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A 000	Initial Comments On April 19, 2022 a unannounced licensure survey and complaint investigation was conducted for this 16 bed Specialty Care Assisted Living Facility (SCALF) with a census of 6. There were two (2) complaints investigated during this survey. Complaint #20200805005 and Complaint #20210915012 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 and require a plan of correction.	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		

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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	A 301		

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A 301	Continued From page 2	A 301		

reviews, the governing authority failed to ensure 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 6 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#2) had been employed as the administrator at the facility approximately nine (9) months at the time of the survey. EI#2 also was administrator for the skilled nursing facility (SNF) on the same property.

During an interview on April 14, 2022, EI#1, Market President/Governing Authority, reported he (EI#1) had become involved with this facility in October 2021. EI#1 reported he (EI#1) or someone from Corporate (Clinical Lead or Human Resources) visited the facility two times a month and he (EI#1) last visited the facility about one month prior to the survey. EI#1 admitted he (EI#1) had found many of the same deficient practices identified by surveyors at the time he (EI#1) last visited the facility. In addition, EI#1 stated he (EI#1) had spoken with a resident's family member about two weeks prior to the survey about a complaint. A family member reported to the ADPH on March 17, 2022, she/he had tried to talk with EI#1 and EI#2 without any action being taken. EI#1 further stated he (EI#1) was based in North Carolina and did not operate other ALF/SCALF facilities in Alabama. EI#1 acknowledged he (EI#1) was not familiar with the Alabama rules for ALFs/SCALFs, but verbalized

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A 301	Continued From page 3	A 301		

his (EI#1's) commitment to operating the facility according to Alabama SBOH rules. The surveyors brought to EI#1's attention the deficiencies related to the kitchen and food service which have been ongoing since 2016. EI#1 stated he (EI#1) was at the facility to help support EI#2 in getting things right this time. EI#1 went on to say they (EI#1 and EI#2) would take an extensive look at the issues and make sure the problems were resolved. EI#2 told the surveyors EI#1 had been supportive in her (EI#2's) role as administrator.

The Alabama Department of Public Health received two SCALF complaints which were investigated and substantiated during the onsite survey. In addition, complaints received for the assisted living facility (ALF) on the same campus were investigated for the SCALF during the survey due to the facilities having the same ownership and management. The complaints involved inadequate housekeeping and alleged the facility was "filthy" as well as a concern about the quality of the food served to residents. Surveyors were able to substantiate these complaints also and cited numerous housekeeping and maintenance deficiencies while at the facility. In addition, widespread deficient practices were cited during the survey including unreported contagious diseases, an unreported elopement, physicians' orders not followed, staff not adequately trained, inadequate health supervision by facility nurses, inadequate activities for residents, fire drills and fire alarm inspections not completed, inadequate resident call system, failure to sanitize dishes and multiple kitchen deficiencies related to maintenance of kitchen, improper food handling and food service. On April 14, 2022, EI#1 was asked by surveyors if there was a plan to close the facility due to the

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A 301	Continued From page 4	A 301		

widespread noncompliance. EI#1 stated there was no plan to close the facility.

EI#1 made a visit to the facility on April 19, 2022 and met with the surveyors. EI#1 apologized to surveyors for the deficiencies at the facility. EI#1 was asked by surveyors if there was a plan to hire an administrator for ALF/SCALF who did not also have responsibility for the SNF. EI#1 stated there was no plan to hire an administrator solely for ALF/SCALF and he (EI#1) planned for EI#2 to continue as administrator. EI#1 added that a new Registered Nurse (RN)/Care Coordinator (EI#9) had been hired and would start on April 22, 2022. Surveyors stressed to EI#1 that EI#9 would need extensive training by someone who had adequate knowledge of SBOH rules. EI#1 verbalized understanding. On April 19, 2022, EI#2 informed surveyors she (EI#2) was working to set up ALF/SCALF training for EI#1 and EI#2 in the future.

On April 19, 2022, surveyors asked EI#1 how he (EI#1) planned to resolve the deficiencies in a timely manner. EI#1 explained someone from the Corporate Operations Team would visit the facility at least once a week to check on the progress. EI#1 said that he (EI#1) and EI#2 would be making a plan that day and expected to have the kitchen and maintenance problems worked on in approximately 14-28 days. EI#1 told the surveyors he (EI#1) had 30 years experience in turning around poor performing facilities and had confidence they (EI#1 and EI#2) could bring this facility into compliance. EI#1 reiterated to surveyors his (EI#1's) commitment to bringing the facility to full compliance with the SBOH rules for SCALFs and to maintaining that compliance.

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A 302	Continued From page 5	A 302		
A 302	420-5-20-.03 (e) Administration. (e) Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). All residents shall be informed of new policies or changes in existing policies that may have bearing on the resident. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies 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.	A 302		

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A 302	Continued From page 6 (ix) Infection control. (x) Meal service, timing, menus and food preparation, storage, and handling. (xi) Fire safety and emergency plan, fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness. (xii) Staffing and conduct of staff while on duty. (xiii) Oxygen administration and storage if used in the facility. (xiv) Dietary Policies. The dietitian, 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.	A 302		

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A 302	Continued From page 7 (IV) Food substitutions or alternatives. (V) Method to ensure an adequate dietary plan is implemented for any resident with a therapeutic diet or special dietary needs. (VI) Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food. (VII) Provision of necessary services to any resident requiring adaptive devices to eat. (VIII) Procedure for the handling of potentially hazardous foods such as meat, milk, 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 policies and procedures for management and operation of the facility. Findings: According to the facility's 1.18 Housekeeping Services Policy and Procedure, "...To ensure all residents live in a clean, homelike environment...All common areas will be the	A 302		

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A 302	Continued From page 8	A 302		

responsibility of the Community to keep clean...Cleaning of residents' rooms will be done by Community Staff...This will include dusting, bathroom cleaning, vacuuming and trash removal...". The community did not keep common areas and residents' rooms clean. Refer to deficiency 1002 for additional information.

According to the facility's SH Fire Protection Systems Policy and Procedure, "...Fire Alarms:..A bi-annual inspection must be conducted by a qualified contractor...Fire Drills must be held monthly...at least quarterly on each shift...". The facility did not have the Fire Alarm System inspected semiannually and did not conduct monthly fire drills on each shift. Refer to deficiency 1101 for additional information.

According to the facility's AL504-SCALF Plan of Care Policy and Procedure, "...The registered nurse (RN) will develop a written plan of care for each resident prior to or at the time of admission...Based on resident's assessments, diagnoses...Identify resident care problem areas and formulate written interventions to address those problems...Evaluate the implementation of the interventions and the resident's response to the interventions and modify the plan of care as necessary...The plan of care will reflect the current condition of the resident at all times...All entries on the plan of care will be accurately dated...Level of assistance needed with Activities of Daily Living (ADLs)...". The facility RN failed to ensure residents' care plans were current and contained appropriate interventions to meet the care needs of the residents. Refer to deficiency 611 for additional information.

According to the facility's 1.15 Executive Director Responsibilities Policy and Procedure, "...An

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A 302	Continued From page 9 Executive Director ...will be responsible for the day-to-day operations...Ensuring that an adequate number of personnel are employed to meet resident needs and regulatory agency requirements...Ensuring the...Community admits only those residents whose needs can be met...Maintaining a file for incident reports...". The Executive Director/Administrator did not properly oversee the day-to-day operations of the facility. Refer to deficiency 303 for additional information. According to the facility's AL107-ALF/SCALF Governing Authority Policy and Procedure, "...Genesis Health Care Assisted living Facilities (ALF)/Specialty Care Assisted Living Facilities (SCALF) have a governing authority that consists of the Executive Director...The governing authority must give complete information to the Department identifying...Changes to the information listed within 15 days of the change...". The Department (ADPH) was not notified of a change of administrator within 15 days. Refer to deficiency 305 for additional information. According to the facility's 1.1 Accident/Incidents Policy and Procedure, "...All accidents or incidents occurring on Genesis Healthcare Living Community premises must be reported...Document the accident/incident onto...state-required Incident Report within 24 hours of the occurrence...". The facility failed to report an elopement and failed to report an outbreak of COVID-19. Refer to deficiency 508 for additional information.	A 302		
A 303	420-5-20-.03 (2) (a) Administration. (2) The Administrator.	A 303		

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A 303	Continued From page 10 (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 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	A 303		

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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.

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#2, Administrator, failed to adequately perform her (EI#2's) duties to ensure the proper

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and safe management of the day to day operations of the facility. These failures placed all 6 residents of the facility at risk of harm.

Findings:

On April 12-19, 2022, surveyors with the ADPH conducted an onsite survey and complaint investigation at the facility. Two (2) complaints were investigated. The complaints contained allegations which included inadequate staffing, an elopement not reported, inadequate activities for residents, a dirty kitchen and failure to provide menus to residents. Surveyors substantiated these complaints while onsite and identified other deficient practices as well.

EI#2 became administrator at the facility in July 2021, about seven (9) months prior to the survey. EI#2 was also the administrator for a SNF on the same property. During interviews with staff, on April 12 and 13, 2022, the surveyors received a report that EI#2 was at the facility every one to two weeks and allowed the Care Coordinator to run the facility. During an interview on April 18, 2022, surveyors asked EI#2 if she (EI#2) had adequate time to fulfill duties as administrator of three facilities. EI#2 stated she (EI#2) was able to perform the duties of administrator for ALF, SCALF and SNF. EI#2 added she (EI#2) had been given a job to do and she (EI#2) would get it done.

Multiple resident care issues were identified by surveyors. The current facility RN (EI#3) was also the Director of Nursing for the SNF. A new RN/Care Coordinator had been hired but was not scheduled to begin the duties until April 22, 2022. Both EI#3 and EI#20 (previous facility RN) admitted they (EI#3 and EI#20) did not have

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adequate knowledge of SBOH rules for ALFs/SCALFs. EI#3 stated she (EI#3) would be training the new RN/Care Coordinator, in spite of this inadequate knowledge of the rules. Resident assessments had not been completed by the RN. In fact, surveyors were informed by EI#3 and EI#20 a comprehensive assessment form was not available for use at the facility. Resident care plans were not current. Physicians' orders were not followed for residents' medications. An elopement and contagious disease outbreak were not reported to the ADPH. Activities for residents were inadequate. Monthly resident assessments were not completed or were completed by a Licensed Practical Nurse (LPN), not by the RN as required.

Multiple housekeeping and maintenance issues were cited as a result of EI#2's failure to provide adequate oversight of the facility's day to day operations. The kitchen had been cited for several deficient practices in previous surveys while the building was being used as an ALF. These deficient practices continued at the time of the current survey.

During an interview on April 19, 2022, EI#2 stated she (EI#2) had previously worked as administrator of a SNF in Alabama. EI#2 also stated she (EI#2) hoped to attend training in ALF/SCALF rules in the next few months.

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.

305 - The ADPH was not notified of a change in administrator.

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A 303	Continued From page 14 401 - The minimum staffing ratio was not maintained at the facility. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 402 - Required screening of employees was not completed prior to hire and prior to resident contact. 403 - Personnel records did not contain required information. 405 - The RN and Care Coordinator duties were not fulfilled on a daily basis. 406 - Staff were not adequately trained. Some staff were not certified in cardiopulmonary resuscitation and worked alone. 504 - The facility failed to provide a safe and decent environment for residents at all times. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 506 - A resident's medical record did not contain a personal effects inventory. 508 - Incidents including contagious disease outbreak and elopement of a resident were not reported to the ADPH. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 601 - Physicians' orders were not followed for residents' medications. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 602 - Resident medical exams did not contain	A 303		

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A 303	Continued From page 15 required information. 604 - There was inadequate health supervision of residents by the facility RN. 605 - There was inadequate general observation of a resident. 611 - Residents' care plans were not current and did not contain interventions to meet the care needs of the residents. 612 - Resident activities were inadequate. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 613 - There was no physician's order for a resident to maintain custody of a medication. 615 - Residents' Medication Administration Records (MARs) were not signed by the nurse. 616 - The facility failed to properly utilize a system in place to account for all controlled substances in its possession. 702 - Dishes were not sanitized. Kitchen facilities were dirty. Food was not properly stored and protected from contamination. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 703 - Mealtimes were not posted in the food service area and menus were not provided to residents. Meals were not palatable and appealing. 804 - The kitchen equipment was not maintained in acceptable and sanitary condition. Most of the kitchen equipment was not functional. THIS	A 303		

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A 303	Continued From page 16 DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 1001 - The premises and building were not adequately maintained. There were odors in the facility. The water temperature in the Beauty Salon exceeded the temperature allowed in a SCALF. 1002 - Residents' rooms and bathrooms, common areas and hallways were in need of cleaning. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 1101 - Fire drills and fire alarm inspections were not conducted as required. 1203 - Lights were not functional in residents' bathrooms and in the kitchen. The residents' call system was not functional in all rooms.	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 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.	A 305		

