STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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, a licensure survey and complaint investigation was conducted for this 32-bed Specialty Care Assisted Living Facility (SCALF) with a census of 16. There were two (2) complaints investigated during this survey. Complaint #20211027003 and Complaint #20211227011 were substantiated. Deficiencies were cited as a result of the complaint investigations. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practices resulted in the potential for harm to all residents.	A 000		
A 301	420-5-20-.03 (1) (a) (b) (c) (d) Administration. (1) The Specialty Care Assisted Living Facility Governing Authority. (a) A specialty care 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.	A 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 301	Continued From page 1 2. Each person or entity who has an ownership interest of 10 percent or more in the real property or building used by the specialty care 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	A 301		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 301	Continued From page 2	A 301		

the facility operated in compliance with the SBOH rules for SCALFs. The governing authority's lack of adequate oversight and the administrator's failure to perform her duties as administrator resulted in widespread deficient practices which placed all 16 residents of the facility at risk for harm due to this failure to apply the SBOH 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 approximately 7 months at the time of the survey. During an 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. In addition, 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 Registered Nurse (RN). 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 two complaints which were investigated and substantiated during the onsite survey. In addition, a complaint received for the assisted living facility (ALF) in the same building was investigated for the SCALF during the survey due to the facilities having the same ownership and management. The complaint involved residents not receiving medications and was also found to

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 301	Continued From page 3 be a deficient practice in the SCALF. EI#2 stated the facility was already addressing the problem for the ALF and had brought in the pharmacy to conduct audits, but the pharmacy had not begun audits of the SCALF at that time. Multiple medications had not been administered to residents, placing them at risk of harm. Numerous deficient practices were identified during the onsite survey, including policies and procedures not implemented, retention of residents who required skilled care which had exceeded 90 days, 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 staff training and incidents not reported and investigated as required. EI#2 reiterated to surveyors his (EI#2's) commitment to bringing the facility to full compliance with the SBOH rules for SCALFs and to maintaining that compliance.	A 301		
A 302	420-5-20-.03 (e) Administration. (e) Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative	A 302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 302	Continued From page 4	A 302		

payee(s). All residents shall be informed of new policies or changes in existing policies that may have bearing on the resident. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies shall cover the following:

(i) Facility responsibility to protect all residents from abuse, neglect, and exploitation.

(ii) How allegations of abuse, neglect, and exploitation will be handled by the facility.

(iii) Resident confidentiality.

(iv) Admission and continued stay criteria.

(v) Discharge criteria and notification procedures for residents and sponsors.

(vi) Facility responsibility when a resident's personal belongings are lost.

(vii) What services the facility is capable and not capable of providing.

(viii) Medication management.

(ix) Infection control.

(x) Meal service, timing, menus and food preparation, storage, and handling.

(xi) Fire safety and emergency plan, fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness.

(xii) Staffing and conduct of staff while on

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 302	Continued From page 5 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 is nutritionally compromised or is not eating adequate quantities of food.	A 302		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 302	Continued From page 6 (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 facility failed to follow state guidelines for reporting a COVID-19 outbreak. Refer to deficiency 508 for additional information. The	A 302		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 302	Continued From page 7 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	420-5-20-.03 (2) (a) Administration. (2) The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the specialty care 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. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days. 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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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

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A 303	Continued From page 8 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 actually 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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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 303	Continued From page 9 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 16 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. Two (2) complaints were investigated. The complaints contained allegations that residents' sponsors were not contacted for resident care needs and when changes in resident's condition occurred. Surveyors substantiated these complaints while onsite and identified other deficient practices as well. EI#1 became administrator at the facility in June 2021, about seven (7) months prior to the survey. During an interview on February 3, 2022, EI#1 stated she (EI#1) was never given the time to perform administrator duties because she was also functioning in her previous role as Associate Executive Director. EI#1 added her (EI#1's) administrator license was placed on the wall because EI#2 did not have a license. Multiple resident care issues were identified by surveyors. The facility RN had been employed at	A 303		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 303	Continued From page 10	A 303		

the facility about five (5) months at the time of the survey and was also the facility's care coordinator. Residents were not assessed as required upon admission and when significant change in status occurred. Documentation of resident weights was not available in the facility. Residents' medical examinations were incomplete. Resident care plans were not current to meet the care and safety needs of the residents. Seven (7) residents had recently or currently tested positive for COVID-19 and proper precautions were not being followed by staff to prevent the spread of infection. Residents had gone without medications for as long as six (6) days.

During the interview on February 3, 2022, EI#1 stated she (EI#1) was aware there were issues with the medical director not refilling medications timely, but she (EI#1) was not aware residents had gone for several days without medications. EI#1 stated she (EI#1) was not aware resident assessments were not being completed in the SCALF. EI#1 stated EI#4, RN, was not properly trained and was doing the best she (EI#4) could do. According to EI#1, EI#3, Corporate Nurse, was responsible for training EI#4. EI#1 added EI#4 was initially hired as the memory care coordinator but later assumed additional responsibilities in the assisted living facility due to no care coordinator in the assisted living facility. EI#1 also stated she (EI#1) was unaware a resident's sponsor was not notified of a clinic scheduled at the facility which offered COVID-19 booster vaccines. According to EI#1, it was her (EI#1's) understanding all sponsors were notified. EI#1 also added she (EI#1) made rounds at the facility daily for observation of residents and staff and reported her (EI#1's) findings to EI#2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 303	Continued From page 11 The following deficiencies were cited as a result of the administrator's failure to apply the SBOH rules to the day to day operations of the facility, as well as the lack of oversight of the administrator by the governing authority. 302 - The facility failed to follow its own policy for infection control during a COVID-19 outbreak. 305 - The facility failed to report a change in administrator to the ADPH. 402 - Potential employees were not screened for abuse prior to hire. 403 - Employee files did not contain license verification and initial resident contact date. 405 - The RN/Care Coordinator failed to perform their duties. 406 - Nursing training and special needs training in diabetes were not completed for all staff. 501 - Residents' weight records were not available to surveyors. 504 - The facility failed to maintain a safe and decent environment and failed to follow community standards of care. 508 - Incidents were not reported to the ADPH as required, were not reported timely, and were not adequately investigated. 601 - Physicians' orders were not followed or not obtained for residents' care. 602 - Residents' Medical Examinations were incomplete.	A 303		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 303	Continued From page 12 603 - The facility failed to ensure a resident had the opportunity to receive a COVID-19 booster vaccine. 604 - Residents did not receive adequate assessment and health supervision. 611 - Residents' care plans were not current and did not address all care needs of the residents. 612 - Residents who had wandering/exit-seeking behaviors/elopements did not have a specific activity program to address the behaviors. 616 - Controlled substances were not accounted for each shift. 618 - Resident oxygen use was not documented on the Medication Administration Record (MAR). 621 - Residents who required care beyond the capability of the facility were not promptly discharged to an appropriate level of care. 703 - There was inadequate potable water available in the facility. 1101 - Fire drills were not conducted monthly and quarterly on each shift. Fire alarm and sprinkler inspections were not conducted semi-annually.	A 303		
A 305	420-5-20-.03 (2) (c) Administration. (c) Department Notification. 1. The licensee of a specialty care assisted living facility shall provide written notification of voluntary closure of the facility to	A 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 305	Continued From page 13 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: Based on record review and interview, the facility failed to provide written notification of change in administrator to the 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#2 stated he (EI#2) 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	420-5-20-.04 (3) Personnel. (3) Employee Screening. (a) Prior to any resident contact, such as	A 402		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 402	Continued From page 14 but not limited to assistance with activities of daily living, newly employed personnel shall have a physical examination certifying that the employee is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to residents through normal staff to resident contact. Employees who develop signs or symptoms of infectious skin lesions or diseases that would be capable of transmission to residents through normal staff to resident contact shall not be permitted to have resident contact until free from such signs and symptoms. (b) Not more than 30 days prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis. (c) Vaccines. Specialty care assisted living facilities shall immunize employees in accordance with current recommended Centers for Disease Control and Prevention (CDC) guidelines (www.cdc.gov/vaccines). Any particular vaccination requirement may be waived or delayed by the State Health Officer in the event of a vaccine shortage. (d) A specialty care assisted living facility shall not hire an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry. This Rule is not met as evidenced by: Based on record reviews and interview, potential employees were not screened for abuse as required. Findings:	A 402		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 402	Continued From page 15 Review of employee files on January 5, 2022 revealed EI#1, EI#4 and EI#9 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#9 was not screened for abuse at all. EI#1 was unable to provide documentation of timely abuse screenings for these employees.	A 402		
A 403	420-5-20-.04 (4) Personnel. (4) Personnel Records. A specialty care 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.	A 403		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 403	Continued From page 16 This Rule is not met as evidenced by: Based on record review and interview, employees' personnel records did not contain required information to include verification of current nursing license, screening for abuse and date of initial resident contact. Findings: Current License Verification/Aide Abuse Registry Screening Review of employee files on January 5, 2022, revealed EI#9, Licensed Practical Nurse (LPN), was hired at the facility on February 9, 2021. There was no documentation EI#9's current nursing license was verified. In addition, there was no verification EI#9 was screened through the Alabama Department of Public Health Nurse Aide Abuse Registry. EI#1 did not provide the required license verification and abuse screening for EI#9 to the surveyors. Date of Initial Resident Contact Review of employee files on January 5, 2022, revealed four of four files (EI#1, EI#4, EI#9 and EI#12) did not contain the date of the employee's initial resident contact. EI#1 agreed the required information had not been documented in the files.	A 403		
A 405	420-5-20-.04 (6) (7) (8) Personnel. (6) Medical Director. Each specialty care assisted living facility shall have a medical director who is a physician currently licensed to	A 405		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 405	Continued From page 17	A 405		

