 2022, the surveyor discovered the monthly assessments had not been completed for the residents during the months of June and July of 2021. The surveyor discussed the lack of health supervision with EI#2 and EI#4. EI#4 informed the surveyor she (EI#4) was not hired as the Director of Resident Care until August 2021. EI#2 stated the previous Director of Resident Care was responsible for the monthly assessments but did not perform her job as she should have.	A 604		

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A 604	Continued From page 49 In addition to the June 2021 and July 2021 monthly assessments not being done as noted above the following residents were not assessed monthly. RI#2 was not assessed September 2021, November 2021, and December 2021. RI#4 was not assessed for October 2021, November 2021, and December 2021. RI#5 was not assessed for August 2021 and September 2021. RI#9 was not assessed August 2021. Monthly Medication Awareness: During an interview with EI#4 on January 4, 2022, the surveyor inquired how the residents were assessed monthly to determine their ability to safely self administer their medications. EI#4 informed the surveyor she (EI#4) was not aware this was to be done monthly. Monthly Weights: During review of the monthly weights the surveyor found the following residents did not have weights recorded for several months in a row: RI#1 - September - December 2021 RI#2 - July - December 2021 RI#4 - April - July 2021, September - December 2021 RI#5 - April 2021, June - November 2021 RI#6 - November - December 2021 RI#9 - June - August 2021 On January 6, 2022, EI#4, Resident Care Director, acknowledged the residents should be weighed every month and the results recorded.	A 604		

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A 611	Continued From page 50	A 611		
A 611	420-5-4-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall be based on the initial medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be reviewed and updated based on the annual examination, and all other physician examinations, diagnoses, and recommendations of the resident's treating physician, and the resident's monthly assessments. The plan of care shall be developed and updated in cooperation with the resident and, if appropriate, the sponsor. All entries on the plan of care shall be accurately dated. 1. The plan shall at all times reflect the current condition of the resident and document the personal care and services required from the facility by the resident. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following: 2. A listing of the resident's individual needs or problems that require intervention by the facility.	A 611		

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A 611	Continued From page 51 3. A listing of interventions provided by the facility to address the resident's identified needs or problems. 4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider. 5. Activities of Daily Living. Residents of assisted living facilities shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident. (i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested. (ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips. (iii) Hair. Resident's hair shall be kept clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be	A 611		

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A 611	Continued From page 52 provided assistance with personal safety. 6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, residents' care plans were not current and did not contain interventions to meet the care needs of the residents. Findings: RI#1 had been residing at the facility since July 12, 2021, with diagnoses to include, arthritis and neuropathy due to Lyme disease, macular degeneration, depression, hypertension, cervicalgia and urge incontinence. RI#1 was a recent admit to hospice services in December 2021, with a terminal diagnosis of brain and lung cancer. During interviews with staff the surveyor learned RI#1's health had declined quickly. The morning of January 4, 2022, the surveyor observed RI#1's death to be imminent. RI#1 was pale, thin, and could not respond verbally. RI#1 had labored respirations and was using oxygen. On January 5, 2022, the surveyor was told by the sitter RI#1 was only taking sips of water through a straw and only able to swallow a few spoonfuls of applesauce. The surveyor conducted a body audit when the sitter and EI#16, Care Partner, performed incontinent care. RI#1 had an area of redness (approximately 3 cm) with a purple center on the left hip due to a pressure injury.	A 611		

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A 611	Continued From page 53 EI#16 told the surveyor she (EI#16) was turning RI#1 every 2 hours and supporting her/him with pillows. RI#1 expired the afternoon of January 6, 2022, with the sitter at the bedside. RI#1's care plan was dated, "As of 1/4/2022", however, it did not address RI#1's end of life needs and her/his current condition. There were no interventions for pain management, how to maintain skin integrity or nutritional needs. The care plan did not reflect RI#1 was bedridden and required total care with bathing, toileting, dressing and eating. Refer to deficiencies 601, 615, and 618 for additional information on RI#1. RI#2 was admitted to the facility on June 30, 2021. The Resident Medical Exam/Plan of Care dated July 1, 2021, listed the following diagnoses, rheumatoid arthritis, GERD, hypothyroidism, abnormal gait, hearing impaired, history of cerebrovascular accident (CVA) and myocardial infarction (MI), however, none of these pertinent diagnosis were listed on the care plan with interventions for the care partners to observe or monitor. RI#4 was admitted to the facility on March 24, 2021, with the following diagnoses, age related physical debility, anxiety, stage 3 chronic kidney disease, hypertension, bladder prolapsed, cough and reflux. During an interview with EI#1 and EI#4 on January 4, 2022, the surveyor was told RI#4's behaviors were difficult to control and a meeting was planned with the family to discuss a discharge from the facility. According to the monthly assessment documentation on March 25, 2021, the behaviors were noted shortly after admission. The surveyor was introduced to RI#4 by EI#7, LPN, but RI#4 was not interested in having a visitor in her/his room. RI#4 was being seen by behavioral health services and RI#4 was	A 611		