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A 305	Continued From page 17 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 April 12, 2022, EI#2 informed the surveyors she (EI#2) had been administrator since July 2021. However, a review of SBOH records revealed no written notification had been received by the SBOH when EI#2 became administrator. EI#2 stated she (EI#2) had sent an email regarding the change in administrator but could not recall who the email was sent to. On April 18, 2022, EI#2 told the surveyors she (EI#2) could not retrieve the email she (EI#2) sent when she (EI#2) became the new administrator.	A 305		
A 401	420-5-20-.04 (1) (2) Personnel. (1) A specialty care assisted living facility shall ensure adequate personnel are employed and on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. No specialty care assisted living facility shall have fewer staff on duty than specified in Table A below. Even if this minimum staffing ratio is met, the governing authority of a specialty care assisted living facility shall have additional staff on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. Facilities with resident bedroom wings separated from the remainder of the facility by a lockable door shall maintain dedicated staff to these areas adequate to meet all care and safety needs of the residents in these areas at all times.	A 401		

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A 401	Continued From page 18	A 401		

Table A

Staff Number	7 AM - 3 PM	3 PM - 11 PM	11 PM - 7 AM
2	1 -16 Residents	1 - 16 Residents	1 - 16 Residents
3	17 - 24 Residents	17 - 36 Residents	17 - 48 Residents
4	25 - 32 Resident	37 - 48 Residents	49 - 64 Residents
5	33 - 40 Residents	49 - 60 Residents	65 - 80 Residents
6	41 - 48 Residents	61 - 72 Residents	81 - 96 Residents
7	49 - 56 Residents	73 - 84 Residents	97 - 112 Residents
8	57 - 64 Residents	85 - 96 Residents	113 - 128 Residents
9	65 - 72 Residents	97 - 108 Residents	129 - 144 Residents
10	73 - 80 Residents	109 - 120 Residents	145 - 160 Residents
11	81 - 88 Residents	120 - 132 Residents	161 - 176 Residents
1 Additional Staff	For each 8 residents, or any fraction thereof, by which the census exceeds 88	For each 12 residents, or any fraction thereof, by which the census exceeds 132	For each 16 residents, or any fraction thereof, by which the census exceeds 176

(a) A specialty care assisted living facility shall be staffed at all times by at least one individual who has a current certification in

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A 401	Continued From page 19 cardiopulmonary resuscitation (CPR). (b) A specialty care assisted living facility must be sufficiently staffed to ensure the safe evacuation of all residents in the event of a fire or emergency. (2) Employee Schedule. A specialty care assisted living facility shall post a schedule of employees indicating names and days and hours scheduled to work. This schedule shall be retained in the facility for 6 months after use. In the event of an unplanned staff shortage which would make it otherwise impossible to meet the staffing requirements imposed by these rules, a facility may employ a certified nurse aide who has not received the training specified in these rules. For the purposes of this subsection, a certified nurse aide is defined as an individual who has been deemed or determined to be competent by the Alabama Nurse Aide Registry maintained by the Alabama Department of Public Health. This individual may not work unless accompanied at all times by an individual who is appropriately trained in accordance with these rules. Such employment shall last only until the facility has employed staff trained in accordance with the above. In no event may the period during which such staff is employed in a facility exceed 120 consecutive hours. This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to maintain the minimum required staffing at all times. In addition,	A 401		

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the facility was not staffed at all times by at least one individual who had current certification in CPR.

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

Findings:

The Alabama Department of Public Health received a complaint which alleged employees were working alone in the SCALF unit. Surveyors were able to substantiate this complaint during the onsite survey.

Inadequate Number of Staff on Duty

On April 12, 2022, employee schedules for the months of March 2022 and April 2022 were reviewed. One nurse and one Personal Care Assistant (PCA) were scheduled for the SCALF at all times.

Employees were interviewed about staffing concerns on April 12 and 13, 2022. Both EI#13, PCA, and EI#15, PCA, stated they (EI#13 and EI#15) had been left alone in the SCALF at times when the nurse would go to the assisted living facility (ALF) on the same property to assist with medications. Both EI#10, LPN, and EI#11, LPN, stated they (EI#10 and EI#11) had left one PCA alone in the SCALF multiple times to go to the ALF to assist with medications.

No CPR Certified Staff on Duty

Review of employee schedules for the month of April 2022 revealed the following dates when no staff were scheduled to work who were currently certified in CPR: April 2 from 7:00 AM until 6:00

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A 401	Continued From page 21 PM (EI#10 and EI#15); April 3 from 10:00 AM until 6:00 PM (EI#10 and EI#15); April 9 from 7:00 PM until 6:00 AM (EI#11 and EI#13): April 10 from 7:00 PM until 6:00 AM (EI#11 and EI#13). None of these employees were certified in CPR at the times they worked. On the morning of April 13, 2022, around 11:40 AM, the surveyor observed EI#15 working alone in the SCALF. EI#9 was also scheduled to work that morning but had left the SCALF to assist with medications in the ALF. EI#9 returned to the SCALF around 12:00 noon. In addition to leaving only one staff member in the SCALF, the unit was left with no staff currently certified in CPR. EI#15 was not certified in CPR at the time the incident occurred. After the deficiency was discussed with EI#2, a CPR certification class was conducted on the night of April 13, 2022. On the afternoon of April 14, 2022, staffing concerns were discussed with EI#2 and EI#3. A corrective action plan was received from EI#2 that same afternoon to address the staffing deficit.	A 401		
A 402	420-5-20-.04 (3) Personnel. (3) Employee Screening. (a) Prior to any resident contact, such as but not limited to assistance with activities of daily living, newly employed personnel shall have a physical examination certifying that the employee is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to residents through normal staff to	A 402		

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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 interviews, the facility failed to screen potential employees prior to hire and prior to resident contact.

Findings:

Review of employee files on April 13 and 18, 2022 revealed the following information.

EI#2, EI#9, EI#10, EI#12, EI#13, EI#15 and EI#16 did not have a physical examination certifying that the employee was free of signs and

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A 402	Continued From page 23 symptoms of infectious skin lesions and diseases that were capable of transmission to residents through normal staff to resident contact. EI#11 was hired on August 12, 2014 but did not have a physical examination documented until March 4, 2015. EI#15 was not evaluated for tuberculosis within 30 days of resident contact. EI#11 was not screened through the Alabama Department of Public Health Nurse Aide Abuse Registry. These findings were discussed with EI#7 on April 14 and 18, 2022. EI#7 did not provide all required information.	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.	A 403		

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A 403	Continued From page 24 (e) Date of hire. (f) Date of initial resident contact. (g) Date employment ceased. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain complete personnel records. Findings: Review of employee files on April 13 and 18, 2022 revealed the following information. EI#13 and EI#15 did not have an application for employment. EI#2, EI#9, EI#10, EI#11, EI#12, EI#13 and EI#15 did not have documented physical examinations. Refer to deficiency 402 for additional information. EI#11 did not have screening through the ADPH Aide Abuse Registry. Refer to deficiency 402 for additional information. EI#2, EI#9, EI#10, EI#11, EI#12, EI#13 and EI#15 did not have a date of initial resident contact. These findings were discussed with EI#7 on April 14 and 18, 2022 after EI#7 did not provide all required information.	A 403		
A 405	420-5-20-.04 (6) (7) (8) Personnel.	A 405		

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(6) Medical Director. Each specialty care assisted living facility shall have a medical director who is a physician currently licensed to 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.

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A 405	Continued From page 26 5. The RN shall identify staff training needs and ensure needed training is 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 and Care Coordinator duties were not performed consistently to ensure the facility operated in compliance with SBOH rules for SCALFs. Findings: At the time of the initial visit to the SCALF unit, on June 17, 2019, EI#3 was the RN and the Care Coordinator for the facility. During an interview on the morning of April 18, 2022, EI#20 reported she (EI#20) later became the RN and Care Coordinator and left the position in December 2021. On the morning of April 12, 2022, EI#3 reported EI#9 had been hired as the RN and Care Coordinator but would not assume the duties until April 22, 2022. EI#3 added a LPN had served as Care Coordinator for a couple of months but had just left the facility about a week prior to the survey. On the morning of April 14, 2022, when asked if she (EI#20) was the current	A 405		

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A 405	Continued From page 27 Care Coordinator, EI#20 replied "I guess I am". Review of resident records on April 13 and 18, 2022 revealed multiple RN duties had not been performed at the facility. No comprehensive assessments had been completed since the facility opened in 2019. In fact, neither EI#3 or EI#20 were aware of a comprehensive assessment form available for use on the unit. PSMS and behavior screenings were not completed for significant changes in residents. Residents' care plans were not current and did not contain appropriate interventions to address the residents' care needs. Monthly assessments of residents for December 2021, January 2022, February 2022 and March 2022 had been completed by an LPN. Significant changes in residents were not communicated to the residents' physicians and sponsors. Staff training needs were not identified and appropriate training provided, including CPR. Refer to deficiencies 406, 604 and 611 for additional information. There was inadequate management of the daily routine delivery of resident care by the Care Coordinator. Physicians' orders were not obtained or not followed. Medications were not administered to residents and the facility failed to notify the resident's physician. Activities were insufficient to meet the care needs of each resident. MARs and narcotic count sheets were not signed. Residents' physical examinations were incomplete. Incidents were not reported to the ADPH as required and were not investigated. Housekeeping and food service did not meet acceptable standards of SBOH rules. Dishes were not sanitized. Food storage was inadequate. Resident rooms, kitchen and common areas were not properly cleaned. Lighting and the resident call system were inadequate. General	A 405		

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A 405	Continued From page 28 observation was not provided for one resident. Staffing did not meet the minimum requirements for a SCALF. The facility was left without staff currently certified in CPR. Refer to deficiencies 401, 508, 601, 602, 612, 613, 615, 616, 702, 804, 1001, 1002 and 1203 for additional information. On April 14, 2022, EI#3 stated she (EI#3) was the current Director of Nursing for the SNF, on the same campus, in addition to her (EI#3's) responsibilities in the SCALF. EI#3 admitted she (EI#3) did not have sufficient time to oversee the SCALF as well as the SNF. EI#3 also took responsibility for CPR training not being completed for SCALF staff, stating she (EI#3) was busy getting the SNF staff certified. EI#3 stated she (EI#3) had not used a comprehensive assessment form at the SCALF and did not know if one was available on the unit. EI#3 also added she (EI#3) had not completed comprehensive assessments, PSMSs and behavior screenings for significant changes in residents and was unfamiliar with what was considered a significant change. EI#3 stated she (EI#3) would be responsible for training EI#9, the new RN and Care Coordinator, who would be starting in a few days. On the morning of April 19, 2022, surveyors discussed with both EI#1 and EI#2 their (surveyors') concerns that EI#9 would need extensive training in RN and Care Coordinator roles as well as training in SBOH rules. Both EI#1 and EI#2 verbalized understanding. EI#2 added she (EI#2) hoped to arrange training in SBOH rules for EI#1, EI#2 and EI#9 in the future.	A 405		
A 406	420-5-20-.04 (9) Personnel.	A 406		

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A 406	Continued From page 29 (9) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. An RN shall identify staff training needs and shall provide or arrange for needed training. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that, prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on specialty care assisted living facilities. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire. 5. Identifying and reporting abuse, neglect, and exploitation. 6. Basic first aid. 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environmental safety.	A 406		

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A 406	Continued From page 30 (b) Prior to providing any resident care, all staff shall complete The Dementia Education and Training Act (DETA) Care Series Training developed by the Alabama Department of Mental Health or equivalent training approved by the State Health Officer. All licensed staff shall complete DETA Brain Series Training, The Pharmacological Management of Dementia, and the Dementia Assessment Series provided by the DETA Program or equivalent training approved by the State Health Officer prior to resident contact. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained. (c) All staff who have resident contact shall be able to demonstrate diversional methods and redirection. All staff shall be able to demonstrate an understanding of the implications of caring for residents with agnosia, amnesia, aphasia, and apraxia. All staff shall be able to demonstrate an understanding of the facility's fire and evacuation plan and all other policies regarding safety, including policies for preventing elopements, responding to elopements, and fall prevention. (d) Cardiopulmonary Resuscitation. A specialty care assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of a specialty care assisted living facility who have contact with residents 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	A 406		

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A 406	Continued From page 31 defibrillator (AED) shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or the American Red Cross in CPR or AED utilization. (e) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training. (f) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff completed all required training. Findings: Review of employee files on April 13 and 18, 2022 revealed the following information. EI#2, EI#9, EI#11, EI#13 an EI#15 had not completed all required initial training for SCALF employees, although some employees had completed portions of the training. All five of the employees had resident contact.	A 406		

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A 406	Continued From page 32 EI#2, EI#10, EI#11, and EI#13 did not have current CPR certification at the time surveyors entered the facility. All five individuals had been employed at the facility greater than 90 days. CPR certification was completed for all of these employees except EI#2 during the onsite survey. The following licensed staff did not complete training in The Pharmacological Management of Dementia and the Dementia Assessment Series: EI#9, RN; EI#10, LPN; EI#11, LPN; EI#12, LPN. EI#2, EI#10, EI#11 and EI#15 did not complete training in the DETA Care Series Training. EI#10, LPN, did not complete the DETA Brain Series Training. EI#2, EI#9, EI#10, EI#11, EI#12, EI#13 and EI#15 did not complete special needs training in diabetes and hospice. The facility currently had one resident who was receiving hospice services and multiple residents with a diagnosis of diabetes. These findings were discussed with EI#7 on April 14 and 18, 2022 after EI#7 did not provide all required information.	A 406		
A 504	420-5-20-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission, of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if	A 504		

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appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate.