practice medicine in Alabama. The medical director is responsible for implementation of resident care policies, and the coordination of medical care in the facility. The medical director shall participate in quality assurance activities in the facility. A nurse practitioner or physician's assistant shall not serve as the medical director of a specialty care assisted living facility.

(7) Registered Professional Nurse. Each facility shall have at least one RN. An RN may also serve as the administrator or as the care coordinator, but not as both. In all instances where the facility's RN is assigned other duties as an administrator or care coordinator the facility must assure that the RN devotes sufficient time and effort to all clinical duties.

(a) Responsibility. The RN shall be responsible for oversite and coordination of resident care.

1. The RN shall assess the residents in the specialty care assisted living facility.

2. The RN shall develop, document, and evaluate resident plans of care.

3. The RN shall consult with the administrator on all issues of resident safety, health, and wellbeing.

4. The RN shall communicate significant resident changes to the resident's physician and sponsor or responsible family member.

5. The RN shall identify staff training needs and ensure needed training is

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 405	Continued From page 18 appropriately provided. 6. The RN shall direct the practice of any licensed practical nurse. (8) Care Coordinator. There shall be a care coordinator who will manage the daily routine delivery of resident care. This person shall be an LPN or RN. An LPN care coordinator shall work under the supervision of the RN in the management and delivery of resident care. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility RN, who is also the facility Care Coordinator, failed to assess residents as required, develop and implement resident care plans, communicate significant changes to the resident's sponsor, identify staff training needs and ensure training was provided, and manage the daily routine delivery of resident care. Findings: Resident Assessments PSMS and behavior screenings of residents were not completed upon admission to the facility. Comprehensive assessments, PSMS and behavior screenings were not completed when residents had a significant change in condition. Resident weights were not completed or not made available to surveyors for review. Refer to deficiencies 501 and 604 for additional information. Resident Care Plans	A 405		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 405	Continued From page 19 Residents' care plans were not current and did not address residents' diagnoses, dietary orders, mobility needs, wandering, behaviors, and significant changes with appropriate interventions to meet the care needs of the residents. Refer to deficiencies 611 and 612 for additional information. Communicate Significant Changes to Residents' Sponsor There was no documentation to indicate a resident's sponsor was notified when significant medication changes were made. There was no documentation to indicate another resident's sponsor was contacted to ensure a COVID-19 booster vaccine was scheduled, if desired. Refer to deficiencies 603 and 604 for additional information. Identify and Implement Staff Training Needs Staff were not trained in special needs of diabetic residents. Oxygen use was not documented on the MAR. Narcotics counts were not always documented. Isolation procedures were not utilized by staff in caring for residents who tested positive for COVID-19. Refer to deficiencies 302, 406, 504, 616 and 618 for additional information. Daily Routine Delivery of Resident Care Residents were not given medications for as long as six (6) days due to medications being unavailable. An elopement was not adequately investigated and documented. Residents' Medical Examinations did not contain required information. Physician's orders were not followed for residents' care. Refer to deficiencies 508, 601 and 602 for additional information.	A 405		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 405	Continued From page 20 EI#4, RN/Care Coordinator, had been employed at the facility since August 2021. On January 5 and 6, 2022, EI#4 informed surveyors she (EI#4) was responsible for oversight of staff and residents on the SCALF as well as on the ALF in the same building. EI#4 stated she (EI#4) was trained by EI#3, Corporate Nurse, but felt she (EI#4) needed additional training to adequately fulfill her duties. EI#4 added she (EI#4) felt overwhelmed by the duties that were placed on her (EI#4) when the previous RN left but she (EI#4) took pride in her (EI#4's) work and wanted to perform her (EI#4's) duties correctly.	A 405		
A 406	420-5-20-.04 (9) Personnel. (9) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. An RN shall identify staff training needs and shall provide or arrange for needed training. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that, prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on specialty care assisted living facilities. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the	A 406		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 406	Continued From page 21 American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire. 5. Identifying and reporting abuse, neglect, and exploitation. 6. Basic first aid. 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environmental safety. (b) Prior to providing any resident care, all staff shall complete The Dementia Education and Training Act (DETA) Care Series Training developed by the Alabama Department of Mental Health or equivalent training approved by the State Health Officer. All licensed staff shall complete DETA Brain Series Training, The Pharmacological Management of Dementia, and the Dementia Assessment Series provided by the DETA Program or equivalent training approved by the State Health Officer prior to resident contact. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained. (c) All staff who have resident contact shall be able to demonstrate diversional methods and redirection. All staff shall be able to demonstrate an understanding of the implications of caring for residents with agnosia, amnesia, aphasia, and apraxia. All staff shall be able to demonstrate an understanding of the facility's fire	A 406		

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CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 406	Continued From page 22 and evacuation plan and all other policies regarding safety, including policies for preventing elopements, responding to elopements, and fall prevention. (d) Cardiopulmonary Resuscitation. A specialty care assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of a specialty care assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within 90 days of hire. A specialty care assisted living facility equipped with an automated external defibrillator (AED) shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or the American Red Cross in CPR or AED utilization. (e) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training. (f) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above.	A 406		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 406	Continued From page 23 This Rule is not met as evidenced by: Based on record review and interview, an employee did not receive required training for licensed staff. In addition, staff were not trained in special needs of residents with diabetes. Findings: Licensed Staff Review of employee files on January 5, 2022, revealed EI#9, LPN, did not receive required training in Dementia Assessment Series and Pharmacological Management of Dementia. EI#1 did not provide documentation of this required training for EI#9 to the surveyors. Diabetes Training Review of employee files on January 5, 2022, revealed four of four employees (EI#1, EI#4, EI#9 and EI#12) did not receive training in diabetes. The facility currently had at least two (2) residents with a diagnosis of diabetes mellitus. EI#1 agreed diabetic training had not been completed as required.	A 406		
A 501	420-5-20-.05 (1) Records and Reports. (1) General. (a) Responsibility for Records. The administrator shall prepare and file all records, or shall oversee the preparation and filing of records. This duty shall be assigned to other employees in the administrator's absence.	A 501		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