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noted by the nurse practitioner to have depression and delusional disorder on December 1, 2021. The care plan did list behaviors, such as cursing, derogatory speech and throwing things, but there were no interventions included to guide the care partners in managing the behaviors.

RI#5 had resided at the facility since March, 28, 2021. The diagnoses listed on the initial Resident Medical Exam Plan of Care were insomnia, dementia, GERD, hypertension, back pain, and peripheral edema. RI# 5 tested positive for COVID-19 on January 3, 2022, and was being quarantined in her/his room. EI#4 documented in the October 2021 and November 2021 monthly assessments RI#5 was wandering the halls at 2:30 AM, showing signs of confusion, and feels like someone was watching her/him at night. RI#5's facility care plan did not address any of these issues and care needs.

RI#6 had been a resident at the facility since October, 21, 2021. The physician listed the diagnoses on the admission Resident Medical Exam to be a femur fracture, hypertension, heart failure, hyperlipidemia, COPD, major depression disorder, and constipation. RI# 6 tested positive for COVID-19 on January 2, 2022, and was being quarantined in her/his room. The care plan did not list any of these as needs or problems that would require intervention by the staff. The care plan did address the level of assistance needed with transferring (2-person), however, the assistance needed with bathing and grooming were not included on the care plan.

RI#7 had resided at the facility since December 2, 2020. RI#7 was receiving wound care to the left leg and right foot. Refer to deficiency 621 for additional information. EI#4 identified bilateral

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A 611	Continued From page 55	A 611		

lower extremity edema on the monthly assessments October 2021, November 2021, and December 2021, which was being treated with a diuretic (Lasix), however, EI#4 did not mention any of these needs or problems on the care plan.

RI#8 was admitted to the facility on May 17, 2021. RI#8 has a significant medical history of COPD and asthma and requires oxygen. Refer to deficiencies 601 and 618 for additional information. On October 18, 2021, RI#8 was treated at the local emergency department for an exacerbation of COPD. RI#8 was hospitalized on October 21, 2021, as a result of a medication error (over sedation). Refer to deficiency 508 for additional information. RI#8 had a fall reported to the physician on December 1, 2021, which resulted in bruising and swelling of the left arm. In the monthly assessments for November 2021 and December 2021, EI#4 noted a weight loss and received an order for Boost. EI#4 also documented RI#8 refuses the Boost because it makes her/him sick. The care plan did not list any of the problems or provide appropriate interventions.

Residents' care plans were not individualized to the specific needs of each resident. The care plans were not updated when significant changes or hospitalizations occurred. They did not contain medical conditions and signs/symptoms to monitor the residents for. The type of diet each resident required was not written on the care plan. The activities of daily living were not fully addressed on each care plan.

On January 6, 2022, EI#4 acknowledged the "Visual/Bedside Individual Service Plan Reports" ("As of 1/4/2022"), presented to the surveyor did

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(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 56 not adequately address the personal care and services required for each resident.	A 611		
A 615	420-5-4-.06 (7) (j) Care of Residents. (j) All medications administered to residents and all medications self-administered with assistance of facility staff in an assisted living facility shall be contemporaneously recorded on a standard medication administration or medication assistance record. "Contemporaneously recorded" means recorded at the same time or immediately after medications are administered. The medication administration or medication assistance record shall include at least the following: 1. The name of the resident to whom the medication was administered or assisted. 2. The name of the medication administered or assisted. 3. The dosage of the medication administered or assisted. 4. The method of administration or assistance. 5. The site of injection or application, if the medication was injected or applied. 6. The date and time of the medication administration or assistance. 7. Any adverse reaction to the medication. 8. The printed name, initials, and written	A 615		