1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility.

2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints.

3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy.

4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and 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

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provide a safe place to keep funds on the premises, an individual account record for each resident shall be maintained by the administrator and an up-to-date record shall be maintained for all transactions.

7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so.

8. Every resident shall have the right to a reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals.

9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident.

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

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providing a more skilled level of care, or unless the resident engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record.

12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person without restraint, interference, coercion, discrimination, or reprisal.

13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file.

14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform 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

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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 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

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A 504	Continued From page 37 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. 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 all residents at all times.	A 504		

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A 504	Continued From page 38 THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received complaints which alleged medications were not given consistently, kitchen utensils were not clean, bugs were present in facility, residents had been combative, a resident tried to escape, mold was present under the sink and staffing was inadequate. All of these complaints were substantiated during the onsite survey. The following deficient practices were cited which jeopardized the safety and wellbeing of all residents of the facility. Employees were not screened and trained, including CPR training. Staffing was inadequate and the facility was often left with only one staff member. The facility was not staffed at all times with at least one staff member certified in CPR. Nurses were not trained in proper assessment of residents. Refer to deficiencies 401, 402, 405 and 406 for additional information. An elopement was not reported and investigated as required with appropriate interventions put in place to prevent a recurrence, placing the resident at risk of harm. Refer to deficiency 508 for additional information. Physicians' orders were not followed for residents' care, including medications which were not administered at all without notification to the physician. Refer to deficiency 601 for additional information. There was inadequate health supervision of	A 504		

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residents, both prior to admission to assess for facility eligibility and with significant changes to determine the need for changes in care. As a result, residents' care plans were not current to meet the care needs of the residents. Physicians and sponsors were not notified of changes in residents' conditions. Refer to deficiency 604 for additional information.

Activities were minimal or non-existent on some days, leaving the residents inactive and increasing the risk of elopement for residents. Refer to deficiency 612 for additional information.

Dishes were not sanitized. The kitchen was dirty. There was no functional dishwasher. Expired foods were not discarded. Meals were not appetizing. Food temperatures were not properly monitored. Food was not protected from contamination. Lights were not fully functional in the kitchen. Mold was present under the kitchen sink. Refer to deficiencies 702 and 804 for additional information.

The building was dirty, inside and out, and in need of repairs. The water temperature in the Beauty Salon exceeded the maximum allowed temperature. Lights were not functional in residents' bathrooms, creating a safety issue. The call system was not functional in some rooms. The Laundry Room contained trash and debris which created a fire hazard. Bugs were seen in the facility. Refer to deficiencies 1001 and 1203 for additional information.

Fire drills and fire alarm inspections were not completed as required. Refer to deficiency 1101 for additional information.

These deficient practices created an environment

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A 504	Continued From page 40 that was unsafe and unacceptable for residents, placing all residents of the facility at risk of harm. During an interview on April 19, 2022, both EI#1 and EI#2 verbalized understanding of the deficient practices and stated they (EI#1 and EI#2) would make things right.	A 504		
A 506	420-5-20-.05 (3) (f) Records and Reports. (f) Inventory of personal effects. 1. Upon admission to the specialty care assisted living facility, all personal property of the resident with a value in excess of $150, as well as any other property designated by the resident, shall be inventoried by the administrator or by a designee of the administrator in the presence of the resident. 2. All inventories shall be entered on an Inventory of Personal Effects Record. Inventory forms shall be signed by both the administrator, the resident or, if appropriate, the sponsor. One copy of the inventory shall be filed in the resident's individual file and one copy given to the resident or sponsor. 3. In the event the resident has no personal effects, this fact shall be entered on the Inventory of Personal Effects Record. 4. Amendments or adjustments shall be made on all copies of the Inventory of Personal Effects Record each time personal property valued in excess of $150 is brought to the facility, or when personal property is brought to the facility and the resident or sponsor requests that it be added to the Inventory of Personal Effects Record, or when any item on the Inventory of	A 506		

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A 506	Continued From page 41 Personal Effects Record is removed from the facility. All amendments shall be signed by the administrator and the resident or sponsor. This Rule is not met as evidenced by: Based on record review and interview, inventory of a resident's personal property was not documented upon admission. Findings: Review of resident records, on April 13, 2022, revealed RI#1 was initially admitted to the facility on May 3, 2021 with diagnoses which included dementia, hypertensive heart and kidney disease, congestive heart failure, diabetes mellitus II, chronic atrial fibrillation, atherosclerotic heart disease, sleep apnea, anxiety disorder, hyperlipidemia, chronic venous insufficiency, peripheral vascular disease, restless leg syndrome and hypothyroidism. Refer to deficiencies 604 and 611 for additional information on RI#1. No inventory of personal effects was documented for RI#1 upon admission. This finding was discussed with EI#3 on the afternoon of April 14, 2022. EI#3 did not provide any additional information.	A 506		
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	A 508		

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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.

(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.

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A 508	Continued From page 43 (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 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.	A 508		

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A 508	Continued From page 44 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. (xi) Names, telephone numbers, and addresses of witnesses. (xii) Date and time relatives or sponsor were notified. (xiii) Out-of-facility treatment.	A 508		

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A 508	Continued From page 45 (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 incident: (i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention. (ii) Elopement by a resident.	A 508		

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A 508	Continued From page 46 (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. (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	A 508		

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A 508	Continued From page 47 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. (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	A 508		

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A 508	Continued From page 48 be kept of all births, deaths, and stillbirths that occur within the specialty care assisted living facility. By the fifth day of each month, the administrator shall make a report of such births, deaths, and stillbirths for the preceding month on such forms as the State Board of Health shall provide to the county health officer, or in counties without a county health officer, to the State Registrar. This report shall be in addition to the official birth, death, and stillbirth certificates. If there are no births, deaths, or stillbirths in any month, a report shall be made stating that fact to the county health officer. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report the elopement of a resident and an outbreak of a contagious disease to the Department's Online Incident Reporting System (OIRS). THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: Outbreak of a Contagious Disease A review of the OIRS on April 11, 2022, by the surveyors, revealed no positive cases of COVID-19 had been reported by the facility. During the onsite visit, surveyors learned there had been two (2) outbreaks of COVID at the ALF and SCALF facilities. The morning of April 14, 2022, surveyors discussed this with EI#2, Administrator, and EI#3, Director of Nursing	A 508		

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(DON). EI#2 and EI#3 stated they (EI#2 and EI#3) were not aware this was a reporting requirement to the OIRS. EI#2 provided the surveyors with a list of six SCALF (6) residents and six (6) SCALF employees who tested positive for COVID-19 in November 2020 and December 2020. The surveyor reviewed the disease reporting requirements with EI#2 and she (EI#2) verbalized understanding and agreed to comply.

Elopement of a Resident

The Alabama Department of Public Health received a complaint which alleged a resident (RI#6) had eloped from the SCALF. Surveyors were able to substantiate this complaint during the onsite survey and verified the incident was not reported to the Department's OIRS.

Review of resident records, on April 13, 2022, revealed RI#6 was admitted to the facility on April 20, 2021 with diagnoses which included major neurocognitive disorder, dementia and hypertension. RI#6 was admitted to a geriatric psychiatric facility on October 22, 2021 due to refusal of care and agitation. RI#6 returned to the SCALF on November 11, 2021.

During an interview on the afternoon of April 13, 2022, EI#15, PCA, informed the surveyors of the following events which occurred on September 14, 2021. The date was verified by pictures on EI#15's personal cell phone which showed scratches to EI#15's arm and bruises to EI#15's wrist. EI#15 was working in the SCALF with EI#20, RN. EI#20 left the SCALF and went to the ALF. EI#15 was left in the SCALF with a housekeeper. RI#6 would frequently push on the front door. Around 9:00 AM, EI#15 was in a resident's room, assisting the resident. The front

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A 508	Continued From page 50 door alarm sounded, indicating the door was open. When EI#15 responded to the alarm, RI#6 was at the front door but still in the building. EI#15 walked past RI#6 and reset the door lock. RI#6 became angry, yelled at EI#15 and scratched EI#15's arm. About an hour later, EI#15 was in the kitchen and again heard the front door alarm. EI#15 responded and observed RI#6 had already exited the building. By the time EI#15 reached RI#6, RI#6 had walked across the front porch and down the front walkway to the parking area and was approximately 20 feet down the paved area of the parking lot. RI#6 grabbed EI#15's arm and began punching it. EI#15 allowed RI#6 to continue holding her (EI#15's) arm and punching it as she (EI#15) walked back to the front door. EI#15 was able to return RI#6 inside the SCALF. EI#20 remained in the ALF during the incident. Review of incidents reported to the Department's OIRS on April 14, 2022 revealed no elopement was reported by the facility on September 14, 2021. On the morning of April 18, 2022, EI#20 was questioned about the reported elopement of RI#6. EI#20 stated she (EI#20) did not report the incident to the State and did not investigate it because she (EI#20) thought RI#6 only got to the porch. EI#20 further stated she (EI#20) was not informed RI#6 was in the street and she (EI#20) was in the ALF during the entire incident.	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 601		

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A 601	Continued From page 51 (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 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	A 601		

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A 601	Continued From page 52 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, facility nurses failed to follow physicians' orders for residents' medications. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: RI#2 Review of resident records, on April 13, 2022, revealed RI#2 was admitted to the facility on September 11, 2021 with diagnoses which included hypertension, osteoporosis and diabetes mellitus. On the morning of April 12, 2022, the surveyor observed medication administration by EI#12, LPN. EI#12 administered and documented Lovastatin 40 milligrams to RI#2 around 8:00 AM. The entry on RI#2's Medication Administration Record (MAR) read, "Lovastatin 40 milligram tablet...1 tab by mouth every day" with an order date of "11/22/21" and a scheduled time of "8 AM". Review of RI#2's facility record on April 13, 2022 revealed a physician's order on the Medical Exam and Plan of Care, dated November 22,	A 601		

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2021 for Lovastatin 40 milligrams one tablet by mouth at bedtime. The Lovastatin was not administered at the time specified by RI#2's physician.

RI#5

The Alabama Department of Public Health received a complaint which alleged nurses were not giving medications consistently. Surveyors were able to substantiate this complaint during the onsite survey.

Review of resident records, on April 13, 2022, revealed RI#5 was admitted to the facility on March 12, 2021 with diagnoses which included schizophrenia, schizoaffective disorder, post-traumatic stress disorder, hypertension and major neurocognitive disorder.

On the morning of April 12, 2022, the surveyor observed EI#12 prepare medications for RI#5 and present a cup containing those medications to RI#5 in the dining room. RI#5 shook his/her head no and did not take the medications. EI#12 informed the surveyor RI#5 refused medications "almost all the time". When asked if the physician was aware that RI#5 was refusing medications, EI#12 stated she (EI#12) was not sure. Review of RI#5's March and April 2022 MARs on April 13, 2022 revealed RI#5 had refused medications frequently since March 9, 2022. These medications included Vitamin D-3 (vitamin supplement), Amlodipine (high blood pressure), Sertraline (depression, post-traumatic stress disorder), Haloperidol (mental disorders), Melatonin (promotes sleep), Donepezil (dementia)and Prazosin (high blood pressure).