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A 501	Continued From page 24 (b) All records and reports required by these rules shall be completed in a timely manner, and shall be maintained and filed in an orderly manner within the specialty care assisted living facility premises. (c) Storage and Safety. Provision shall be made for the safe storage of records within the facility. Records shall be stored in a manner to reasonably protect them from water or fire damage. Records shall be safeguarded from unauthorized access. (d) All facility records, including resident medical records, shall be made readily available for review and copying by representatives of the Alabama Department of Public Health upon request. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to make all records readily available for review and copying by surveyors. Findings: On January 5 and 6, 2022, during the onsite survey, residents' weight records were requested from EI#4, RN and Care Coordinator. On January 6, 2022, EI#4 provided two (2) months of documented weights for each resident but did not provide all weights since admission. EI#4 explained that EI#3, Corporate Nurse, had taken the weight logs from the facility and she (EI#4) did not have access to them. EI#4 further stated she (EI#4) would try to have the documents sent to the facility for review. The complete weight logs were not provided to surveyors.	A 501		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 501	Continued From page 25 During an interview on the morning of February 14, 2022, EI#3 stated she (EI#3) had not removed residents' weight records from the facility. EI#3 added the weights were kept in a binder at the facility and was unsure why they were not available at the time of the survey.	A 501		
A 504	420-5-20-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission, of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate. 1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility. 2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints. 3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy.	A 504		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 504	Continued From page 26 4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time. 5. Every resident shall have freedom to participate in and benefit from social, religious, and community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. 6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the premises, an individual account record for each resident shall be maintained by the administrator and an up-to-date record shall be maintained for all transactions. 7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so. 8. Every resident shall have the right to a reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals. 9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident.	A 504		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 504	Continued From page 27 10. Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to receive or reject medical care, dental care, or other health care services except those required to control communicable diseases. 11. Every resident shall have the right to at least 30 days prior written notice of involuntary relocation or termination of residence from the facility unless the resident is a patient in a facility providing a higher level of care and no longer meets the eligibility and continued stay requirements in these rules, or for medical reasons the resident is considered by a physician to require an emergency relocation to a facility providing a more skilled level of care, or unless the resident engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record. 12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person without restraint, interference, coercion, discrimination, or reprisal. 13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file.	A 504		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 504	Continued From page 28 14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the facility, provided that: (i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care. (ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation. (iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time without recourse. 15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges. 16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities. 17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider	A 504		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 504	Continued From page 29 Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll-free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll-free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area. 18. All state inspection reports and any resulting corrective action plan from the past 24 months shall be posted in a prominent location. If there has been no inspection in the past 24 months, then the results of the most recent inspection and any resulting corrective action plan shall be posted. 19. Every resident shall have the right to 30 days prior written notice to both resident and sponsor of any increase of fees or charges. 20. Every resident shall have the right to 30 days prior written notice of any involuntary change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. 21. Every resident shall have the right to wear his or her own clothes, and to keep and use his or her own personal possessions, including toilet articles, except for personal possessions too large to be stored in the resident's room. 22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings.	A 504		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 504	Continued From page 30 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide a safe and decent 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 and Prevention (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 numerous 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 heart medications, fluid medications, diabetic medications, antipsychotic medications and antidepressants which could cause medical	A 504		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

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CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 504	Continued From page 31	A 504		

complications to the residents when stopped abruptly or omitted. This deficient practice placed the 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. At the time of the onsite survey, at least four residents of the facility were currently positive for COVID-19. On the morning of January 4, 2022, the surveyor observed medication administration by EI#7, LPN. The surveyor entered the rooms of Resident Identifier (RI)#1 and RI#7 with EI#7. EI#7 wore only gloves and a mask inside resident rooms and administered medications to each resident. EI#7 also applied cream to RI#7's legs using gloved hands. EI#7 washed hands after leaving each resident's room. The following day, the surveyor was provided with a list of residents who tested positive for COVID-19 by EI#4. Both RI#1 and RI#7 had tested positive for COVID-19 and should currently have been on isolation procedures for COVID-19. There was no sign on the residents' doors to alert visitors. There was no cart containing PPE outside either room. 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 from a cart that was placed on the unit. This failure to use proper precautions to prevent the spread of

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 504	Continued From page 32 COVID-19 created an unsafe environment to all residents, staff and visitors at the facility.	A 504		
A 508	420-5-20-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in a specialty care assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review. 1. Incidents which require investigation are: (i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as extensive bruising, pain, or injury that is not consistent with actions necessary in providing day-to-day care to a resident or for which medical treatment was sought. (ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid including but not limited to a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office. (iii) The onset of wandering behavior by any resident who is not fully cognitively intact. (iv) Elopement by a resident.	A 508		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 508	Continued From page 33 (v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. (vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules. (vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules. (viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or Staphylococcus aureus). (ix) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (xi) An unplanned occurrence that results in media attention. (xii) A medication error, overdose, or over	A 508		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 508	Continued From page 34 sedation. (xiii) Ingestion by a resident of a toxic substance that requires medical attention. (xiv) Any indication of malfunction of the sprinkler system, or fire alarm system. 2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following: (i) Names of all residents involved. (ii) Names of all staff involved including person in charge at the time of the incident. (iii) When the administrator was notified (date and time). (iv) Circumstances under which the incident occurred. (v) When the incident occurred (date and time). (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken. (viii) The extent and description of injury, if any, to the affected resident or residents. (ix) Immediate treatment rendered. (x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified.	A 508		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 508	Continued From page 35 (xi) Names, telephone numbers, and addresses of witnesses. (xii) Date and time relatives or sponsor were notified. (xiii) Out-of-facility treatment. (xiv) Follow-up care. (xv) Outcome resolution. (xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future. (xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation. (xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request. (xix) The entire investigative file and documentation of all corrective action taken shall be retained for a period of not less than 3 years after the resident is discharged or dies. (xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff. 3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the	A 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 508	Continued From page 36 incident: (i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention. (ii) Elopement by a resident. (iii) Suspected, alleged, confessed, witnessed, or actual abuse, neglect, or exploitation of a resident or residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file. (iv) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (vi) An unplanned occurrence that results in media attention. (vii) Any medication error, overdose, or over sedation. The incident shall be immediately reported to the attending physician, facility medical director, or back-up physician.	A 508		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 508	Continued From page 37 (viii) Ingestion by a resident of a toxic substance that requires medical attention. (ix) Notifiable diseases and health conditions listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04. shall also be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1-.04. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than three years. (x) Any indication of a malfunction of the sprinkler system, fire alarm system, or a door locking device. 4. The report to the Department's Online Incident Reporting System shall include the following: (i) Facility name and direct phone number. (ii) Time and date of the report. (iii) Reporter's name. (iv) Name of resident(s), staff, or visitor(s) involved in the incident. (v) Names of staff on duty at the time of the incident. (vi) Date and time of the incident. (vii) A brief description of the incident.	A 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

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CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 508	Continued From page 38 (viii) Any injury or injuries to resident(s). (ix) Action taken by the facility in response to the incident. (i) Vital Statistics Reports. A record shall be kept of all births, deaths, and stillbirths that occur within the specialty care assisted living facility. By the fifth day of each month, the administrator shall make a report of such births, deaths, and stillbirths for the preceding month on such forms as the State Board of Health shall provide to the county health officer, or in counties without a county health officer, to the State Registrar. This report shall be in addition to the official birth, death, and stillbirth certificates. If there are no births, deaths, or stillbirths in any month, a report shall be made stating that fact to the county health officer. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to report incidents to the Department's Online Incident Reporting System (OIRS) as required, failed to report an incident timely and failed to adequately investigate an incident. Findings: Incidents Not Reported/RI#4 RI#4 was admitted to the facility on April 13, 2021, and had diagnoses which included vascular	A 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 508	Continued From page 39	A 508		

dementia, transischemic attacks and atrial fibrillation. Refer to deficiencies 604, 611 and 612 for additional information on RI#4. During review of RI#4's facility record on January 6, 2022, the surveyor noted a comprehensive assessment of RI#4 which was completed on April 27, 2021, due to "elopements". EI#4, RN/Care Coordinator, was questioned about the elopements and informed the surveyor there was documentation on a facility internal incident report of an elopement by RI#4. The report was provided at the request of the surveyor. The incident report was documented by EI#3 and stated RI#4 exited the building on April 16, 2021, and was picked up in the parking lot by a staff member in the facility bus. EI#4 stated she (EI#4) was unable to locate documentation showing the incident was reported to the ADPH. No incident report was found in the Department's OIRS.

Incidents Not Reported/COVID-19 Outbreak

A review of the OIRS by surveyors on January 3, 2022, revealed no positive cases of COVID-19 had been reported by the facility. When surveyors arrived at the facility on January 4, 2022, they noted a sign posted "No Visitors" for the next ten (10) days (January 1-11, 2022) at the front entrance. Upon entering the building, concierge informed the surveyors that visitors were being restricted due to multiple cases of COVID-19 in the building. Upon arrival on the SCALF unit, the surveyor was made aware of 4 recent positive COVID-19 cases among residents of the facility (one resident who tested positive was in the hospital). Later during the survey, EI#4 provided the surveyor with a list of seven (7) residents in the SCALF who had tested positive for COVID-19 since December 29, 2021. None of these positive cases of COVID-19 had been reported to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 508	Continued From page 40	A 508		

Department's OIRS. EI#4 explained to the surveyors she (EI#4) was working with the state infection control unit to report the positive cases but admitted she (EI#4) had not reported the positive cases to the ALF department.

Incident Not Reported Timely/RI#5

RI#5 was admitted to the facility on October 19, 2021, and had diagnoses which included generalized anxiety, dementia, vitamin D deficiency, reactive hypertension, mild asthma, critical illness myopathy, lung cancer and major depression. Refer to deficiencies 602, 604, 611 and 612 for additional information on RI#5. The ADPH received an incident report (number 20211230018) on December 30, 2021, documenting an elopement by RI#5 from the facility which occurred on December 27, 2021, three days prior to the report. During an interview on January 5, 2022, EI#4 stated the incident was reported late because it occurred during a time when EI#4 was not working.