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A 615	Continued From page 57 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 observation, record review, and interview, the facility failed to properly document on a resident's Medication Administration Record (MAR). Findings: RI#1 had an order written on December 30, 2021, for one Fentanyl 25 MCG/HR patch to be applied to a clean, dry site every 72 hours, and to rotate sites. On January 5 2022 at 7:30 AM, the surveyor observed EI#8, LPN, apply a Fentanyl patch to RI#1's right upper back (RUB). The January 2022 MAR was reviewed and the body location site was not recorded on the MAR. EI#4 explained this was a new order for RI#1 and had not been added to the MAR yet.	A 615		
A 616	420-5-4-.06 (7) (k) (l) (m) (n) (o) Care of Residents. (k) Medications kept under the control or custody of an assisted living facility shall be packaged by the pharmacy and shall be maintained by the facility in unit dose packaging. Medications kept under the control or custody of an assisted living facility that are not available in unit dose packaging must be packaged by the pharmacy and administered by a physician, RN, or LPN or self-administered with assistance under the total control and direction of the resident.	A 616		

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A 616	Continued From page 58 (l) Unless a resident can and does self-manage his or her own medications, an assisted living facility shall require each resident to use a single pharmacy. This does not apply to emergency pharmacy services. All residents need not use the same pharmacy that is used by other residents unless express policy of the assisted living facility provides otherwise and all residents are informed of such policy and provided a copy of such policy prior to or at the time of admission. The assisted living facility shall require pharmacies used for medication supply for residents not self-managing their medications to review all ordered medication regimens for possible errors or adverse drug interactions and to advise the facility and the prescribing health care provider when these are detected. (m) If controlled substances prescribed for residents of any assisted living facility are kept in the custody of the assisted living facility, they shall be stored in a manner that is compliant with state and federal laws, the requirements of the Alabama State Board of Pharmacy, and any requirements prescribed by the State Board of Health. At a minimum, controlled substances in the custody of the facility shall be stored using a double lock system, under proper temperature and humidity controls and permit only authorized personnel access. The facility shall maintain a system to account for all controlled substances in its possession. All other medications in the custody of the facility shall be stored using at least a single lock, under proper temperature and humidity controls and permit only authorized personnel access. This shall include medications stored in a resident's room when the staff and not the resident have access to the medications.	A 616		

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A 616	Continued From page 59 Medications may be kept in the custody of an individual resident who can safely manage his or her medications. Such medications may be stored in a locked container accessible only to the resident and staff, or may be stored and secured in the resident's living quarters, if the room is single occupancy and has a locking entrance. (n) Medication administration or medication assistance records and written physician orders for all over-the-counter drugs, legend drugs, and controlled substances shall be retained for a period of not less than three years. They shall be made available for inspection at reasonable times by residents, anyone authorized by the resident, and by the sponsors of residents. (o) Labeling of Drugs and Medicines. All containers of prescribed medicines and drugs shall be labeled in accordance with the rules of the Alabama State Board of Pharmacy and shall include appropriate cautionary labels, such as, "Shake Well," or "For External Use Only." This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain and follow a system to accurately account for all controlled substances in its possession. Findings: The surveyor observed medication carts located on the first, second, and third floors of the facility. Controlled drugs (narcotics) were double locked in the medication carts. On January 4, 2022 at 3:05 PM, the surveyor observed med techs EI#9	A 616		

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A 616	Continued From page 60 and EI#10 conduct a count of controlled drugs at change of shift on the second and third floors. The surveyor reviewed the "NARCOTIC SIGN IN/OUT SHEET" for December 2021 and January 2022 and found the on coming staff and off going staff did not always sign the sheet to indicate the count was performed or correct. EI#10 explained to the surveyor they did the count but she (EI#10) forgot to get a sheet for yesterday (January 3, 2022). The surveyor also reviewed a Medication/Storage/Cart Audit conducted by the pharmacy on December 30, 2021. The pharmacy reviewer documented there were "40 omissions on shift to shift change log." At the time of the audit, the pharmacy reviewer discussed the findings with EI#4, and EI#8, LPN. On January 5, 2022, the surveyor discussed the above findings with EI#4. EI#4 acknowledged the staff had failed to count and record their signatures as required to verify the controlled substance count was correct. EI#4 stated she (EI#4) had recently instructed the staff to always count controlled substances with a second person each time before their shift was over.	A 616		
A 618	420-5-4-.06 (9) Care of Residents. (9) Oxygen Therapy. (a) A resident of an assisted living facility that requires oxygen therapy shall self-manage his or her own oxygen therapy or self-administer his or her own oxygen therapy with assistance of facility staff. A resident that cannot safely self-manage or self-administer his or her own oxygen therapy with assistance shall have oxygen administered only by a physician, RN, or LPN. A resident that cannot direct his or her	A 618		