On the morning of April 14, 2022, the Certified

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A 601	Continued From page 54 Registered Nurse Practitioner (CRNP) with Remedy Behavioral Health was present at the facility. The CRNP stated she (CRNP) had seen RI#5 in the past but the last time was March 9, 2022. When asked if she (CRNP) was aware RI#5 had not been taking medications recently, the CRNP replied she (CRNP) was aware RI#5 had refused medications in the past. The CRNP added she (CRNP) had not been notified by the facility that RI#5 was not currently taking medications. The CRNP also stated she (CRNP) would see RI#5 that day. There was no documentation in RI#5's facility record that indicated RI#5's physician was aware of RI#5's current medication refusal until April 14, 2022, after the surveyor brought this concern to the attention of the facility and the CRNP. RI#2's and RI#5's medications were not administered as ordered by their physicians. This deficiency was discussed with EI#2 and EI#3 on April 14, 2022. Both verbalized understanding of this deficient practice.	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	A 602		

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A 602	Continued From page 55	A 602		

to the facility. This examination is not required for a resident of a facility dually licensed as an assisted living facility and as a specialty care assisted living facility in those cases when the resident is transferred from the assisted living unit to the specialty care assisted living unit in the same facility. In addition to any information 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

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A 602	Continued From page 56 attending physician, the annual physical examination shall contain the following: 1. The resident's weight and vital signs. 2. Changes in diagnoses. 3. Changes in 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.	A 602		

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A 602	Continued From page 57	A 602		

This Rule is not met as evidenced by:
Based on record reviews and interviews, residents' Physical Examination reports did not contain required information.

Findings:

Review of residents' facility records on April 13 and 18, 2022 revealed the following information.

RI#4 was admitted to the facility on July 31, 2019 with diagnoses which included dementia, fatigue, hyperlipidemia and organic brain syndrome. Refer to deficiencies 604 and 611 for additional information on RI#4. RI#4's Initial Physical Examination was documented on July 25, 2019. An Annual Physical Examination was documented on April 15, 2021. No Annual Physical Examination was documented for the year 2020. On April 18, 2022, EI#20 confirmed the Annual Physical Examination for 2020 was not completed.

RI#5 had resided at the facility since March 12, 2021. Refer to deficiencies 601, 604, 605, 611 and 615 for additional information on RI#5. No baseline weight was documented on RI#5's Initial Medical Examination, dated March 8, 2021. This finding was discussed with EI#3 on the morning of April 14, 2022.

RI#7 was admitted to the facility on November 2, 2019 with diagnoses which included dementia without behaviors, atherosclerotic heart disease, osteoarthritis, chronic obstructive pulmonary disease, atrial fibrillation, hyperlipidemia, hypertension and history of transischemic

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A 602	Continued From page 58 attacks. RI#7 was discharged from the facility to a skilled nursing facility on August 17, 2021. RI#7's Initial Physical Examination, dated November 1, 2019, did not contain RI#7's baseline vital signs and weight. This finding was discussed with EI#3 on the morning of April 14, 2022.	A 602		
A 604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility RN or care coordinator shall screen prospective residents for eligibility for admission into the specialty care assisted living facility. The screening shall include a clinical history, a mental status examination to include aphasia screening, a geriatric depression screen, a physical self-maintenance screen, and a behavior screen. Appendix A herein, contains the Physical Self Maintenance Scale (PSMS) form and the Behavior Screening form. These forms shall be completed to screen physical functioning and behaviors. The PSMS and Behavior Screen assessments shall be completed by the RN or care coordinator upon admission, annually, and when there is a change in the resident's status. The facility RN shall perform a comprehensive assessment of each prospective 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	A 604		

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A 604	Continued From page 59 assess each resident monthly and more often when necessary to identify changes in the resident's health status. The monthly assessment shall include a review of monthly weights, falls, incidents, elopements, behavioral symptoms, medications, changes in resident status, and appropriateness of the resident's plan of care. (c) Comprehensive Assessment. The facility RN shall perform a comprehensive assessment and communicate with the resident's attending physician and with the resident's sponsor or responsible family member when a decline in health status or behavior occurs, or if the resident develops any of the following problems: 1. Weight loss: (i) Each month, the facility shall accurately weigh and record the weight of each resident. (ii) A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half percent or greater weight loss in a period of 3 months or less, or a 10 percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician. 2. Falls (two or more falls within a 30 day period).	A 604		

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A 604	Continued From page 60 3. Elopement. 4. Any sign and symptom of adverse drug reaction, interaction or over sedation, or circumstances which contraindicate medications that have been prescribed for the resident. 5. Unmanageable, combative, or potentially harmful behavior(s). 6. Any accident with injury. (d) Focused Assessments. The RN or LPN shall conduct focused assessments when necessary to identify changes in resident status. (e) Any change in resident status requires immediate documentation and implementation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide adequate health supervision of residents to determine eligibility for admission and retention as well as to determine the residents' care needs and establish appropriate interventions. Findings: Review of residents' records on April 13 and 18, 2022 revealed the following information. Monthly assessments for the months of December 2021, January 2022, February 2022 and March 2022 were completed by an LPN who	A 604		

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A 604	Continued From page 61 was serving as Care Coordinator at the time. RI#1 was re-admitted to the facility on February 6, 2022 with diagnoses which included dementia, hypertensive heart and kidney disease, congestive heart failure, diabetes mellitus, chronic atrial fibrillation, atherosclerotic heart disease, sleep apnea, anxiety disorder, hyperlipidemia, chronic venous insufficiency, peripheral vascular disease, restless leg syndrome and hypothyroidism. Refer to deficiencies 506 and 611 for additional information on RI#1. No comprehensive assessment was completed to assess for facility eligibility. No PSMS and Behavior Screening were completed for RI#1 upon admission. RI#1 developed wounds to the lower extremities while residing at the facility and began receiving home health services for wound care on February 8, 2022. No comprehensive assessment, PSMS and Behavior Screening were completed for this significant change. No monthly assessment and weight were documented for RI#1 in March 2022. RI#2 had resided at the facility since September 11, 2021. Refer to deficiencies 601, 611 and 615 for additional information on RI#2. RI#2 did not have a comprehensive assessment completed to assess for facility eligibility and did not have a PSMS completed upon admission. RI#2's monthly assessments for December 2021, January 2022, February 2022 and March 2022 were completed by an LPN. RI#3 was admitted to the facility on September 27, 2021 with diagnoses which included hyponatremia, diabetes mellitus, anemia, hyperlipidemia, osteoarthritis, hypertension, gastroesophageal reflux disorder and dementia. Refer to deficiencies 611 and 613 for additional	A 604		

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information on RI#3. RI#3 did not have a comprehensive assessment completed to assess for facility eligibility. RI#3 sustained a 13 percent weight loss for one month in October 2021. No comprehensive assessment, PSMS and Behavior Screening were completed for this significant change.

RI#4 had resided at the facility since July 31, 2019. Refer to deficiencies 602 and 611 for additional information on RI#4. RI#4 did not have a comprehensive assessment completed to assess for facility eligibility. RI#4 was admitted to hospice services on April 11, 2022 with a diagnosis of Alzheimer's disease. On the morning of April 12, 2022, the surveyor observed RI#4 transfer from the bed to the wheelchair. The transfer required two people to assist RI#4. RI#4's facility care plan read, "...Transfers: Independent...". Obviously RI#4 had a decline in condition. However, RI#4 had not been assessed to include a comprehensive assessment, PSMS and Behavior Screening when the significant changes in RI#4's condition occurred.

RI#5 had resided at the facility since March 12, 2021. Refer to deficiencies 601, 602, 605 and 615 for additional information on RI#5. RI#5 did not have a comprehensive assessment completed to assess RI#5 for facility eligibility. RI#5 had multiple behaviors listed on the facility care plan, including "...draws on shirts and jackets with sharpies...voids in bathroom sink and bathtub...states (he/she) showers but does not, refuses assistance...goes in bedroom, locks (his/her) door and yells sometimes...talks to (himself/herself) in (his/her) room...does not allow staff in room at times...does have mood swings and will slam the door and tell staff bye at times...refuses meds; especially at night time

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meds...". In fact, RI#5 had refused medications for several weeks at the time of the survey. No comprehensive assessment, PSMS and Behavior Screening were documented for these significant changes in RI#5's condition.

RI#6 had resided at the facility since April 20, 2021. Refer to deficiencies 508, 611 and 612 for additional information on RI#6. No comprehensive assessment was completed to assess RI#6 for facility eligibility. RI#6 eloped from the facility on September 14, 2021 and also had a history of exit seeking and aggressive behaviors. RI#6 had even been admitted to a geriatric psychiatric facility in October 2021 due to unmanageable behaviors. No comprehensive assessment, PSMS and Behavior Screening were completed when these behaviors occurred.

RI#7 was admitted to the facility on November 2, 2019 and discharged from the facility on August 17, 2021 to a skilled nursing facility. Refer to deficiency 602 for additional information on RI#7. No comprehensive assessment was completed to assess RI#7 for facility eligibility. RI#7 eloped from the facility on July 27, 2020. No comprehensive assessment, PSMS and Behavior Screening were completed when this significant change occurred.

No comprehensive assessment forms were completed for any residents prior to admission or with significant change. There was not documentation that residents' physicians and sponsors were notified when significant changes occurred. When interviewed on April 18, 2022, EI#20 stated she (EI#20) had served as the RN and Care Coordinator but was never given a comprehensive assessment form to complete for each resident. EI#20 only completed the

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A 604	Continued From page 64 screening forms and a clinical history form on admission. EI#20 also admitted she (EI#20) did not complete PSMS and Behavior Screening forms for each significant change in a resident. On the morning of April 14, 2022, EI#3, DON and current facility RN, stated she (EI#3) did not have adequate knowledge of what was considered a significant change in residents' condition and was not aware of a comprehensive assessment form to be used at the SCALF.	A 604		
A 605	420-5-20-.06 (3) (f) Care of Residents. (f) Observation. Each specialty care assisted living facility shall provide general observation and health supervision of the residents to identify changes in all residents' health conditions and physical abilities, and awareness of the need for medical attention or nursing services as the changes develop. Whenever a resident requires medical attention, nursing services, or changes in personal care and assistance with activities of daily living provided by the facility, the facility shall arrange for or assist the residents in obtaining necessary services. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide general observation and health supervision of a resident	A 605		

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to identify changes in the resident that required medical attention and arrange for the resident to obtain necessary services.

Findings:

Review of resident records, on April 13, 2022, revealed RI#5 had resided at the facility since March 12, 2021. Refer to deficiencies 601, 602, 604, 611 and 615 for additional information on RI#5. During the five days onsite at the facility, the surveyor observed RI#5 mainly stayed in his/her room with door closed and would only come out to the dining room when meals were served. When RI#5 came to the dining room, he/she appeared unkempt, sometimes unshaven and hair uncombed. RI#5 did not interact with other residents and sat alone at a dining table in the corner. RI#5 did not participate in activities at the facility.

The surveyor observed RI#5's room with EI#12 on the morning of April 12, 2022 while RI#5 was in the dining room. The bathroom floor was cluttered with an absorbent underpad, clothing items and trash and the toilet contained urine and feces. The toilet seat was dirty. Several snack food items were noted in the bedroom. There was a hospital bed in a high position against the wall. The call light in the bedroom did not have a string for use to activate the call system.

EI#12 attempted to administer RI#5's medications, crushed and in pudding, on the morning of April 12, 2022. RI#5 refused and EI#12 documented the medications as refused on RI#5's MAR. EI#12 informed the surveyor RI#5 refused medications most of the time but she (EI#12) was not sure if RI#5's physician was aware RI#5's medications were not given. Also on

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the morning of April 12, 2022, EI#13, PCA, informed the surveyor RI#5 did not let staff in his/her room and she (EI#13) did not enter the room at night and did not see RI#5 unless RI#5 came to breakfast before her (EI#13's) shift ended. The surveyor observed EI#13 knock on RI#5's door that morning and inform RI#5 through a closed door that breakfast had arrived. RI#5 verbalized understanding through the closed door.

On April 12, 2022, EI#20, previous RN and Care Coordinator at the facility, was asked about RI#5. EI#20 stated she (EI#20) worked at the facility when RI#5 was admitted and was eventually able to get RI#5 to talk to her (EI#20) a little. EI#20 stated RI#5 had to be "pushed" to take a bath. EI#20 was asked if RI#5 would allow her (EI#20) to perform a physical assessment or skin assessment and EI#20 stated she (EI#20) was not sure. No comprehensive assessment had been performed on RI#20 prior to admission or since admission, even though significant changes were documented in RI#5's Monthly Summaries, including the following entries: March 12, 2022, "...refusing meds more frequently...mother passed-resident more withdrawn since..."; February 28, 2022, "...is not wanting to bathe...keeps to (his/her) self...". RI#5's refusal of care and increased withdrawal required assessment by the RN and notification to RI#5's physician and sponsor to determine appropriate interventions. This health supervision was not completed.

Review of RI#5's MARs on April 13, 2022 revealed RI#5 had frequently refused medications since March 9, 2022. On April 18, 2022, EI#20 stated the CRNP with Remedy Behavioral Health visited the facility weekly and was available to see

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the residents who were identified by staff as needing a visit. On April 14, 2022, this CRNP informed the surveyor she (CRNP) had not been made aware that RI#5 was currently refusing medications. The CRNP also informed the surveyor she (CRNP) had not visited RI#5 since March 9, 2022. The CRNP had been available at the facility but was not informed of the need for intervention due to RI#5's significant changes.