Incident Not Adequately Investigated/RI#5

During review of the elopement incident involving RI#5 which occurred on December 27, 2021, the surveyor requested the entire investigative file from EI#4. EI#4 provided the surveyor with a Physician's Orders form which contained documentation of a timeline of events involving RI#5 which occurred on December 27, 2021. The form was completed by the facility RN on duty at the time the incident occurred. EI#4 also provided to the surveyor a copy of the report which was submitted to the ADPH OIRS. The following information was missing from the investigative file: date and time administrator was notified; date and time relatives or sponsor were notified;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 508	Continued From page 41 statements from all witnesses. There was conflicting information as follows: the written statement reported RI#5 was returned to the facility by a "good samaritan" and a care partner; the incident report stated RI#5 was returned to the facility by police. The investigation was incomplete and contained conflicting information. EI#4 stated she (EI#4) talked to witnesses and submitted information in the incident report based on those interviews. EI#4 added she (EI#4) failed to obtain written statements from all witnesses.	A 508		
A 601	420-5-20-.06 (1) Care of Residents. (1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician. (a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her choice. If the resident is unable to designate an attending physician, or does not wish to designate an attending physician, the facility shall assist the resident in identifying an attending physician who will serve the resident. A resident shall be permitted to change the designation of his or her attending physician at any time. Whenever a resident requires medical attention, an attempt shall first be made to contact the resident's attending physician, except in medical emergencies requiring activation of the local EMS system (911 or other emergency call). (b) Back-up Physician Support. Each specialty care assisted living facility shall have an agreement with one or more duly licensed physicians to serve in those instances when a resident's own attending physician cannot be	A 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 601	Continued From page 42 reached, and to provide temporary medical attention to any resident whose attending physician is temporarily not available. A nurse practitioner or physician's assistant shall not serve as the back-up physician in a specialty care assisted living facility. (c) All physician orders shall be written in accordance with community standards. If verbal orders are used, they are to be used infrequently. A physician verbal order shall only be accepted by an RN or LPN employed by the facility and authorized to do so by facility policy and procedures and state law. All verbal orders shall be reduced to writing on the physicians' order sheet by a licensed facility nurse and shall be dated and signed by the nurse receiving the order. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, or another practitioner who is responsible for the care of the resident and authorized to write orders by facility policy. All verbal orders must be authenticated within such time period as provided by facility policy, but in no case shall exceed 30 days following entry of the order. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to follow physicians' orders for residents' care and failed to obtain physicians' orders to ensure continuity of care for residents. Findings: Failure to Follow Physician's Orders/RI#6	A 601		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 601	Continued From page 43 RI#6 was admitted to the facility on January 15, 2021, and had diagnoses which included dementia, diabetes mellitus II, hypothyroidism, urinary incontinence, recurrent falls and osteoarthritis. RI#6 was currently hospitalized. Refer to deficiencies 603, 604 and 611 for additional information on RI#6. On May 12, 2021, a speech therapy evaluation was ordered for RI#6 due to choking episodes. On January 5, 2022, the surveyor requested the speech evaluation and speech notes for RI#6 from EI#4. EI#4 was unable to locate any speech therapy consults or notes for RI#6 and stated she (EI#4) was unsure if the evaluation had been completed since she (EI#4) did not work at the facility at that time. Failure to Follow Physicians' Orders/Medications On January 5, 2022, residents' MARs for the months of December 2021 and January 2022 were reviewed. The following medications were documented on residents' MARs as "resident refused". For RI#1, between the dates of December 7 and January 3, six (6) medication doses were documented as not given to RI#1 due to "resident refused". These medications included Lantus solostar and Humalog insulin. It was also noted RI#1 frequently refused fingerstick blood sugars which were ordered five times daily and documented on the MAR. For RI#3, between the dates of December 12 and 17, nine (9) medication doses were documented as not given to RI#3 due to "resident refused". These medications included Donepezil, Mirtazapine and Quetiapine Fumarate. For RI#6, between the dates of December 10 and 25, twenty-three (23) medication doses were documented as not given to RI#6 due to "resident refused." These medications included Zinc Oxide, Donepezil, Quetiapine Fumarate and Metformin. For RI#7,	A 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 601	Continued From page 44 between the dates of December 10 and 31, seventeen (17) medication doses were documented as not given to RI#7 due to "resident refused". These medications included Cerave moisturizing cream and Zinc Oxide. It was also noted RI#7 frequently refused blood pressure checks which were to be recorded on the MAR. Also blood pressure checks for January 2 and 3 for RI#7 were documented as "physically unable to take." 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 medications were refused for several doses. No documentation was present to indicate residents' physicians were notified of the multiple doses of medications that had been refused by these residents. Failure to Obtain Physicians' Orders for Continuity of Care Review of residents' MARs on January 5, 2022, for the months of December 2021 and January 2022, revealed the following medications were not administered to residents due to "awaiting pharmacy delivery." RI#1 did not receive: Carvedilol 3.125 milligrams on December 26 at 8:00 AM and 6:00 PM and on December 27 at 6:00 PM. RI#3 did not receive: Eliquis 2.5 milligrams on December 31 at 6:00 PM; Cefdinir 300 milligrams on December 31 at 6:00 PM; Zinc Sulfate 220 milligrams on January 1 at 8:00 AM. RI#6 did not receive: Metformin 500 milligrams at 6:00 PM on December 6 and 7; Cefdinir 300 milligrams at 6:00 PM on December 21. RI#7 did not receive: Folic Acid 1 milligram on December 13 and 14 at 8:00 AM; Pantoprazole 40 milligrams on December 26, 27, 28, 29 and 30 at 8:00 AM; Culturelle Capsule on December 26 and 27 at 8:00 AM; Carvedilol 6.25 milligrams on	A 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 601	Continued From page 45 December 30 at 8:00 AM, on December 31 at 8:00 PM, on January 1 at 8:00 PM, on January 2 and 3 at 8:00 AM and 8:00 PM and on January 4 at 8:00 AM; Lasix 20 milligrams on January 4 at 8:00 AM. On January 5 and 6, 2022, when questioned about the omitted medications for these residents, both EI#4 and EI#7 stated, when residents were out of medications, refills were requested from the physician. However, the medications could not be sent from the pharmacy until a new order was obtained from the physician. EI#4 said she (EI#4) had made repeated attempts to obtain refills by calling and faxing the physician which sometimes took 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. Until a response could be obtained from the physician, the resident was without the medications, placing the residents at risk of harm.	A 601		
A 602	420-5-20-.06 (2) (a) (b) (c) Care of Residents. (2) Medical Examination Record. (a) Initial Physical Examination. Not more than 30 days prior to admission of any resident to a specialty care assisted living facility, the resident or prospective resident shall be examined by a physician. For purposes of the initial physical examination, a physician currently licensed and in good standing with the Medical Licensure Commission of any state may complete this physical assessment. The physician shall report his or her findings in writing to the facility. This examination is not required for a resident of a facility dually licensed as an assisted living facility and as a specialty care	A 602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 602	Continued From page 46	A 602		

assisted living facility in those cases when the resident is transferred from the assisted living unit to the specialty care assisted living unit in the same facility. In addition to any information otherwise required by the facility's policies and procedures and in addition to any other information the physician recommends or believes is pertinent, the initial physical examination record shall contain the following:

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

2. Medication presently prescribed (name, dosage, and strength of drug, frequency, and route of administration).

3. A statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident-to-resident contact.

4. Documentation of evaluation for tuberculosis within the previous 12 months.

(b) Annual Physical Examination. In addition to the admission physical examination, each resident shall be examined annually by a physician, and findings from the annual physical examination shall be documented with a copy placed in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent or recommended by the resident's attending physician, the annual physical examination shall contain the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 602	Continued From page 47 1. The resident's weight and vital signs. 2. Changes in diagnoses. 3. Changes in condition. 4. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration). 5. Changes in treatment. (c) Change of Condition Physical Examinations. Changes in the resident's condition that require a physician examination and result in a change in diagnoses, condition, medications, or treatments shall be reported to the facility and documented in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent, or recommended by the resident's treating physician, this physical examination shall contain a listing of the following: 1. Changes in diagnoses. 2. Changes in condition. 3. Changes in medications prescribed (name, dosage and strength of drug, frequency, and route of administration). 4. Changes in treatment. This Rule is not met as evidenced by:	A 602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 602	Continued From page 48 Based on record review and interviews, residents' Initial Medical Examinations did not contain required information. Findings: RI#1 RI#1 was admitted to the facility on February 1, 2021, and had diagnoses which included hypertension, congestive heart failure, hyperlipidemia, dementia, osteoarthritis, reactive depression, diabetes mellitus II, hyponatremia and history of falls. Refer to deficiencies 504, 601, 604, 611 and 621 for additional information on RI#1. RI#1's initial Medical Exam/Plan of Care, dated January 7, 2021, did not contain RI#1's baseline temperature and respiratory rate. EI#4 agreed the required information was not documented. RI#5 RI#5 had resided at the facility since October 19, 2021. Refer to deficiencies 508, 604, 611 and 612 for additional information on RI#5. RI#5's initial Medical Exam/Plan of Care, dated September 28, 2021, did not contain RI#5's baseline respiratory rate. In addition, the Medical Exam did not contain a statement by the physician that RI#5 was free of signs and symptoms of infectious skin lesions and diseases that were capable of transmission to other residents through normal resident-to-resident contact. EI#4 agreed the required information was missing.	A 602		
A 603	420-5-20-.06 (2) (d) Care of Residents. (d) Vaccines. Specialty care assisted	A 603		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 603	Continued From page 49 living facilities shall immunize residents in accordance with current recommended CDC guidelines. Any particular vaccination requirement may be waived or delayed by the State Health Officer in the event of a vaccine shortage. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure residents were given the opportunity for immunization in accordance with current recommended CDC guidelines. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The ADPH received a complaint which alleged the facility made little or no effort to obtain a COVID-19 booster vaccination for a resident. Surveyors were able to substantiate there was no documentation of a contact to the resident's sponsor to obtain authorization for the COVID-19 booster vaccine. RI#6 had resided at the facility since January 15, 2021. Refer to deficiencies 601, 604 and 611 for additional information on RI#6. On January 5, 2022, the surveyor asked EI#4, RN and Care Coordinator, about the procedure for residents to receive a COVID-19 booster vaccination. EI#4 stated phone calls were placed to residents' sponsors by EI#15, LPN, to obtain authorization for the residents to receive the booster vaccines. EI#4 added, if the sponsor did not call back and give consent, the resident did	A 603		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 603	Continued From page 50	A 603		

not receive the vaccination. The surveyor requested vaccination records for RI#6 and was provided documentation from the pharmacy that RI#6 received the first COVID-19 vaccine dose on January 21, 2021, and the second COVID-19 vaccine dose on February 15, 2021. However, there was no documentation RI#6 had received the COVID-19 booster vaccination even though EI#4 stated the COVID-19 booster had been offered to all residents. EI#4 was unable to provide documentation for when or if RI#6's sponsor was contacted to obtain authorization for the vaccine but stated one EI#15 contacted all sponsors and left messages for them if the phone calls were not answered. EI#4 was unsure if anyone talked with RI#6's sponsor or when the phone call was made in an attempt to contact RI#6's sponsor.

On the afternoon of February 1, 2022, the surveyor spoke with EI#15 by phone. EI#15 acknowledged she (EI#15) was given a list of residents whose sponsors she (EI#15) was to contact to determine which residents wanted to receive a COVID-19 or flu vaccine. EI#15 stated a vaccination clinic was scheduled in October 2021 to administer first and second dose COVID-19 vaccines, COVID-19 booster vaccines and flu shots. When asked if she (EI#15) spoke with RI#6's sponsor about the vaccines, EI#15 stated she (EI#15) did not. EI#15 further stated she (EI#15) did not remember who she (EI#15) contacted as the sponsor for RI#6 and did not remember if she (EI#15) left a message for the sponsor. When asked if there was documentation of any phone calls, EI#15 responded there was not but she (EI#15) did provide a list of residents who wished to receive a vaccine to EI#4.

The current CDC guideline for COVID-19 booster

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 603	Continued From page 51 vaccines is "Everyone ages 12 years and older who is fully vaccinated is recommended to get a COVID-19 booster shot." RI#6 tested positive for COVID-19 on December 24, 2021 at the facility.	A 603		
A 604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility RN or care coordinator shall screen prospective residents for eligibility for admission into the specialty care assisted living facility. The screening shall include a clinical history, a mental status examination to include aphasia screening, a geriatric depression screen, a physical self-maintenance screen, and a behavior screen. Appendix A herein, contains the Physical Self Maintenance Scale (PSMS) form and the Behavior Screening form. These forms shall be completed to screen physical functioning and behaviors. The PSMS and Behavior Screen assessments shall be completed by the RN or care coordinator upon admission, annually, and when there is a change in the resident's status. The facility RN shall perform a comprehensive assessment of each prospective resident for facility eligibility. This assessment shall document identified care needs and serve as a baseline for the RN plan of care and future assessments. (b) Monthly Assessments. The RN shall assess each resident monthly and more often when necessary to identify changes in the	A 604		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 604	Continued From page 52 resident's health status. The monthly assessment shall include a review of monthly weights, falls, incidents, elopements, behavioral symptoms, medications, changes in resident status, and appropriateness of the resident's plan of care. (c) Comprehensive Assessment. The facility RN shall perform a comprehensive assessment and communicate with the resident's attending physician and with the resident's sponsor or responsible family member when a decline in health status or behavior occurs, or if the resident develops any of the following problems: 1. Weight loss: (i) Each month, the facility shall accurately weigh and record the weight of each resident. (ii) A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half percent or greater weight loss in a period of 3 months or less, or a 10 percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician. 2. Falls (two or more falls within a 30 day period). 3. Elopement.	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 604	Continued From page 53 4. Any sign and symptom of adverse drug reaction, interaction or over sedation, or circumstances which contraindicate medications that have been prescribed for the resident. 5. Unmanageable, combative, or potentially harmful behavior(s). 6. Any accident with injury. (d) Focused Assessments. The RN or LPN shall conduct focused assessments when necessary to identify changes in resident status. (e) Any change in resident status requires immediate documentation and implementation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility RN failed to complete and document required assessments and health supervision of residents. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: Assessments and Health Supervision/RI#9 The ADPH received a complaint which alleged a resident's sponsor was not notified of multiple medication changes and did not authorize the medication changes. The complaint also alleged the medication changes caused the resident to	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 604	Continued From page 54	A 604		

have inappropriate behaviors which led to an admission to a geriatric psychiatric facility. Surveyors were able to substantiate there was no documentation the resident's sponsor was notified of the medication changes or authorized the medication changes.

RI#9 was admitted to the facility on May 24, 2021, and had diagnoses which included vitamin B deficiency, vascular dementia with behavioral disturbance, glaucoma, hypertension, atherosclerotic heart disease and coronary artery disease. Refer to deficiency 611 for additional information on RI#9.

Review of RI#9's facility record on January 5, 2022, revealed the following information. On August 5, 2021, RI#9 demonstrated aggressive behaviors toward another resident. In July and August 2021, incidents were documented when RI#9 would take silverware from the dining room and hide it in the bedroom. On September 28, 2021, October 4, 2021, and October 13, 2021, RI#9 was aggressive and combative toward staff. On September 8, 2021, RI#9 began services with a different physician and, on September 10, 2021, the new physician discontinued RI#9's Atorvastatin (cholesterol), Memantine (dementia) and Nifedipine (heart, blood pressure). Also, on September 10, 2021, RI#9's Olanzapine (antipsychotic) was decreased from 5 milligrams daily at bedtime to 2.5 milligrams daily at bedtime for 30 days then the Olanzapine was to be discontinued. On September 24, 2021, Depakote (seizures, mood stabilizer) was ordered for RI#9. There was no documentation RI#9's sponsor was notified of these significant medication changes.

On October 27, 2021, (when the complaint was received by ADPH), the supervisor of the SCALF

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 604	Continued From page 55	A 604		

unit contacted EI#4 by telephone and asked if RI#9's sponsor had been notified of the medication changes. EI#4 stated RI#9's sponsor was notified by phone two (2) days after the changes occurred and added EI#7 was present during the phone conversation with RI#9's sponsor. The ADPH supervisor then asked EI#7 if RI#9's sponsor was notified of the medication changes and EI#7 replied "I think it was the same day". During interviews on January 5 and 6, 2022, both EI#4 and EI#7 stated RI#9's sponsor had been notified of the medication changes but the dates and times were unclear. Both EI#4 and EI#7 reported the sponsor had been notified during a visit to the facility. The information provided by EI#4 and EI#7 concerning the medication changes and notification to sponsor was conflicting.

No comprehensive assessment, PSMS or behavior screening was documented for any of these changes to determine RI#9's physical, functional and behavioral status and RI#9's eligibility for SCALF. RI#9 was removed from the facility by the sponsor on October 14, 2021. A 30-day discharge notice was issued to RI#9 on October 27, 2021, and RI#9 was admitted to a geriatric psychiatric facility on October 28, 2021.