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A 618	Continued From page 61 administration of oxygen and cannot be taught to direct his or her administration of oxygen shall be appropriately discharged. (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 unless oxygen therapy is self-managed by the resident. (c) If a resident receives oxygen therapy in a facility: 1. All oxygen equipment, such as tubing, masks, and nasal cannula shall be maintained in a safe and sanitary condition. 2. All oxygen tanks shall be safely maintained and stored. 3. The facility shall require safe use of oxygen therapy. No smoking and appropriate precautionary signs shall be posted. 4. 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, interview, and record reviews, the facility failed to ensure all residents could safely self-manage their own oxygen therapy. In addition, the facility staff did not document the date, time, rate, and proper function of the equipment on the Medication	A 618		

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A 618	Continued From page 62 Administration Record (MAR) at least once per shift. Findings: RI#1 was receiving hospice services due to a terminal diagnosis of brain and lung cancer. On January 4, 2022, the surveyor observed RI#1 in bed moaning and she/he did not respond verbally. The surveyor also noted RI#1's death to be imminent. RI#1 was receiving oxygen at 3 liters per minute (LPM) via nasal cannula. The December 2021 and January 2022 MAR did not include the oxygen on the MAR. EI#4 acknowledged RI#1 could not direct her/his care. RI#8 had a medical history of chronic obstructive pulmonary disease (COPD) and was observed the morning of January 4, 2022, receiving oxygen at 2.5 LPM via nasal cannula. The surveyor asked RI#8 how much oxygen she/he was supposed to get and RI#8 replied "I think it's 20." The surveyor asked EI#7, LPN, how many liters of oxygen did the physician order for RI#8 and EI#7 said she (EI#7) was not sure. EI#7 went onto say RI#8 would move the oxygen setting when she/he had an anxiety attack. The surveyor reviewed RI#8's records, but there was not an order for oxygen administration. On January 6, 2022, EI#4 told the surveyor she (EI#4) was looking for the physician's order for oxygen, but could not find it. The surveyor was unable to determine if RI#8 was receiving the appropriate amount of oxygen. The December 2021 and January 2022 MAR did not include the oxygen on the MAR.	A 618		
A 621	420-5-4-.06 (11) (b) Care of Residents.	A 621		

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A 621	Continued From page 63 (b) Retention 1. An assisted living facility shall not allow any resident to return to the assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the facility is licensed to provide or the facility is capable of providing. 2. An assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility. 3. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in an assisted living facility. 4. An assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless: (i) The individual is capable of performing and does perform all tasks related to his or her own care; OR (ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity BUT the individual has sufficient cognitive ability to direct his or her own care AND the individual is able to direct others and does direct others to provide the physical assistance needed to complete such tasks, AND the facility staff is capable of providing such assistance and does provide such assistance. If the facility chooses to offer this assistance, the facility shall develop and	A 621		

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A 621	Continued From page 64 implement a policy and procedure to ensure safe practices by facility staff. 5. If a resident of an assisted living facility is diagnosed with a terminal illness other than dementia and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90 days. If the facility is unable or becomes unable to meet the needs of a resident receiving hospice care, or if a resident receiving hospice care requires care beyond what the facility may lawfully provide pursuant to this section, then the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for assisted living facilities. The facility would in all cases remain responsible for ensuring the appropriate delivery of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident. 6. All skilled services provided in the facility, such as but not limited to wound care or insertion of a urinary catheter, shall be provided by the staff of properly licensed or certified agencies. Skilled services shall not be delegated to facility staff. 7. Residents that develop acute infectious pulmonary disease, such as active tuberculosis, or other diseases capable of transmission to other individuals through normal person-to-person contact shall be immediately	A 621		

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A 621	Continued From page 65 transferred to an appropriate level of care until certified by a physician to be free of a contagious condition. 8. No assisted living facility shall be operated in whole or in part in a manner that prevents free and unhindered egress from the facility by any of its residents. 9. An assisted living facility shall not retain any resident who cannot safely reside in the facility unless his or her egress from the facility is restricted. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility retained a resident with unmanageable behaviors. In addition, the facility retained a resident that required wound care which was not being performed by a properly licensed agency. Findings: RI#4 was admitted to the facility on March 24, 2021, with the following diagnoses, age related physical debility, anxiety, stage 3 chronic kidney disease, hypertension, bladder prolapsed, cough, and reflux. During an interview with EI#1 and EI#4 on January 4, 2022, the surveyor was told RI#4's behaviors were difficult to control and a meeting was planned with the family to discuss a discharge from the facility. According to the monthly assessment documentation on March 25, 2021, the behaviors were noted shortly after admission. RI#4 had refused weights since admission, refused blood pressure checks, and monthly assessments for the last three (3) months. EI#1 and EI#4 were aware of the	A 621		