On the morning of April 12, 2022, EI#4, Maintenance Director, stated he (EI#4) frequently talked with RI#5 and had repaired the call light in RI#5's room that morning. EI#4 stated RI#5 always allowed him (EI#4) in his/her room, adding that it was all in how RI#5 was approached.

RI#5's facility care plan documented the following Problems/Needs for RI#5: "resident draws on shirts and jackets with sharpies...resident voids in bathroom sink and bathtub...resident states (he/she) showers but does not, refuses assistance...resident is at risk of elopement...delusions and hallucinations due to history of schizophrenia...resident goes in bedroom, locks (his/her) door and yells sometimes...resident talks to (himself/herself) in (his/her) room...resident does not allow staff in room at times...resident does have mood swings and will slam the door and tell staff bye at times...resident refuses meds especially at night time meds...". There were inadequate interventions to address these care needs and behaviors, making it difficult to determine if RI#5 was actually refusing interventions or if appropriate interventions were being offered by staff.

Inadequate health supervision had been provided for RI#5 to address RI#5's unique behaviors and

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A 605	Continued From page 68 care needs. RI#5's physician had not been notified of significant changes even though the CRNP visited the facility weekly. Intervention by the CRNP did not occur until April 14, 2022, when notified by the surveyor. RI#5 did not respond to the surveyor when spoken to on April 12, 2022. On April 18, 2022, surveyors discussed with EI#2, EI#3 and EI#9 the need to properly assess and observe RI#5's behaviors to ensure RI#5 is eligible and remains eligible for the SCALF based on documented history of noncompliance. EI#2, EI#3 and EI#9 verbalized understanding.	A 605		
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		

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A 611	Continued From page 69 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.	A 611		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 611	Continued From page 70 (iii) Hair. Residents' hair shall be kept clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be provided assistance with personal safety. 6. As changes in medication and 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 specific interventions to address the residents' care needs. In addition, residents were not assisted to maintain a clean, well-kept appearance. Findings: Review of residents' facility records on April 13, 14 and 18, 2022 revealed the following information. It was noted that care plan entries were not always dated and were not signed. Due to the absence of signatures, surveyors were unable to determine if all care plan entries were completed by a RN. RI#1	A 611		

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A 611	Continued From page 71 RI#1 had resided at the facility off and on since May 3, 2021. Refer to deficiencies 506 and 604 for additional information on RI#1. RI#1 was tearful at times during the survey and appeared depressed. RI#1's hair was observed to be greasy and uncombed during the entire survey. In addition, an odor of urine was noted in RI#1's room and around RI#1 when RI#1 was out of his/her room. When interviewed on the afternoon of April 13, 2022, EI#15 stated she (EI#15) would bathe RI#1 while RI#1 was seated on the toilet and was unable to bathe RI#1 in the shower due to bandages on his/her legs. EI#15 stated she (EI#15) attempted to wash RI#1's hair while RI#1 was seated on the toilet but added it was difficult. EI#15 added she (EI#15) was unsure when RI#1's hair was last washed. RI#2 RI#2 had resided at the facility since September 11, 2021. Refer to deficiencies 601, 604 and 615 for additional information on RI#2. During a tour of the facility on the morning of April 12, 2022, absorbent underpads were noted on the floor in RI#2's room. EI#13 explained to the surveyor that the pads were placed there because RI#2 would urinate on the floor. This behavior was not addressed on RI#2's facility care plan with appropriate interventions. RI#3 RI#3 had resided at the facility since September 27, 2021. Refer to deficiencies 604 and 613 for additional information on RI#3. RI#3 was observed during the survey using a wheelchair for mobility. In addition, RI#3 was demanding toward staff at times. In October 2021, RI#3 sustained a	A 611		

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A 611	Continued From page 72	A 611		

weight loss of 13 percent for one month (167 pounds on September 27, 2021 and 145 pounds on October 28, 2021). These care needs were not addressed on RI#3's facility care plan with appropriate interventions to prevent further weight loss and to manage RI#3's behaviors.

RI#4

RI#4 had resided at the facility since July 31, 2019. Refer to deficiencies 602 and 604 for additional information on RI#4. RI#4 was admitted to hospice services on April 11, 2022. On the morning of April 12, 2022, the surveyor observed EI#12 and EI#13 transfer RI#4 from the bed to the wheelchair. The transfer required two people due to RI#4 stiffening and pulling against staff. RI#4's facility care plan read, "...Transfers: Independent..." and did not reflect RI#4's current functional status.

RI#5

RI#5 had resided at the facility since March 12, 2021. Refer to deficiencies 601 602, 604, 605 and 615 for additional information on RI#5. On the morning of April 12, 2022, EI#13 informed the surveyor RI#5 was "paranoid" and would not let her (EI#13) in the room. RI#5's facility care plan contained the following "Problems/Needs": "Resident draws on shirts and jackets with sharpies"; "Resident voids in bathroom sink and bathtub"; "Resident states (he/she) showers but does not, refuses assistance"; "Resident does not allow staff in room at times"; "Resident goes in bedroom, locks (his/her) door and yells sometimes". Although these problem areas and needs were identified for RI#5, no specific interventions were documented for staff to follow to address RI#5's needs and behaviors and to

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A 611	Continued From page 73 ensure RI#5 was safe and received adequate care. RI#6 RI#6 had resided at the facility since April 20, 2021. Refer to deficiencies 508, 604 and 612 for additional information on RI#6. RI#6 reportedly eloped from the facility on September 14, 2021. All five days of the onsite survey, RI#6 was observed sitting by the front door of the facility and would immediately go to the door when someone approached or rang the doorbell. RI#6's actual elopement was not listed as a "Problem/Need" on the care plan, only a "risk of elopement". An intervention listed under "risk of elopement" read, "offer activities one on one with resident". This intervention was not observed being implemented during the onsite survey, even when RI#6 demonstrated increased anxiety and would begin walking the halls. There were no specific activities listed on RI#6's care plan to address RI#6's high risk of elopement. Resident care plans were discussed with EI#2 and EI#3 on April 14, 2022 and with EI#20 on April 18, 2022. EI#20 stated she (EI#20) completed residents' care plans until December 2021 when she (EI#20) left the unit. EI#20 stated she (EI#20) was unsure what was needed on the care plans and would like to have had training on what was expected. Resident care plans were also discussed with EI# 9 on April 19, 2022. EI#9 was scheduled to begin RN duties at the facility on April 22, 2022.	A 611		
A 612	420-5-20-.06 (4) (c) (d) (e) (f) Care of Residents.	A 612		

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A 612	Continued From page 74 (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 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.	A 612		

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A 612	Continued From page 75	A 612		

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to provide activities appropriate to each resident every day, including a resident who had eloped.

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

Findings:

The Alabama Department of Public Health received a complaint which alleged activities at the facility were insufficient. Surveyors were able to substantiate this complaint during the onsite survey.

The afternoon of April 13, 2022, surveyors reviewed the March 2022 and April 2022 Activity Calendars with EI#8, Activities Director. EI#8 said she (EI#8) had been an employee at the facility for over 20 years and accepted the Activities Director position in February 2022. EI#8 added she (EI#8) had not worked the past two weeks and assumed the PCAs conducted activities with residents when she (EI#8) was not at the facility. EI#8 told the surveyors she (EI#8) worked Monday through Friday and had been trying to improve the activities program. EI#8 informed the surveyors the previous Activities Director did not provide enough activities for the residents in the ALF and did not go to the SCALF at all. EI#8 said she (EI#8) tried to engage the residents in activities but the residents did not show an interest in participating at times. EI#8 added she (EI#8) had been given a budget of only $25.00 per month for all expenses related to activities.

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A 612	Continued From page 76 The activities calendar for the month of April 2022 was posted in the facility and was reviewed on April 12, 2022. For April 12, 2022, the schedule included manicures, lunch tunes and beauty shop. None of these activities were provided on that date. The surveyor observed EI#8 coloring pictures with three SCALF residents on the morning of April 12, 2022. On April 13, 2022, the surveyor observed very brief activities of kick ball and chair exercise which lasted approximately 10 minutes each. The April 2022 activities planned for Saturday ("Word Search" and "Coloring Pages") and Sunday ("Read a Book or Magazine" and "Watch TV") were not designed to encourage socialization with the other residents and were not appropriate for all SCALF residents. On April 13, 2022, EI#8 explained the "Lunch Tunes", scheduled Monday-Friday, as music which was played during the lunch meal. This did not involve participation of the residents or socialization. A sign on the door of the Beauty Shop stated the beautician would be at the facility on Tuesdays. Surveyors were at the facility on Tuesday, April 12, 2022 and Tuesday, April 19, 2022. The beautician did not come during the time surveyors were onsite. When questioned about the Beauty Shop on April 13, 2022, EI#8 stated the beautician did not come on April 12, 2022 and the facility never knew when she (beautician) would be there. One resident (RI#6) had a history of exit seeking and wandering at the facility as well as an elopement in September of 2021. Refer to deficiency 508 for additional information on the elopement. RI#6 was observed daily during the five days of the onsite survey sitting in a chair by the front door. RI#6 would frequently walk to the	A 612		

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A 612	Continued From page 77 door and look out or attempt to open the door. Each time someone came to the door from outside, RI#6 would get up and attempt to open the door. This was the same door that RI#6 had eloped through. RI#6 was frequently alone in the front common area or with another resident, not with facility staff. RI#6's facility care plan listed an intervention under "risk of elopement" which read, "offer activities one on one with resident". RI#6's care plan also read, "Resident becomes very agitated when (he/she) attempts to open the door and alarm goes off". One on one activities with RI#6 were not observed during the survey. On the afternoon of April 13, 2022, both EI#8 and EI#9 were interviewed about RI#6. Both agreed specific activities were needed for RI#6 which would be appropriate and would keep RI#6 engaged to reduce the risk of elopement. EI#9 stated she (EI#9) would contact RI#6's sponsor to find out what activities RI#6 enjoyed. On the morning of April 19, 2022, EI#2 reassured the surveyor EI#8 would be provided the training and resources necessary to develop an adequate activity program to enrich the residents' lives.	A 612		
A 613	420-5-20-.06 (5) (a) (b) (c) (d) (e) Care of Residents. (5) Medications. (a) Medications, as defined in these rules, shall be prescribed specifically for the resident by an individual currently licensed to prescribe medications in Alabama. A currently licensed physician in good standing with the Medical Licensure Commission of any state may prescribe medications to a resident of an assisted	A 613		

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A 613	Continued From page 78 living facility only during the initial physical examination. (b) A physician order is required for a resident to manage and have custody of his or her own medications. (c) A resident may have custody of and manage over the counter topical medications with the written approval of a physician. A physician order is not required for over the counter topical medications that are self-administered by residents and approved by the physician for resident possession. (d) Medication administration, as defined in these rules, shall be conducted only by a physician or an RN or LPN. An RN or LPN shall administer medications to residents in the specialty care assisted living facility only in accordance with physician orders and the Nurse Practice Act. (e) A current copy of A Short Practical Guide for Psychotropic Medications in Dementia Patients or the equivalent shall be in each specialty care assisted living facility as a reference guide. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, there was no physician's order for a resident to have custody of and manage a medication. Findings:	A 613		

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A 613	Continued From page 79 On the morning of April 12, 2022, the surveyor observed RI#3 had possession of a tube of Icy Hot ointment. Review of RI#3's facility record, on April 13, 2022, revealed RI#3 had resided at the facility since September 27, 2021. Refer to deficiencies 604 and 611 for additional information on RI#3. There was no physician's order for RI#3 to have custody of and manage this medication. This finding was discussed with EI#9 on the morning of April 14, 2022 and EI#9 verbalized understanding of the deficient practice. An order was written by the CRNP, on April 15, 2022, for RI#3 to keep the Icy Hot at bedside.	A 613		
A 615	420-5-20-.06 (5) (h) Care of Residents. (5) Medications. (h) All medications administered to residents in a specialty care assisted living facility, shall be contemporaneously recorded on a standard medication administration record. "Contemporaneously recorded" means recorded at the same time or immediately after medications are administered. The medication administration record shall include at least the following: 1. The name of the resident to whom the medication was administered. 2. The name of the medication administered. 3. The dosage of the medication administered. 4. The method of administration.	A 615		

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A 615	Continued From page 80 5. The site of injection or application, if the medication was injected or applied. 6. The date and time of the medication administration or assisted. 7. Any adverse reaction to the medication. 8. The printed name, initials, and written signature of the individual administering the medication or assisting the resident with self-administration of the medication. This Rule is not met as evidenced by: Based on record review and interview, facility nurses failed to document all required information on residents' MARs. Findings: On April 13, 2022, MARs for the month of April 2022 were reviewed for RI#2 and RI#5. Both residents' MARs contained multiple initialed entries of "VB". However, there was no printed name and signature on the "Nurses's Signature" section of the MARs to match the initials "VB". The deficient practice was discussed with EI#3 on the morning of April 14, 2022. EI#3 verbalized understanding of the need for a printed name and signature of each employee who initials the MAR.	A 615		
A 616	420-5-20-.06 (5) (i) (j) (k) (l) (m) Care of Residents.	A 616		

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A 616	Continued From page 81 (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		

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A 616	Continued From page 82	A 616		

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."