An assessment of RI#9 by EI#4 was completed on November 8, 2021, prior to discharge from the geriatric psychiatric facility. The assessment revealed EI#4 was ineligible to return to the facility due to behaviors and PSMS scores. This was the first assessment documented for RI#9 since May 13, 2021, prior to admission to the SCALF. The comprehensive assessment documented RI#9 refused dressing assistance and showers and would become agitated. The Behavior Screen documented refusal of showers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 604	Continued From page 56	A 604		

and dressing assistance, exit seeking/pacing and agitation/uncooperative with suggestions. RI#9's PSMS on November 8, 2021, showed a total score of 19 with a 5 in Grooming (actively negates all efforts of others to maintain grooming) and a 5 in Bathing (does not try to wash self and resists efforts to keep him/her clean). These scores were above the level allowed in a SCALF and reflected behaviors previously documented while RI#9 resided in the SCALF and was not properly assessed by the RN to determine eligibility. During an interview on January 5, 2022, EI#4 stated she (EI#4) did not complete required assessments for RI#9 because she (EI#4) did not have access to the facility's online system where the assessments were documented at the time. EI#4 added she (EI#4) only completed "paper" copies of the assessment forms when conducting a pre-admission assessment or re-admission assessment of a resident.

RI#9 demonstrated multiple behaviors toward residents and staff while residing at the facility and multiple medications changes were made to address these behaviors. However, RI#9 was not adequately assessed by the facility RN when significant changes occurred to determine RI#9's eligibility to remain at the facility or possible need for a higher level of care.

Resident Weights

On January 5, 2022, the surveyor requested weight logs for residents from EI#4. On January 6, 2022, EI#4 provided the surveyors with a binder which contained two months of weights for some residents. EI#4 explained to the surveyors the additional weight logs had been removed from the facility by EI#3 and EI#4 did not currently have access to them. Surveyors asked if the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 604	Continued From page 57	A 604		

weight logs could be sent to the facility during the survey for review. The complete weight logs were never provided to surveyors during the onsite survey. Surveyors were unable to determine if significant weight loss had occurred for residents. Weights were not documented as required and made available for surveyors to review.

Comprehensive Assessments/PSMS/Behavior Screenings

During interviews on January 5 and 6, 2022, EI#4 informed surveyors she (EI#4) had not completed comprehensive assessments, PSMS and behavior screenings of residents when significant changes occurred because she (EI#4) did not have access to the facility's online system for completing these forms. EI#4 admitted the resident assessment forms had not been completed and added some residents may have been ineligible if the assessments were documented. EI#4 stated she (EI#4) completed assessments of residents prior to admission but also admitted a PSMS and behavior screening were not completed upon admission to the facility. EI#4 had access to the paper forms of these resident assessments but did not complete them for significant change. Residents were not properly assessed to determine their care needs and to determine the level of care required to meet those needs. The following additional residents' records were reviewed and deficient practices noted in resident assessment and health supervision.

