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A 000	Initial Comments On April 19, 2022, an unannounced licensure survey and complaint investigation was conducted for this 16 bed Assisted Living Facility (ALF) with a census of seven 7. There were three (3) complaints investigated during this survey. Complaint Intake ID: 20200805006, Intake ID: 20210915012, and Intake ID: 20220317013 were substantiated and deficiencies were cited as a result of the investigation. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities. The deficient practices resulted in the potential for harm to all residents.	A 000		
A 301	420-5-4-.03 (1) (a) (b) (c) (d) Administration. The Assisted Living Facility Governing Authority. (a) An assisted living facility shall have an identified sole proprietorship, corporation, partnership, limited partnership, or other business entity that is its governing authority, or it shall have a designated individual or group of designated individuals who serve as its governing authority. A facility must give complete information to the Department identifying: 1. Each person who has an ownership interest of 10 percent or more of the governing authority. 2. Each person or entity who has an	A 301		

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A 301	Continued From page 1	A 301		

ownership interest of 10 percent or more in the real property or building used by the assisted living facility to offer its services.

3. Each officer and each director of the corporation if the governing authority is a corporation.

4. Each partner, including any limited partners, if the governing authority is a partnership.

(b) The governing authority shall submit any changes to the information listed above to the Department within 15 days of the change.

(c) Responsibility of Staff to Governing Authority. The administrator, medical staff, facility personnel, and all auxiliary organizations shall be directly or indirectly responsible to the governing authority. For the purposes of these rules, auxiliary organizations include but are not limited to licensed or certified outside providers, consultants, management companies that are not the facility license holder.

(d) The governing authority is responsible for appointing and supervising the administrator who is responsible for overall management and the day-to-day operation of the facility. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the governing authority failed to ensure the facility operated in compliance with the SBOH

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rules for ALFs. 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 7 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 or Speciality Care Assisted Living Facility (SCALF) facilities in Alabama. EI#1 acknowledged he (EI#1) was not familiar with the Alabama rules for ALFs/SCALFs, but verbalized his (EI#1's) commitment to operating the facility

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A 301	Continued From page 3	A 301		

according to Alabama SBOH rules. The surveyors brought to EI#1's attention the problems with the kitchen have been ongoing since 2014. EI#1 stated he (EI#1) was at the facility to help support EI#2 in getting things right this time. EI#1 went onto say we (EI#1 and EI#2) will take an extensive look at this and make sure the problems are 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 three (3) ALF complaints which were investigated and substantiated during the onsite survey. In addition, complaints received for the SCALF on the same campus were investigated for the ALF during the survey due to the facilities having the same ownership and management. The complaint involved inadequate housekeeping and alleged the facility was "filthy". Surveyors were able to substantiate numerous housekeeping and maintenance deficiencies while at the facility. In addition, widespread deficient practices were cited during the survey including contagious diseases (COVID) not reported, staff not adequately trained, ineligible residents, inadequate activities for residents, fire drills and fire alarm inspections not completed, inadequate resident call system, failure to sanitize dishes, multiple kitchen deficiencies, 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 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 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

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A 301	Continued From page 4 an administrator for ALF/SCALF who did not also have responsibility for the SNF. EI#1 stated there was no plan to hire an ALF/SCALF administrator and he (EI#1) planned for EI#2 to continue as administrator. EI#1 added that a new Registered Nurse/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 arranging 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 ALFs and to maintaining that compliance.	A 301		
A 302	420-5-4-.03 (1) (e) Administration. Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and	A 302		

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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 residents. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies shall cover the following:

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

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

(iii) Resident confidentiality.

(iv) Admission and continued stay criteria.

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

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

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

(viii) Medication management.

(ix) Infection control.

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

(xi) Fire safety and emergency plan, fire

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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.

(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.

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A 302	Continued From page 7 (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. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON AUGUST 6, 2014 and MARCH 1, 2016 Findings: According to the facility's 1.15 Executive Director Responsibilities Policy and Procedure, "...An 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...". The Executive Director did not	A 302		

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A 302	Continued From page 8 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 in 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 outbreak of COVID-19 within 24 hours of the diagnosis. Refer to deficiency 508 for additional information. According to the facility's AL203-ALF Medication Management Policy and Procedure, "...Disposal of Medications: Medications of residents who are discharged or transferred to another facility will be returned to the resident...The responsible party will sign a statement that these medications have been received...". There was no disposition documentation of a resident's medication at the time of discharge from the facility. Refer to deficiency 617 for additional information.	A 302		

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A 302	Continued From page 9 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 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 resident's rooms clean. Refer to deficiencies 804 and 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 hold monthly fire drills on each shift. Refer to deficiency 1101 for additional information.	A 302		
A 303	420-5-4-.03 (2) (a) Administration. The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an	A 303		

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administrator shall meet all applicable statutory requirements.