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A 616	Continued From page 83 This Rule is not met as evidenced by: Based on record reviews and interviews, facility nurses failed to properly utilize the system in place to account for controlled substances in the facility's possession. Findings: On the morning of April 12, 2022, the surveyor observed EI#9 and EI#12 count narcotics in the facility's possession at change of shift. Both EI#9 and EI#12 signed the "Shift Count" form after counting the narcotics to indicate the count was correct. However, the "Shift Count" form for the month of April 2022 was reviewed and the following discrepancies were found. There was no "Nurse's Signature Coming on Duty" for the following dates and times: April 6th at 8:00 AM; April 7th at 8:00 AM; April 9th at 6:00 PM; April 10th at 6:00 PM. There was no "Nurse's Signature Going Off Duty" for the following dates and times: April 6th at 4:00 PM; April 7th at 4:00 PM; April 9th at 6:00 AM; April 10th at 1:00 AM; April 11th at 8:00 AM; April 12th at 12:00 AM. This deficient practice was discussed with EI#2 and EI#3 on April 14, 2020. Both EI#2 and EI#3 verbalized understanding that the "Shift Count" forms should be signed by both nurses at each count.	A 616		
A 702	420-5-20-.07 (2) Food Service. (2) Food Handling Procedures. (a) Dish and Utensils Washing, Disinfection, and Storage.	A 702		

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A 702	Continued From page 84 1. Wash water shall be changed with sufficient frequency to avoid gross contamination, and final rinse water shall be kept clean and clear. 2. Hand washed repeated service and multi-service utensils and dishes, after washing and rinsing, shall be sanitized by either of the following methods: (i) Utensils and dishes shall be completely immersed for a period of not less than 30 seconds in water that is at least 171 degrees Fahrenheit (pouring scalding water over utensils and dishes does not meet this requirement); or (ii) A cold water sanitizer: A sanitizing solution shall be used in accordance with the manufacturers' instructions. Utensils and dishes shall be completely immersed for a period of not less than 10 seconds in a clean solution containing not less than 50 ppm, and not more than 200 ppm, of available chlorine bleach or its equivalent or 30 seconds 12.5 ppm of iodine or the amount of time specified by the manufacturer in a 200 ppm quaternary ammonium solution. Water temperature must be at least 75 degrees Fahrenheit. Water temperatures and chemical concentrations shall be monitored and documented prior to dishwashing. A record of each test shall be maintained for at least three months. 3. Dishes and utensils shall be allowed to air dry. 4. After washing, rinsing, sanitizing, and air-drying, all repeated use service ware (utensils	A 702		

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and dishes) shall be stored in a clean, dry place that is protected from pests, dust, splash, and other contaminants. Utensils shall be handled in such a way as to prevent contamination from hands and clothing.

5. The results from the use of dishwashing machines shall be equivalent to those obtained from the method outlined above, as documented in material provided from the manufacturer and kept on file at the facility.

(b) Ice. Crushed or chipped ice shall be protected from splash, drip, and hand contamination during storage and service. The ice scoop shall be stored in a holder inside the ice bin in a manner to prevent ice from coming into contact with the handle, or it may be stored in an airtight container outside the ice bin.

(c) Protection of Food from Contamination.

1. Food and food ingredients shall be stored, handled, and served so as to be protected from pests, dust, rodents, droplet infection, unsanitary handling, overhead leakage, sewage backflow, and any other contamination. Sugar, syrup, and condiment receptacles shall be provided with lids and shall be kept covered when not in use.

2. Medications, biologicals, poisons, detergents, and cleaning supplies shall not be kept in the refrigerator nor in other areas used for storage of food.

3. Food shall not be stored on the floor. All food and food ingredients stored on shelving

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must be placed on shelving that is at least six inches above the floor.

4. Refrigerators shall maintain a maximum temperature of 41 degrees Fahrenheit. Freezers shall maintain at a maximum temperature of 0 degrees Fahrenheit. Thermometers shall remain in refrigerators and freezers at all times.

5. All leftover foods shall be labeled and dated with a "use by date," so that it may be consumed or discarded by that date, which is no more than three days from the date is was prepared.

6. All food products shall be used by the manufacturer's indicated date or discarded.

7. Food shall be prepared either in the licensed facility or another location even when that location is not part of the licensed facility. All food preparation areas used by the facility shall be subject to the same inspections as though part of the licensed facility. The licensed facility is responsible to ensure adequate equipment and measures are used so that food is not contaminated in transport and foods that are transported are held and served at the appropriate temperature at all times.

8. Hot food shall be maintained at a minimum temperature of 135 degrees Fahrenheit and cold foods at a maximum temperature of 41 degrees Fahrenheit.

9. Frozen food items (raw and cooked) shall be thawed under refrigeration or under running water prior to preparation. Frozen food

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may also be thawed as part of the cooking process when indicated by package directions. Raw meats shall be stored below and away from vegetables, fruits, and other foods to prevent contamination (meat juices dripping on other foods).

10. Laundry shall not be brought through the food preparation or service area.

(d) Storage and Service of Milk and Ice Cream.

1. Milk and fluid milk products shall be served only from the original containers in which they were received from the distributor. This shall not apply to cream for coffee, cereals, and milk for milk drinks which may be dispensed from a readily cleanable container approved for such use.

2. Milk and fluid milk products shall be stored in such a manner that bottles or containers from which the milk or milk product is to be poured or drunk will not become contaminated from drip or contact with foods. Milk shall be maintained and stored at a maximum temperature of 41 degrees Fahrenheit and shall not be served at a temperature warmer than 45 degrees Fahrenheit unless specifically requested to be served at a warmer temperature by a resident.

3. Contaminating substances shall not be stored with or over open containers of ice cream. Ice cream dippers, spatulas, and other serving utensils shall be cleaned between uses.

(e) Kitchen Garbage and Trash

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A 702	Continued From page 88 Handling. 1. Kitchen garbage and trash shall be placed in suitable containers with tight-fitting lids and properly stored pending removal. Kitchen garbage and trash shall not be allowed to accumulate in the kitchen and shall be removed from the premises at frequent intervals. 2. After being emptied, all garbage cans and trash cans shall be washed and dried before reuse. (f) Employees' Cleanliness. 1. Employees engaged in the handling, preparation, and serving of food shall wear clean clothing at all times. Employees shall wear hair restraints, for example, hairnets, headbands, caps, or other adequate means to prevent contamination of food from hair. Employees whose duties include contact with residents shall change clothing or wear a clean covering over clothing before handling, preparing, or serving food. 2. Employees handling food shall wash their hands thoroughly before starting work each day, immediately after contact with any soiled matter, and before returning to work after each visit to the rest room. 3. Street clothing not worn by the employee shall be stored in lockers, dressing rooms, or closets designated for staff use. (g) Live Fowl or Animals. Live fowl or animals shall not be allowed in the food service area.	A 702		

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A 702	Continued From page 89 (h) Smoking and Spitting. Smoking, other use of tobacco products, and spitting within the food service area shall be prohibited for all staff, residents, and visitors. (i) Dining in Kitchen. Dining in the kitchen shall not be permitted in Congregate assisted living facilities. (j) Paper for Food Wrapping. Only new paper, foil, or plastic wrap shall be used for wrapping of foods. (k) Laundering of clothing shall not be permitted in food preparation or service areas. This Rule is not met as evidenced by: Based on observations and interviews, proper food handling procedures were not practiced in the facility's kitchen. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received complaints about food service at the facility including dirty utensils and dishwasher not functional. Surveyors substantiated these allegations during the onsite survey and found numerous other areas of noncompliance related to food handling procedures. Surveyors entered the facility early on the morning of April 12, 2022. The kitchen and dining area was toured with EI#12 and the following	A 702		

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deficient practices were found.

The dishwasher was not functional. Upon return to the kitchen later that morning, EI#10 was handwashing dishes and utensils from breakfast. When asked how she (EI#10) sanitized the dishes, EI#10 explained she (EI#10) got the water as hot as possible and added Dawn dish detergent. The dishes were washed in one of the two sink compartments then rinsed in the second compartment. After rinsing, the dishes were placed in drains on the counter to air dry. EI#10 stated no chemicals were used to sanitize the dishes and water temperatures were not checked prior to dishwashing. EI#10 confirmed the dishwasher had not worked in some time.

Hairnets and clothing coverings were not worn by staff when serving food to residents. The food was plated by dietary personnel in the kitchen, then the plates were taken to the residents by nurses or caregivers in the dining room. On the morning of April 12, 2022, EI#10 confirmed hairnets and aprons were not used by staff when taking food to residents. EI#10 stated she (EI#10) did not think there were any hairnets and aprons available on the unit.

On the counter in the kitchen were four canisters with lids which contained what appeared to be cereal and flour. Each canister contained a scoop or a styrofoam cup which was stored on top of the food ingredient inside the container, causing contamination to the food after use of the scoop.

In the refrigerator were three pitchers containing a dark liquid that appeared to be tea. The containers were not labeled and did not contain a "use by date". A large styrofoam cup was in the refrigerator, covered loosely with plastic wrap and

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A 702	Continued From page 91 labeled "pudding 3-28-22". The bottom of the refrigerator contained multiple spilled substances. During an interview on April 12, 2022, EI#6, Dietary Manager, explained food was prepared in the kitchen of the SNF on the same campus and transported in warming units to the ALF and SCALF. Once in the kitchen of the SCALF, food was plated by dietary staff and taken to residents by SCALF staff. EI#6 stated the temperature of the food was not checked prior to plating of the food in the SCALF kitchen. On April 13, 2022 at 9:20 AM, the surveyor inspected the SNF kitchen located on the same campus. The surveyor discussed the serious deficiencies found in the ALF and SCALF on the previous day with EI#6. EI#6 acknowledged there were problems but she (EI#6) had been working hard to correct them since becoming the Dietary Manager in November 2021. EI#6 told the surveyor the SCALF stove had been repaired and a new cook had been hired on April 12, 2022. EI#6 explained the plan was to resume cooking the food on site for ALF and SCALF residents rather than in the SNF kitchen. On April 19, 2022, surveyors discussed with EI#1 and EI#2 the numerous deficiencies in the facility's kitchen and food service. Although the facility had only been open as a SCALF since 2019, the building had been used prior to that time as an ALF and was owned and managed by the same company. Similar deficiencies had been cited during surveys conducted on August 6, 2014, March 1, 2016 and on February 5, 2019. EI#1 stated he (EI#1) was committed to making things right and he (EI#1) expected the kitchen issues to be addressed in approximately 14-28 days.	A 702		

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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 accommodate the resident's needs.	A 703		

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A 703	Continued From page 93 (d) Alternate food selections or substitutes shall be made available to all residents. (e) A facility shall not obtain food from charitable organizations. A facility shall not avoid serving a meal by sending or transporting residents to missions, soup kitchens, or other charitable facilities for meals. (f) The amount of food on hand shall be sufficient to serve three meals per day to all residents for 3 days. Non-perishable food and potable water shall be maintained in the facility in sufficient quantity to serve three meals per day to all residents for 3 days. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to post meal times and the current week's menu as required. In addition, the facility failed to consistently provide the residents with palatable and visually appealing meals. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged menus were not provided to residents. In addition, a complaint was received for the ALF unit, on the same campus, regarding the quality of the food served to the residents. This complaint was also investigated for the SCALF. Surveyors were able to substantiate the complaints during the onsite	A 703		

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A 703	Continued From page 94 survey and identified the following deficient practices. Posting of Meal Times and Menu During a tour of the facility on the morning of April 12, 2022, no weekly menu or meal times were posted in the food service area. When interviewed that same morning, EI#6, Food Service Manager, stated she (EI#6) would make sure the items were posted. On April 13 and 14, 2022, daily menus were posted but no weekly menu. Palatable Meals The morning of April 12, 2022 around 7:00 AM, the surveyor observed EI#21, Dietary Day Aide plating the food for the residents in the ALF kitchen. The surveyor was unable to identify most of the items placed on the plates. EI#21 told the surveyor it was hard boiled eggs, oatmeal, hash brown potatoes and coffee cake. The oatmeal was dry and thick and scooped into the shape of a ball. The hash browns were white and also scooped into a ball. The hash browns were not crispy and had the appearance of mashed potatoes. The coffee cake was falling into pieces and unidentifiable. The boiled eggs, potatoes and oatmeal were all similar in color and shape and were not appealing to the eye. The same food was observed being served to the SCALF residents that morning. On April 14, 2022, the breakfast was also not visually appealing. The oatmeal and French toast were scooped into balls. The French toast appeared to be gooey and was not served in slices as written on the menu or as one would expect it to be served. The food did not appear palatable.	A 703		