RI#1

RI#1 had resided at the facility since February 1, 2021. Refer to deficiencies 504, 601, 602, 611 and 621 for additional information on RI#1. RI#1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 604	Continued From page 58 developed a wound to the buttock which required home health on August 13, 2021 and tested positive for COVID-19 on January 3, 2022, at the facility. No comprehensive assessment, PSMS or behavior screen were completed when these significant changes occurred. RI#3 RI#3 was admitted to the facility on June 18, 2021, and had diagnoses which included bilateral mastectomy, dementia, chronic depression, bipolar disorder, hyperlipidemia, osteoarthritis and osteoporosis. Refer to deficiencies 601 and 611 for additional information on RI#3. On December 24, 2021, RI#3 tested positive for COVID-19 at the facility. No comprehensive assessment, PSMS or behavior screen had been completed since June 9, 2021, (prior to admission) in spite of this significant change. RI#4 RI#4 had resided at the facility since April 13, 2021. Refer to deficiencies 508, 611 and 612 for additional information on RI#4. On September 22, 2021, RI#4 became verbally and physically aggressive toward another resident in the dining room. On December 29, 2021, RI#4 tested positive for COVID-19 at the facility. On January 6, 2022, EI#4 reported to the surveyor RI#4 had sustained significant weight loss at the facility. This could not be confirmed as the facility did not provide RI#4's entire weight log to the surveyors. No comprehensive assessment, PSMS and behavior screening were completed for these significant changes. RI#5	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 604	Continued From page 59 RI#5 had resided at the facility since October 19, 2021. Refer to deficiencies 508, 602, 611 and 612 for additional information on RI#5. RI#5 eloped from the facility on December 27, 2021. No comprehensive assessment, PSMS and behavior screening were completed for this significant change. RI#6 RI#6 had resided at the facility since January 15, 2021 and was currently in the hospital. Refer to deficiencies 601, 603 and 611 for additional information on RI#6. In May 2021, RI#6 had choking episodes and the physician ordered a speech therapy evaluation. Multiple care partners reported in interviews, on January 5, 2021, RI#6 had declined physically and would frequently refuse or resist care. On December 24, 2021, RI#6 tested positive for COVID-19 at the facility. No comprehensive assessment, PSMS and behavior screening were completed for these significant changes. RI#7 RI#7 was admitted to the facility on May 10, 2021, and had diagnoses which included coronary artery disease, hypertension, atrial fibrillation, osteoarthritis diffuse, neuropathy, restless leg syndrome, hypothyroidism, vitamin B deficiency and iron deficiency anemia. Refer to deficiencies 504, 601, 611 and 621 for additional information on RI#7. On August 27, 2021, RI#7 began home health services for a wound to the right medial foot. On November 2, 2021, RI#7 developed bilateral edema, redness and warmth of the lower extremities and was started on Keflex (antibiotic). RI#7 recently tested positive for COVID-19 at the facility. No comprehensive assessment, PSMS	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 604	Continued From page 60 and behavior screening were completed for these significant changes. EI#4 was repeatedly asked about these assessment forms for the above residents on January 5 and 6, 2022. The assessments were not provided to the surveyors during the onsite survey. Residents were not properly assessed by the facility RN to determine their care needs and to determine their eligibility to remain at the facility, placing all residents of the facility at risk of harm.	A 604		
A 611	420-5-20-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. The RN shall develop written plans of care for each resident prior to or at the time of admission. The plans of care shall be based on resident's assessments, diagnoses, and recommendations of the resident's physician. The plan of care shall be developed in cooperation with the resident, if appropriate, and the sponsor. The RN shall identify resident care problem areas and formulate written interventions to address those problems. The RN shall evaluate the implementation of the interventions and the resident's response to the interventions and modify the plan of care as necessary.	A 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 61 1. The plan shall at all times reflect the current condition of the resident. All entries on the plan of care shall be accurately dated. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following: 2. A listing of the resident's individual needs or problems that require intervention by the facility. 3. A listing of interventions provided by the facility to address the resident's identified needs or problems. 4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider. 5. Activities of Daily Living. Residents of a specialty care assisted living facility shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident. (i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested. (ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips. (iii) Hair. Residents' hair shall be kept	A 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 62 clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be provided assistance with personal safety. 6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, residents' care plans were not current and did not contain interventions to meet the care needs of the residents. Findings: RI#1 RI#1 had resided at the facility since February 1, 2021. Refer to deficiencies 504, 601, 602, 604 and 621 for additional information on RI#1. RI#1 had a wound to the buttock and was receiving home health services for wound care. RI#1 frequently refused fingerstick blood sugars and medication, including insulin. RI#1 had diagnoses of diabetes mellitus II and congestive heart failure which required specific monitoring for symptoms of exacerbation. RI#1 was currently positive for	A 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 63 COVID-19. RI#1 did not have a bed and slept in the recliner. RI#1's facility care plan did not address RI#1's pertinent diagnoses and these specific care needs with appropriate interventions to meet RI#1's care needs. RI#2 RI#2 was admitted to the facility on February 1, 2021, and had diagnoses which included acute encephalopathy, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, hypertension, hyperlipidemia, hypothyroidism, rheumatoid arthritis and dementia. Refer to deficiency 618 for additional information on RI#2. RI#2 was observed using oxygen continuously during the survey. RI#2 used a wheelchair for mobility. On September 1, 2021, RI#2 had extreme shortness of breath and was sent to the emergency room. On December 5, 2021, RI#2 was started on Lasix (fluid pill) due to edema. RI#2's facility care plan did not contain pertinent diagnoses with signs and symptoms of complications to report, did not direct use of a wheelchair or oxygen and did not address the significant changes in RI#2's status with appropriate interventions. RI#3 RI#3 had resided at the facility since June 18, 2021. Refer to deficiencies 601 and 604 for additional information on RI#3. RI#3 sustained a fall on June 24, 2021, which resulted in a fractured humerus. On December 24, 2021, RI#3 tested positive for COVID-19 at the facility. These significant changes were not addressed on RI#3's facility care plan with appropriate interventions to meet RI#3's care needs.	A 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 64 RI#4 RI#4 had resided at the facility since April 13, 2021. Refer to deficiencies 508, 604 and 612 for additional information on RI#4. During the survey, RI#4 was observed wandering about the facility most of the day. RI#4 had eloped from the facility in April 2021. According to RI#4's most recent behavior screening, which was completed on April 27, 2021, RI#4 "...does not like to feel forced to do things...demanding at times regarding going home...can push at people...exit seeks...alternate reality... ." RI#4 sustained a fall on December 19, 2021. EI#4 reported RI#4 had sustained significant weight loss at the facility which resulted in a physician's order for Boost, one can 3 times a day between meals. These specific care needs were not addressed on RI#4's facility care plan with appropriate interventions to keep RI#4 and all residents safe and to prevent further falls, weight loss or elopement. RI#5 RI#5 had resided at the facility since October 19, 2021. Refer to deficiencies 508, 602, 604 and 612 for additional information on RI#5. RI#5 sustained a fall on November 3, 2021. On December 27, 2021, RI#5 eloped from the facility. RI#5 was observed during the survey pushing on exit doors and looking for a car. RI#5's facility care plan did not address the fall or the elopement/wandering/exit seeking. Interventions had not been developed to keep RI#5 safe. RI#6 RI#6 had resided at the facility since January 15, 2021. Refer to deficiencies 601, 603 and 604 for additional information on RI#6. During interviews	A 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 65 on January 4, 2022, care partners reported RI#6 had declined, was incontinent of bowel and bladder, was uncooperative with care and frequently required assistance from at least two staff members to provide care. RI#6 sustained falls on June 10, 2021, and on August 30, 2021. On December 24, 2021, RI#6 tested positive for COVID-19 at the facility. RI#6 had choking episodes in May 2021. RI#6 had diagnoses of diabetes mellitus II and recurrent falls. RI#6's facility care plan did not address any of these issues and care needs. Adequate interventions had not been developed and implemented to keep RI#6 and other residents safe and to ensure RI#6's care needs were met. RI#7 RI#7 had resided at the facility since May 10, 2021. Refer to deficiencies 504, 601, 604 and 621 for additional information on RI#7. RI#7 had diagnoses of hypertension and atrial fibrillation. RI#7's care plan did not include signs and symptoms of complications to monitor for and report with these diagnoses. RI#7 had received wound care to the ankle, provided by home health, since August 27, 2021. On October 10, 2021, RI#7 sustained a fall. On November 2, 2021, RI#7 developed edema, redness and warmth of the lower extremities and was started on an antibiotic. RI#7 was positive for COVID-19 at the time of the survey and had frequent cough and generalized weakness. These specific care needs were not addressed on RI#7's facility care plan with appropriate interventions. RI#9 RI#9 resided at the facility from May 24, 2021, until October 14, 2021. Refer to deficiency 604 for	A 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 66 additional information on RI#9. During interviews on January 4, 2022, care partners reported RI#9 had been aggressive during care. Review of RI#9's facility record revealed multiple written reports of RI#9 being physically aggressive, urinating in inappropriate places and taking silverware from the dining room. RI#9 had multiple medication changes due to behaviors. The only reference to behaviors on RI#9's facility care plan was "Monitor-Behaviors." RI#9 had diagnoses of glaucoma and vascular dementia with behavioral disturbances, indicating potential for behaviors and possible visual deficit. There were no specific interventions on the facility care plan to address the behaviors and care needs and to protect RI#9 as well as other residents and staff. Residents' care plans were not individualized to meet the specific needs of each resident. The care plans were not updated when significant changes occurred. They did not contain medical conditions and signs/symptoms of complications to monitor the resident for. The type of diet each resident required was not written on the care plan. EI#4 stated she (EI#4) had been working to individualize the care plans but had not been able to print them off.	A 611		
A 612	420-5-20-.06 (4) (c) (d) (e) (f) Care of Residents. (c) Activity Program. There shall be an activity program designed to meet the individual needs of each resident. The facility shall maintain supplies and equipment as necessary to implement the activity programs. Every day the facility shall provide activities appropriate to residents with dementia. Residents who have	A 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 612	Continued From page 67 wandering behaviors shall have a documented activity program to manage this behavior. (d) Pets residing at the facility or used in activity programs shall be in good health and shall have current vaccinations as required by law. Vaccination certificates, or copies of vaccination certificates, shall be kept on file at the facility to demonstrate compliance with this requirement. (e) Mail, Telegrams, and Other Communications. 1. Incoming mail, telegrams, and other written communications addressed to the resident shall be delivered to the resident unopened. Outgoing mail shall be promptly delivered to regular postal channels upon receipt from the resident. Residents shall be permitted to receive telephone calls at the facility in complete privacy. 2. Personnel of the facility shall assist residents with communications, such as writing letters or assisting with writing letters, or reading mail out loud if requested to do so. (f) Appointments. Residents shall be assisted in making and keeping appointments. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, residents who exhibited wandering and exit seeking behaviors did not have a specific activity program designed to meet their individual	A 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 612	Continued From page 68 needs. Findings: RI#4 had resided at the facility since April 13, 2021. Refer to deficiencies 508, 604 and 611 for additional information on RI#4. RI#4 was noted during the survey wandering about the facility most of the day. During interviews on January 4, 2022, care partners reported RI#4 walked all day and sometimes at night and would push on doors, looking for his/her spouse. Review of RI#4's facility record on January 6, 2022, revealed RI#4 eloped from the facility in April 2021. RI#5 had resided at the facility since October 19, 2021. Refer to deficiencies 508, 602, 604 and 611 for additional information on RI#5. During interviews on January 4, 2022, care partners reported RI#5 also wandered frequently during the day and would often push on doors, looking for a car. RI#5 was observed during the survey pushing on exit doors. Review of RI#5's facility record on January 6, 2022, revealed RI#5 had also eloped from the facility on December 27, 2021. Neither of these residents had a specific activity program documented which was designed to meet their individual needs and to manage their wandering behaviors. Due to this deficient practice, both residents were at increased risk for another elopement. EI#4 agreed specific interventions had not been documented for these two residents.	A 612		
A 616	420-5-20-.06 (5) (i) (j) (k) (l) (m) Care of Residents.	A 616		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 616	Continued From page 69 (i) Medications kept under the control or custody of a specialty care assisted living facility shall be packaged by the pharmacy and shall be maintained by the facility in unit dose packaging. Medications kept under the control or custody of the specialty care assisted living facility that are not available in unit dose packaging must be packaged by the pharmacy and administered by a physician, RN, or LPN. (j) Unless a resident can and does self-manage his or her own medications, a specialty care assisted living facility shall require each resident to use a single pharmacy. This does not apply to emergency pharmacy services. All residents need not use the same pharmacy that is used by other residents unless express policy of the specialty care assisted living facility provides otherwise and all residents are informed of such policy and provided a copy of such policy prior to or at the time of admission. The specialty care assisted living facility shall require pharmacies used for medication supply for residents not self-managing their medications to review all ordered medication regimens for possible errors or adverse drug interactions and to advise the facility and the prescribing health care provider when these are detected. (k) If controlled substances prescribed for residents of any specialty care assisted living facility are kept in the custody of the specialty care assisted living facility, they shall be stored in a manner that is compliant with state and federal laws, the requirements of the Alabama State Board of Pharmacy, and any requirements prescribed by the Alabama State Board of Health. At a minimum, controlled substances in the custody of the facility shall be stored using a	A 616		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

(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 616	Continued From page 70 double lock system, under proper temperature and humidity controls and permit only authorized personnel access. The facility shall maintain a system to account for all controlled substances in its possession. All other medications in the custody of the facility shall be stored using at least a single lock, under proper temperature and humidity controls and permit only authorized personnel access. This shall include medications stored in a resident's room when the staff and not the resident have access to the medications. Medications may be kept in the custody of an individual resident who can safely manage his or her medications. Such medications may be stored in a locked container accessible only to the resident and staff, or may be stored and secured in the resident's living quarters, if the room is single occupancy and has a locking entrance. (l) Medication administration records and written physician orders for all over-the-counter drugs, legend drugs, and controlled substances shall be retained for a period of not less than 3 years. They shall be available for inspection and copying on demand by agents of the State Board of Health. They shall be made available for inspection at reasonable times by residents, anyone authorized by the resident, and by the sponsors of residents. (m) Labeling of Drugs and Medicines. All containers of prescribed medicines and drugs shall be labeled in accordance with the rules of the Alabama State Board of Pharmacy and shall include appropriate cautionary labels, such as, "Shake Well," or "For External Use Only."	A 616		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 616	Continued From page 71	A 616		

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to maintain a resident's medication in unit dose packaging and failed to consistently follow a system in place to account for all controlled substances in its possession.