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A 621	Continued From page 66 behaviors, such as cursing, derogatory speech and throwing things, but had not issued a discharge notice. RI#7 was admitted to the facility on December 2, 2020, with diagnoses to include, heart disease, pulmonary hypertension, spinal stenosis, cardiac pacemaker, osteoarthritis, abdominal aortic aneurysm, and ataxia following cerebrovascular disease. The morning of January 4, 2022, EI#4 informed the surveyor RI#7 had wounds on the lower extremities in which home health had been recently treating. EI#4 explained RI#7's Medicare had termed three (3) days ago and the daughter was being allowed to reinforce the bandages until home health could be re-certified. EI#4 said she (EI#4) was aware this was not allowed and had notified EI#1 and EI#2. Later in the day on January 4, 2022, the surveyor visited with RI#7 in her/his room. RI#7 told the surveyor her/his daughter was a registered nurse and had come that morning to wrap her/his legs. The surveyor observed the lower extremities to be wrapped in ace bandages. RI#7 told the surveyor the home health nurses had been coming three (3) times a week to change the dressings, but could not come this week. At the request of the surveyor, EI#1 obtained a copy of the most recent Home Health Certification and Plan of Care. The certification period was January 3, 2022 to March 3, 2022. The home heath records documented the nurse would perform wound care on a left lower leg laceration and corns/callous right foot. On January 6, 2022, EI#1 informed the surveyor wound care was planned to resume by home health on January 8, 2022.	A 621		
A 703	420-5-4-.07 (3) Food Service.	A 703		

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A 703	Continued From page 67 (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 accommodate the resident's needs. (d) Alternate food selections or	A 703		

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A 703	Continued From page 68 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 interview the facility failed to ensure a sufficient quantity of potable water for all residents for 3 days. Findings: On January 4, 2022, at 1:40 PM, the surveyor toured the kitchen. The surveyor inspected the dry pantry and storage room where the emergency water was stored for the ALF and SCALF residents. The facility was short 49 gallons which was not enough water on site to meet the needs of the ALF and SCALF residents for three (3) days. EI#6, Food and Beverage Director, acknowledged this was not enough water and informed the surveyor on January 5, 2022, the facility had obtained a sufficient amount of water for the number of residents in the ALF and SCALF.	A 703		

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A1101	Continued From page 69	A1101		
A1101	420-5-4-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift of Group and Congregate facilities. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the currently adopted Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs. (d) Roller latches are prohibited on doors	A1101		

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(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
A1101	Continued From page 70 separating corridors from adjacent spaces. (e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that: 1. Minimizes leaks and spills. 2. Adequately protects against inappropriate access. 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.	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D5150	A. BUILDING: _____ B. WING _____	02/14/2022

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A1101	Continued From page 71 3. The fire alarm system and the sprinkler system shall be inspected by licensed, trained, and qualified personnel at least semiannually for compliance with the respective codes. Inspection and testing reports shall be maintained in the facility for a period of at least 3 years. This Rule is not met as evidenced by: Based on record reviews and interviews, fire drills were not performed monthly and quarterly on each shift. In addition, fire alarm and sprinkler inspections were not performed semiannually. Findings: Fire Drills Review of the facility's fire drill reports on January 4, 2022 revealed no fire drills were documented for the ALF during the following months of 2021: March, June, July, August, October and November. In addition, fire drills were not documented quarterly on each shift for any of the four quarters in 2021. During an interview on the afternoon of January 4, 2022, EI#5, Maintenance, stated he (EI#5) was responsible for monthly fire drills and alternated the monthly fire drills between the ALF and the specialty care assisted living facility (SCALF) in the same building. EI#5 stated he (EI#5) was not aware fire drills were to be performed in both ALF and SCALF each month. EI#5 added he (EI#5) would immediately begin performing separate fire drills for ALF and SCALF each month. Fire Alarm and Sprinkler System Inspections	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1101	Continued From page 72 Review of the facility's fire alarm and sprinkler system inspections on January 4, 2022 revealed only one inspection was documented for the year 2021 in the month of April 2021. During an interview on the afternoon of January 4, 2022, EI#5 confirmed the fire alarm and sprinkler inspections had only been performed one time for the year 2021 and no inspection had been performed since April 2021. On January 5, 2022, EI#5 informed the surveyor a fire alarm and sprinkler inspection had been scheduled and would be completed during the onsite survey. CONNIE CHERRY, REGISTERED NURSE DEBRA FREEMAN, REGISTERED NURSE	A1101		