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A 703	Continued From page 95 The surveyor discussed the food presentation concerns with EI#6, Dietary Manager. EI#6 agreed the hash browns were not appealing and she (EI#6) had already discussed the proper way to prepare hash browns with the cook. EI#6 told the surveyor the food tasted better than it looked. The surveyor explained to EI#6 if a resident was not interested in the looks of the food at first glance they were not going to eat it and EI#6 agreed.	A 703		
A 804	420-5-20-.08 (4) Physical Facilities. (4) Food Service Facilities. (a) Floors. Floors in food service areas shall be of such construction as to be easily cleaned, sound, smooth, non-absorbent, without cracks or crevices, and shall be provided with approved and conveniently located facilities for the disposal of floor wash water. (b) Walls and Ceilings. Walls and ceilings of food service areas shall be of tight and substantial construction, and smoothly finished. The walls and ceilings shall be without horizontal ledges and shall be washable up to the highest level reached by splash and spray. Roofs and walls shall be maintained free of leaks. All openings to the exterior shall be provided with doors or windows, which prevent the entrance of rain or dust during inclement weather. (c) Screens or Outside Openings. Openings to the outside shall be effectively screened, or suitable provisions made equal to screening (such as fly fans). Screen doors shall be equipped with self-closing devices.	A 804		

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A 804	Continued From page 96 (d) Lighting. The kitchen, dishwashing area, and the dining room shall have adequate light. (e) Ventilation. Vent/exhaust hoods, vented to the outdoors, shall be provided over cooking surfaces to aid in removing cooking odors. Group homes with residential stoves may use a residential hood sized for the stove. Commercial exhaust hoods shall be installed when commercial cooking equipment is used. Congregate facilities shall use a commercial exhaust hood system. (f) Employee Toilet Facilities. Toilet rooms, if provided, shall not open directly into any room or space in which food is prepared, stored, displayed, or served, nor into any room in which utensils are washed or stored. Toilet rooms shall include a lavatory with a soap dispenser and disposable towels, and shall be well lighted and ventilated. (g) Hand washing Facilities. Each Group and Congregate specialty care assisted living facility shall provide a hand washing lavatory in the kitchens which shall be equipped with a soap dispenser and a supply of soap, disposable towels, and hot and cold running water through a mixing valve or combination faucet. The use of a common towel and common bar soap is prohibited. Hands shall not be washed in sinks where food is prepared. (h) Refrigeration Facilities. Adequate refrigeration facilities, automatic in operation for the storage of perishable foods, shall be provided Refrigeration shall be maintained at 41 degrees Fahrenheit or less. All refrigerators shall be	A 804		

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A 804	Continued From page 97	A 804		

provided with thermometers. All refrigerators shall be kept clean.

(i) Equipment and Utensil Construction. Equipment and utensils, except single service utensils, shall be so constructed as to be easily cleaned and shall be kept in good repair. No cadmium plated, lead, or readily corrodible utensils or equipment shall be used.

(j) Separation of Kitchen from Resident Rooms and Sleeping Quarters. Any room used for sleeping quarters shall be separated from the food service area by a solid wall with no direct openings. Sleeping accommodations shall not be permitted within the food service area.

(k) Clean Rooms. Floors, walls, and ceilings of rooms in the food service area shall be clean and free of an accumulation of rubbish, dust, grease, dirt, etc.

(l) Clean Equipment. Equipment in the food service area shall be clean and free of dust, grease, dirt, etc.

(m) Clean Counters, Tables, Tablecloths, and Napkins. Tables and counters, which are used for food service, shall be kept clean. Tablecloths and cloth napkins shall be laundered after each use.

(n) Location and Space Requirements. Food service facilities shall be located in a specifically designated area and shall include the following rooms and space: kitchen, dishwashing, food storage, and dining room.

(o) Equipment. Minimum equipment in

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A 804	Continued From page 98 the kitchen shall include the following: 1. Range. In a Group specialty care assisted living facility, a residential use range is permitted. A Congregate specialty care assisted living facility shall have a heavy duty range suitable for institutional use with double oven, or equivalent. 2. Refrigerator. A Group specialty care assisted living facility may use a residential refrigerator. A Congregate specialty care assisted living facility shall have a heavy-duty refrigerator suitable for institutional use. 3. Fire extinguisher. Five-pound type BC for residential hoods and K type for commercial hoods. 4. Dishwashing. The dishwashing equipment for Group assisted living facilities shall be either residential type using cold water sanitizers or commercial type with a booster water heater. Dishwashing equipment for all Congregate assisted living facilities shall be commercial type using a booster water heater or an automatic dispensing sanitizing chemical system. 5. A three-compartment sink with a booster heater or chemical sanitizing system for the third compartment shall be provided in Congregate assisted living facilities. 6. Garbage cans with cover. (p) Food Storage. A well-ventilated, cool food storage room, pantry, or cabinets shall be provided. Adequate shelving, bins, suitable cans,	A 804		

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A 804	Continued From page 99 and raised platforms shall be provided and kept clean. Perishable food shall be stored at least six inches above the floor. The storeroom shall be of such construction as to prevent the invasion of rodents and insects, the seepage of dust and water, leakage, or any other source of contamination. (q) Dining Room. 1. A resident dining room, or rooms, shall be provided which is large enough to seat not less than 100 percent of the bed capacity. (r) Water Heating Equipment. Equipment for heating an ample supply of water, under pressure, for all washing purposes shall be provided. Hot water shall be piped to all hand-washing facilities, and to each compartment of all dishwashing and laundry sinks. Water heaters shall be of the automatic type. This Rule is not met as evidenced by: Based on observations and interviews, the food service facilities were not properly maintained. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received complaints about the food service facility including mold under sink in kitchen and	A 804		

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A 804	Continued From page 100	A 804		

dishwasher not functional. Surveyors substantiated these allegations during the onsite survey and found numerous other areas of noncompliance related to food service facilities.

Surveyors entered the facility early on the morning of April 12, 2022. The kitchen and dining area were toured with EI#12 and the following deficient practices were found.

The dishwasher, ice machine and stove/oven were not functional.

An unused cart for transporting food was stored beside the refrigerator. When the cart was moved, the floor under the cart was covered in trash and dirt. The trash can was stored beside the oven. When the trash can was moved, the floor under the trash can was dirty and the area behind the oven/stove was exposed and was filthy. In fact, the entire floor of the kitchen was in need of sweeping and moping.

Cabinet doors were old and sticky. One cabinet had no door and was open. Inside the cabinet were three partial loaves of bread and two individual packages of snack cakes. One drawer did not have a bottom and was useless.

Baking sheets stored in the cabinets were completely coated in black baked-on substance.

A portable air conditioner was in the window over the sink. It was coated in dust/dirt. The window sill and window pane around the air conditioner were covered in dust and grime. Thick heavy spider webs and trash/leaves could be seen on the outside of the window.

The cabinet under the sink had areas of mold.

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A 804	Continued From page 101 Spider webs were noted in the corners of cabinets and a dirt/dust buildup was on baseboards and corners on the floor. A can opener was mounted on the side of the countertop beside the stove and had black residue on the sides and bottom. There was a door which led from the kitchen directly outside to the fenced area. A three-door freezer unit was located on the concrete walkway outside this door. Only the left door of the freezer was functional. The other doors had to be forcefully opened due to ice buildup inside. The lights were not functional in one half of the kitchen. On April 13, 2022 at approximately 12:00 noon, the surveyors reviewed the above concerns with EI# 5, Housekeeping Manager. EI#5 told the surveyor the housekeeping department was not responsible for cleaning the kitchen. During an interview on April 12, 2022, EI#6, Dietary Manager, acknowledged the numerous deficient practices cited in the SCALF kitchen and stated the facility would address the issues. The afternoon of April 14, 2022, EI#2 told the surveyors the kitchen repairs were in the process of being made and the mold had been removed from underneath the sink. On April 19, 2022, surveyors discussed with EI#1 and EI#2 the numerous deficiencies in the facility's kitchen and food service. Although the facility had only been open as a SCALF since 2019, the building had been used prior to that	A 804		

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A 804	Continued From page 102 time as an ALF and was owned and managed by the same company. Similar deficiencies had been cited during surveys conducted on August 6, 2014, March 1, 2016 and on February 5, 2019. EI#1 stated he (EI#1) was committed to making things right and expected the kitchen issues to be addressed in approximately 14-28 days.	A 804		
A1001	420-5-20-.10 (1) Sanitation and Housekeeping. (1) Sanitation. (a) Water Supply. 1. If at all possible, all water shall be obtained from a public water supply. If it is impossible to connect to a public water system, the private water supply shall meet the approval of the local County Health Department. 2. Water under pressure of not less than 15 pounds per square inch shall be piped within the building to all sinks, toilets, lavatories, tubs, showers, and other fixtures requiring water. Tubs, showers, sinks, lavatories, and other fixtures used by residents shall have hot water supplied. Hot water accessible to residents shall in no case exceed 110 degrees Fahrenheit. (b) Disposal of Liquid and Human Wastes. 1. There shall be installed within the building a properly designed waste disposal system, connecting to all fixtures to which water under pressure is piped. 2. All liquid and human waste, including floor wash water and liquid waste from	A1001		

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refrigerators, shall be disposed through trapped drains into a public sewer in localities where such system is available.

3. In localities where a public sanitary sewer is not available, liquid and human waste shall be disposed through trapped drains into a sewage disposal system approved by the local County Health Department. The sewage disposal system shall be of a size and capacity based on the number of residents and personnel housed and employed in the institution. Where the sewage disposal system is installed at an existing facility prior to granting of a license, it shall be inspected and approved by the local County Health Department.

(c) Premises. The premises shall be kept neat and clean. The property shall be free of rubbish, weeds, ponded water, or other conditions, which may create a health, safety, or sanitation hazard.

(d) Control of Insects, Rodents, and other Pests. Each facility shall be kept free of ants, flies, roaches, rodents, and other pests. Proper and lawful methods for their eradication or control shall be used. Droppings shall be evidence of infestation by pests.

(e) Toilet Room Cleanliness. Floors, walls, ceilings, and fixtures of all toilet rooms shall be kept clean and free of objectionable odors. These rooms shall be kept free of an accumulation of rubbish, cleaning supplies, toiletry articles. The use of a common towel and common bar soap is prohibited.

(f) Garbage Disposal.

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A1001	Continued From page 104 1. Garbage must be kept in water-tight suitable containers with tight-fitting covers. Garbage containers must be emptied at frequent intervals and shall be thoroughly cleaned and aired before using again. 2. Garbage and waste shall be disposed of in accordance with local and state regulations. (g) Control of Odors. The facility shall be free of objectionable odors. This Rule is not met as evidenced by: Based on observations and interviews, hot water accessible to residents exceeded the allowed temperature, bugs were present in the facility, odors were not controlled and the premises were not kept neat and clean. Findings: The Alabama Department of Public Health received a complaint of bugs in the SCALF. Surveyors were able to substantiate this complaint and cited other deficient practices related to sanitation during the onsite survey. On the morning of April 12, 2022, the water temperature was checked in the Beauty Salon by the surveyor and EI#4, Maintenance Director. The temperature was 117 degrees Fahrenheit. The water temperature was adjusted by EI#4 and rechecked with a result of 102 degrees Fahrenheit. On the morning of April 12, 2022, surveyors	A1001		

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observed multiple dead bugs on the floor of the activities area beside the front door of the facility. EI#5 was made aware of the concern during an interview on April 13, 2022.

Multiple times during the onsite survey, a urine odor was noted around and inside RI#1's room. The odors were also noted when RI#1 was in the dining room. RI#1 was incontinent of urine. On the morning of April 13, 2022, the surveyor found RI#1, in his/her room, seated in a wheelchair, with a puddle of urine under the wheelchair. During interviews with EI#2 and EI#3 on the afternoon of April 14, 2022, the odors were discussed and EI#3 stated the issue would be addressed.

On April 12, 2022 at 6:24 AM, the surveyor observed the dumpster located between the ALF and SCALF. The dumpster was within a concrete enclosure. The dumpster was surrounded with trash, plastic plates and forks, debris, leaves, sticks, a pipe, and a mattress lying on the ground. The dumpster doors were open and visible to the residents and visitors. Later in the day, the surveyors interviewed EI#5, Housekeeping Manager, about the dumpster hazards. EI#5 said everyone was responsible for the clean up around the dumpster because the overflow was not picked up by the city.