Findings:

Medication Not Unit Dose Packaged

During observation of medication administration by EI#7 on the morning of January 4, 2022, the surveyor noted a bottle of medication for RI#8 in the drawer of the medication cart. The medication was dated June 1, 2021, and labeled as Calcitrol 0.5 micrograms. The bottle contained multiple doses of the medication and was used to administer RI#8's morning medication. When questioned as to why the medication was not unit dose packaged, EI#7 stated RI#8's medications came from a different pharmacy and that medication had always been in a bottle. EI#4 agreed the medication was incorrectly packaged.

Controlled Substances Accounting System

On the afternoon of January 4, 2022, the surveyor observed EI#7 and EI#8 count controlled substances. The count was recorded on the Narcotic Sign In/Out Sheet by both EI#7 and EI#8. Review of the most recent Narcotic Sheets revealed signatures were not always present to confirm the counts were completed and correct. There was only one shift count documented for the entire day on December 5, 19, 27 and 28, 2021. There were no signatures for 7:00 AM-3:00 PM shift on December 23, 2021, and for 7:00

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

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A 616	Continued From page 72 AM-3:00 PM on December 31, 2021. EI#4 agreed the narcotics accounting system had not been properly utilized.	A 616		
A 618	420-5-20-.06 (7) Care of Residents. (7) Oxygen Therapy. (a) A resident of a specialty care assisted living facility that requires oxygen therapy shall have oxygen administered only by a physician, RN, or LPN. (b) Oxygen use including date, time, rate, and proper function of the equipment shall be documented on the medication administration or medication assistance record at least once per shift. 1. If a resident receives oxygen therapy in a facility: 2. All oxygen equipment, such as tubing, masks, and nasal cannula shall be maintained in a safe and sanitary condition. 3. All oxygen tanks shall be safely maintained and stored. 4. The facility shall require safe use of oxygen therapy. No smoking and appropriate precautionary signs shall be posted. 5. The facility shall ensure that each resident using oxygen therapy maintains an adequate supply of oxygen. Refer to National Fire Protection Association (NFPA) 99 for Oxygen Storage Requirements.	A 618		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

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A 618	Continued From page 73 This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to document a resident's oxygen use on the MAR as required. Findings: RI#2 had resided at the facility since February 1, 2021. Refer to deficiency 611 for additional information on RI#2. RI#2 had a physician's order for oxygen at two (2) liters/minute and was observed during the survey using the oxygen continuously. RI#2's oxygen use was not documented on the MAR to include date, time, rate and proper function of the equipment at least once per shift. EI#4 stated she (EI#4) would add the oxygen to RI#2's MAR and instruct the nurses to document oxygen use.	A 618		
A 621	420-5-20-.06 (9) (b) Care of Residents. (b) Retention. 1. A specialty care assisted living facility shall not allow any resident to return to the specialty care assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the specialty care assisted living facility is licensed to provide or the facility is capable of providing. 2. A specialty care assisted living facility shall not retain a resident that has a PSMS score greater than 23 or a score of five in feeding, dressing, grooming, bathing or a score of four or five in physical ambulation.	A 621		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

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CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 621	Continued From page 74 3. A specialty care assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility. 4. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in a specialty care assisted living facility. 5. A specialty care assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless: (i) The individual is capable of performing and does perform all tasks related to his or her own care; OR (ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity but the individual has sufficient cognitive ability to direct his or her own care and the individual is able to direct facility staff and does direct facility staff to provide the physical assistance needed to complete such tasks, and the facility staff is capable of providing such assistance and does provide such assistance. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. 6. If a resident of a specialty care assisted living facility is diagnosed with a terminal illness and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90	A 621		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 621	Continued From page 75 days. If the facility is unable or becomes unable to meet the needs of a resident receiving hospice care, or if a resident receiving hospice care requires care beyond what the facility may lawfully provide pursuant to this section, then the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for specialty care assisted living facilities. The facility would in all cases remain responsible for ensuring the appropriate delivery of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility retained residents who required skilled nursing care which had exceeded 90 days. Findings: RI#1 RI#1 had resided at the facility since February 1, 2021. Refer to deficiencies 504, 601, 602, 604 and 611 for additional information on RI#1. On January 4, 2022, the surveyor observed RI#1 being toileted by care partners. The surveyor noted a bandage to RI#1's sacral/buttock area which was partially intact. On January 4, 2022, EI#7 informed the surveyor RI#1 was receiving wound care from home health. Review of home	A 621		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT EASTCHASE MEMORY CARE, THE	2551 EASTCHASE LANE MONTGOMERY, AL 36117

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A 621	Continued From page 76 health records on January 6, 2022, revealed RI#1 had a stage 2 pressure ulcer to the right buttock with date of onset August 13, 2021. On January 6, 2022, EI#4 stated RI#1's pressure ulcer had been difficult to treat because RI#1 sat in the recliner most of the day and did not have a bed in the room. EI#4 added RI#1 preferred to sleep in the recliner, making it impossible to turn and relieve the pressure on the wound. RI#1 had received wound care to the buttock wound for almost 5 months at the facility. EI#4 stated she (EI#4) needed to issue a 30-day discharge notice to RI#1's sponsor. RI#7 RI#7 had resided at the facility since May 10, 2021. Refer to deficiencies 504, 601, 604 and 611 for additional information on RI#7. On the morning of January 4, 2021, during observation of medication administration, the surveyor noted bandages to RI#7's lower legs/feet. EI#7 informed the surveyor home health was providing wound care to RI#7. Review of home health records on January 6, 2022, revealed RI#7 had a wound of unknown origin to the right medial foot with a date of origin August 27, 2021. RI#7 also had a previous wound to the left medial foot which was treated by home health from September 10, 2021 until November 8, 2021, when the wound resolved. RI#7 had received wound care to the right foot for greater than four months at the facility. EI#4 stated to the surveyor, on January 6, 2022, she (EI#4) knew RI#7's wound had been present longer than 90 days and she (EI#4) needed to issue a 30-day discharge notice.	A 621		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

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A 703	Continued From page 77	A 703		
A 703	420-5-20-.07 (3) Food Service. (3) Dietary Service. (a) Number of Meals. No fewer than three meals shall be provided each 24 hours. Food service shall be provided in a resident's room during temporary illness if necessary. The diet shall be well-balanced, palatable, properly prepared, and sufficient in quantity and quality to meet the nutritional needs of the residents in accordance with Dietary Reference Intakes of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The food must be adapted in type and preparation to the habits, preferences, and physical abilities of the residents. (b) Timing of Meals. A time schedule for serving meals to residents and personnel shall be established. Meals shall be served approximately five hours apart with no more than 14 hours between the evening meal and breakfast. The time schedule of meals shall be posted with the menu. The facility shall make evening snacks available after service of the evening meal. The facility shall provide fluids throughout the day and shall make between-meal nourishment (snacks) available. (c) Menu. The menu shall be planned and written at least 1 week in advance. The current week's menu shall be posted in the food service area and shall be kept on file for the following 2 weeks. For any resident with a physician's order for a therapeutic diet, the facility shall have a copy of the diet and the facility shall document the adjustment of its menu to	A 703		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

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A 703	Continued From page 78 accommodate the resident's needs. (d) Alternate food selections or substitutes shall be made available to all residents. (e) A facility shall not obtain food from charitable organizations. A facility shall not avoid serving a meal by sending or transporting residents to missions, soup kitchens, or other charitable facilities for meals. (f) The amount of food on hand shall be sufficient to serve three meals per day to all residents for 3 days. Non-perishable food and potable water shall be maintained in the facility in sufficient quantity to serve three meals per day to all residents for 3 days. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure a sufficient quantity of potable water was available on site 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	A 703		

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A 703	Continued From page 79 of water for the number of residents in the ALF and SCALF.	A 703		
A1101	420-5-20-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All specialty care assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs.	A1101		

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A1101	Continued From page 80 (d) Roller latches are prohibited on doors separating corridors from adjacent spaces. (e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that: 1. Minimizes leaks and spills. 2. Adequately protects against inappropriate access. 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		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

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A1101	Continued From page 81 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 SCALF during the following months of 2021: January, February, March, April, May, September and December. 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 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		

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	P5117	A. BUILDING: _____ B. WING _____	02/14/2022

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A1101	Continued From page 82 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		