On the morning of April 12, 2022, the surveyor and EI#4 observed the outside fenced area behind the SCALF. The concrete walkways were dirty and contained piles of leaves/debris. The outside of all windows had thick buildup of spiderwebs and dirt/leaves. A chair near the door leading from the dining room and two chairs outside the left end exit door were covered with dirt and not suitable for use. Cardboard boxes

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A1001	Continued From page 106 were on the walkways. The two exit gates were covered in spiderwebs. EI#4 stated the lawn service provider was responsible for cleaning the outside area. The dirty outside areas were discussed with EI#1 and EI#2 on April 19, 2022. EI#1 stated the deficiencies would be addressed.	A1001		
A1002	420-5-20-.10 (2) Sanitation and Housekeeping. (2) Housekeeping and Physical Plant Maintenance. The facility must provide a safe, functional, decent, sanitary, and comfortable environment for residents, staff, and the public. (a) Equipment and Supplies. The home shall maintain an adequate quantity of housekeeping and maintenance equipment and supplies. (b) Bathtubs and Lavatories. Bathtubs and lavatories shall be kept clean and in proper working order, and shall not be used for laundering. (c) Resident Bedrooms. Resident bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance. (d) General Storage. 1. Broken beds, extra mattresses, mop buckets, and dust rags shall not be kept in hallways, closets, corners, or occupied resident rooms. Such items must be stored neatly and orderly in designated storage rooms. 2. The use of attics for storage of combustible materials shall be prohibited unless	A1002		

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A1002	Continued From page 107 protected by an automatic sprinkler system and then only in small quantities so as not to create a hazardous condition. 3. Basements used for storage shall meet acceptable standards for storage and shall be designed and constructed in a manner that protects against fire hazards. 4. Flammable materials such as gasoline, motor fuels, lighter fluid, turpentine, acetone, and oil based paint shall not be stored in the facility. Unless prohibited by a facility's own policies, however, a cognitively intact resident who uses lighter fluid to fill a personal cigarette lighter, or one who uses flammable materials such as paint or glue in connection with a personal hobby, may store small quantities of those materials in a safe and secure manner within his or her own room. 5. Poisonous or External Use Substances. Facility cleaning supplies and poisons shall be attended at all times or shall be kept in a secure area. This Rule is not met as evidenced by: Based on observations and interviews, housekeeping failed to provide services necessary to maintain a sanitary, decent and comfortable interior. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings:	A1002		

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The Alabama Department of Public Health received a complaint which alleged the ALF facility on the same campus was "filthy". This complaint was investigated for the SCALF as well as the ALF during the onsite survey. Surveyors were able to substantiate the complaint during the onsite survey. Numerous housekeeping issues were found.

Surveyors toured the facility on the morning of April 12, 2022 with EI#12 and EI#13. The unit was again toured later the same morning with EI#2. The laundry room was observed by the surveyor and EI#4 on April 18, 2022. The following housekeeping issues were identified during the onsite survey.

Spiderwebs were noted in the corners of the hallways.

Baseboards in the hallway near the dining room were dirty.

Residents' toilets were dirty, some with feces and urine on the seats.

Trash was on the floor in the activities area beside the front door.

Residents' bathtubs were dirty and badly stained.

Hallway floors and floors in residents' rooms were in need of sweeping and mopping.

A broken cart was stored on the porch beside the front door during the entire onsite survey.

In the laundry room, areas between the washer/dryer and walls were cluttered with lint, linens, dirt and trash, creating a fire hazard. The

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A1002	Continued From page 109 floors were dirty. Multiple boxes were stored beside the washer/dryer. The vent on the ceiling was coated in dust. Multiple items were stored in the laundry room including a broom and dust pan, ladder, clothing, broken laundry baskets, empty laundry detergent containers and scales. On April 13, 2022, surveyors discussed these issues with EI#5, Housekeeping Manager. EI#5 stated all rooms in the facility should be checked daily by housekeeping for cleaning needs. EI#5 also stated he (EI#5) had requested additional housekeeping staff. The laundry room concerns were also discussed with EI#4 on April 18, 2022. The numerous housekeeping issues were discussed with EI#1 and EI#2 on April 14 and again on April 19 during the onsite survey. EI#1 stated he (EI#1) would make things right.	A1002		
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	A1101		

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A1101	Continued From page 110 areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs. (d) Roller latches are prohibited on doors separating corridors from adjacent spaces. (e) If alcohol-based hand rub dispensers 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	A1101		

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A1101	Continued From page 111 alarm system. In lieu of corridor smoke detection, smoke detectors connected to the building fire alarm system may be installed in each resident's room, open areas, and at smoke doors (except that corridor smoke detection shall not be deleted when its use is dictated by other requirements). 2. Fire alarm and sprinkler system outages of more than 4 hours require evacuation of the facility or the establishment of a continuous fire watch. The fire watch procedure must be coordinated with the Department and the local Fire Marshal. Outages and fire watch documentation shall be reported to the Department within 12 hours or no later than the next duty day, and shall be corrected expeditiously. 3. The fire alarm system and the sprinkler system shall be inspected by licensed, trained, and qualified personnel at least 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, the fire alarm inspections were not performed semiannually. Findings: The facility's fire and safety documentation was reviewed on April 14, 2022, with EI#4, Maintenance Director. The following deficiencies were found.	A1101		

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A1101	Continued From page 112 There were no fire drills documented for the months of January, February, March 2020 or December 2021. The day the fire drills were conducted was not documented on the monthly reports for 2020 or 2021. The fire drills were not conducted on each shift for second quarter 2020, first quarter 2021, and first quarter 2022. The fire alarm system was only inspected once in 2021. EI#4, stated he (EI#4) had been the Maintenance Director since April 14, 2020 and was responsible for the fire and safety documentation. EI#4 verbalized understanding that the fire drills must be conducted monthly at varying times and days and quarterly on each shift.	A1101		
A1203	420-5-20-.12 (5) Physical Environment. (5) General Building Requirements - Group and Congregate. (a) Structural Soundness and Repair. The building shall be structurally sound, free from leaks and excessive moisture, in good repair, and painted with sufficient frequency to be reasonably attractive inside and out. The interior and exterior of the building shall be kept clean and orderly. (b) Temperature to be Maintained. The facility shall maintain a comfortable temperature. A comfortable range is between 71-81 degrees Fahrenheit.	A1203		

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A1203	Continued From page 113 (c) Lighting. Each resident's room shall have artificial light adequate for reading and other uses as needed. All entrances, hallways, stairways, inclines, ramps, cellars, attics, storerooms, kitchens, laundries, and service units shall have sufficient artificial lighting to prevent accidents and promote efficiency of service. Night lights shall be provided in all hallways, stairways, and bathrooms. (d) Screens. All screen doors and operable windows shall be equipped with tight-fitting, full-length 16 mesh screens. Screen doors shall be equipped with self-closing devices. (e) Emergency Lighting. 1. All specialty care assisted living facilities shall provide an emergency artificial lighting system to adequately illuminate halls, corridors, and stairwells in case of electrical power failure. As a minimum, dry cell battery-operated lighting shall be provided to light such spaces. 2. Emergency lighting must provide illumination in accordance with the currently adopted Life Safety Code for at least 90 minutes. (f) Floors. 1. All floors shall be level, smooth and free of cracks, and finished so as to be easily kept clean. The basic requirement for floor finishes shall be wall-to-wall with such finishes as paint, stain, sealer, carpet, sheet vinyl, vinyl tile, hard tile, or other appropriate floor finish.	A1203		

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A1203	Continued From page 114 2. Any differences in floor levels shall not prevent a resident from navigating safely throughout the facility. (g) Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface and shall be kept clean and in good repair. (h) Windows. Operable windows shall be so constructed and maintained so that they fit snugly, and are capable of being opened and closed easily. Windows in specialty care facilities may have devices which prevent full opening of the window. (i) Ceiling Height. Each room occupied by residents shall have a ceiling height of eight feet or more. Existing facilities with ceiling heights less than eight feet shall be acceptable when the height complies with the codes. (j) Handrails. If handrails are installed in halls or corridors, the handrails shall be mounted at 30 - 36 inches above the floor and returned to the wall at each end. (k) Stairways. Stairways shall be well lighted, kept in good repair, and have handrails. Open space under stairs shall not be used for storage purposes. All walls and doors under stairs shall meet the same fire rating as the stairwell. (l) Doors. 1. In each new specialty care assisted living facility, doors of resident bathrooms	A1203		

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A1203	Continued From page 115 connected to resident bedroom shall swing into the bedroom. 2. Bedroom and bathroom doors may be equipped with hardware that will permit a resident to lock himself within the room, provided a master key is readily accessible for the staff at a central location. 3. Resident bedroom and other exit access doors in specialty care assisted living facility shall be at least three feet wide. 4. Exterior egress doors except the main entry/exit door, may be equipped with a delayed egress locking system installed in accordance with NFPA 101. Other exterior egress doors may be arranged to prevent free and unhindered egress from specialty care assisted living facilities, in accordance with the Special Requirements portion of this section. 5. Exit doors swinging outward shall swing out over a landing having a minimum length and width equal to the door's width at the same level as the floor level, except existing doors shall not have more than a four inch step down. (m) Ventilation. The building shall be well ventilated at all times to prevent accumulation of objectionable odors. Kitchens, laundries, service rooms, toilets, and bathrooms shall be ventilated by windows, gravity vents, or mechanical means as necessary to prevent offensive odors from entering other parts of the facility. (n) Fire Extinguishers. Fire	A1203		

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A1203	Continued From page 116	A1203		

extinguishers shall be provided for each hall, kitchen, and laundry, of type and capacity appropriate to the need.

1. Each fire extinguisher shall receive an annual inspection with maintenance, and recharging when necessary, by a fire equipment servicing representative. An annual servicing tag shall be attached to the extinguisher reflecting the name of the servicing company, representative, day, month, and year of maintenance.

2. A visual inspection of each fire extinguisher shall be conducted monthly by a designated staff of the facility and documented on the attached extinguisher tag by the designated staff person.

(o) Call System. A central electric or electronic call system shall be conveniently provided for each resident, usable in bedrooms and bathrooms. The call system shall be certified to meet the applicable Underwriters Laboratories standard.

(p) Manufactured homes/mobile homes are not permitted.

(q) Fireplaces and inserts shall be inspected and cleaned annually, and shall comply with the currently adopted building code. Openings shall be protected with screens or doors.

(r) Exit marking. In all facilities, a sign bearing the word "EXIT" in plain legible block letters shall be placed at each exit. Additional signs shall be placed in corridors and passageways wherever necessary to indicate the

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A1203	Continued From page 117 direction of exit. Letters of signs shall be at least four inches high. All exit and directional signs shall be kept clearly legible by continuous internal electric illumination and have battery back-up or emergency power. (s) Heating, Lighting, and other Service Equipment. 1. Central or individual room gas heating systems shall be of the enclosed flame type equipped with automatic flame shut-off control and shall be vented directly to the outside. Heating units of any type shall be located to avoid direct contact with any combustible material and shall be maintained in accordance with manufacturer's recommendation. 2. Open flame and portable heaters are prohibited in specialty care assisted living facilities. This does not apply to a fire place with gas logs protected as noted elsewhere in these rules. 3. Lighting shall be restricted to electricity. Electric wiring, motors, and other electrical equipment in all specialty care assisted living facilities shall be in accordance with local electrical codes and the NFPA National Electrical Code. This Rule is not met as evidenced by: Based on observations and interviews, the building was not kept in good repair, lighting was inadequate and the residents' call system was not totally functional. Findings:	A1203		

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A1203	Continued From page 118 The following maintenance concerns were identified by surveyors on April 12 and 18, 2022. A large hole was noted in the hallway ceiling beside resident room number 1. The ceiling in resident room number 1 was cracked and badly stained. Parts of the ceiling material had fallen to the floor. The surveyor was informed by EI#20 the hole and ceiling damage had been there for several weeks when there was a leak in the roof. Repairs to the ceiling were started during the onsite survey. Door facings in the dining room area were in need of paint. Walls and door facings in resident room number 7 were damaged and in need of paint. The laundry room had a very large opening in the ceiling which was later repaired by EI#4. Ceiling lights in the bathrooms were not working in resident rooms 8 and 13. Half of the ceiling lights in the kitchen were not functioning. There were no strings on the call lights in resident bedroom number 10 and in resident bathroom number 6. The strings were used to activate the call system. These maintenance and safety issues were acknowledged by EI#4, Maintenance Director, during the onsite survey. The deficiencies were also discussed with EI#1 and EI#2 on April 19, 2022. EI#1 stated he (EI#1) and EI#2 would correct the deficiencies.	A1203		

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A1203	Continued From page 119 CONNIE CHERRY, REGISTERED NURSE DEBRA FREEMAN, REGISTERED NURSE	A1203		