4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences.

5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age.

6. The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character.

7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week.

8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment and adequate care being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement.

9. The facility administrator is responsible for ensuring that required training is provided to all staff.

10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely

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A 303	Continued From page 11 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) duties to ensure the proper and safe management of the day to day operations of the facility. EI#2 also failed to ensure the facility operated in accordance with the rules of the SBOH for ALFs and failed to ensure previously cited deficiencies were corrected and compliance with SBOH rules for ALFs was maintained. These failures placed all seven (7) residents of the facility at risk of harm. Findings: On April 12-14, 2022 and April 18-19, 2022, the ADPH surveyors spent five (5) days conducting an onsite survey and complaint investigations at the facility. Three (3) complaints were	A 303		

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investigated for the ALF as well as two (2) complaints for the SCALF. The surveyors found the concerns were impacting both the SCALF and ALF facilities. The concerns and photographs were submitted to ADPH by employees and a family member.

The complaints contained allegations including, call light not available, ineligible residents, residents not properly assessed, kitchen equipment does not work, dirty facility/kitchen, odors, mold in kitchen/resident's rooms, poor food quality, spiderwebs, and administrator does not take action to address problems. Surveyors substantiated these complaints while onsite and identified other deficient practices as well. Of the twenty-three (23) deficiencies cited six (6) were related to care of residents and four (4) were associated with housekeeping and sanitization. There was a long standing history since 2014 of the facility having an unacceptable kitchen with repeated deficiencies cited again. Refer to deficiencies 702 and 804.

EI#2 became Administrator of the facility July 2021, nine (9) months prior to the survey. EI#2 was also the administrator for a SNF on the same property. EI#2 stated she (EI#2) had previously worked as administrator of a SNF in Alabama. During interviews with staff, the surveyors were told 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, 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. EI#2 said she (EI#2) had the support from EI#1 she (EI#2) needed. During an interview on April 19, 2022, EI#2 stated she (EI#2) hoped to attend training in

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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 and the lack of oversight provided by the Governing Authority.

302 - The facility did not follow policies and procedures for the day to day operation of the facility. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON AUGUST 6, 2014 and MARCH 1, 2016.

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

401 - The ALF was not always staffed with someone with a current CPR status.

402 - Required screening of employees was not completed prior to hire and prior to resident contact. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON AUGUST 6, 2014.

403 - Personnel records did not contain required information.

405 - The staff did not have the required training. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON AUGUST 6, 2014 and MARCH 1, 2016.

504 - A safe and decent environment was not provided for residents at all times. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

508 - An outbreak of a contagious disease was

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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 303	Continued From page 14 not reported to the Department. 602 - A resident's initial medical examination did not include a baseline weight and annual examinations were not available. 611- The resident care plans were not updated and did not include appropriate interventions. Residents were not assisted with a clean and well-kept appearance. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON MARCH 1, 2016 and FEBRUARY 5, 2019. 612 - Resident activities were inadequate. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 614 - Resident was not offered the opportunity to demonstrate the correct utilization of the unit dose system. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON MARCH 1, 2016 and FEBRUARY 5, 2019. 617 - The disposition of all medications was not documented. 621 - A resident was retained that required a higher level of care. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 702 - Dishes were not sanitized. Kitchen was very dirty. Food was not properly stored and protected from contamination. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON MARCH 1, 2016 and FEBRUARY 5, 2019.	A 303		

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A 303	Continued From page 15 703- The food was not palatable and the current week's menu was not posted in the food service area. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MARCH 1, 2016. 804 - The kitchen was not clean and the staff did not have paper towels to use after hand washing. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON AUGUST 6, 2014 and FEBRUARY 5, 2019. 1001 - The premises and building were not adequately maintained. There were odors in the facility. 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. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON AUGUST 6, 2014 and MARCH 1, 2016. 1203 - The electronic call system was not functional in all rooms. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.	A 303		
A 305	420-5-4-.03 (2) (c) Administration. (c) Department Notification.	A 305		

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A 305	Continued From page 16 1. The licensee of an assisted living facility shall provide written notification of voluntary closure of the facility to the State Board of Health at least 30 days prior to the expected closure date. 2. The State Board of Health shall be provided written notification not later than 15 days after any change in administrator. 3. The State Board of Health shall be provided written notification not later than 15 days after any change in management company. This Rule is not met as evidenced by: 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 of change in administrator had been received by the SBOH. 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 surveyor she (EI#2) could not retrieve the email she (EI#2) sent when she (EI#2) became the new administrator.	A 305		
A 401	420-5-4-.04 (1) (2) Personnel. Personnel.	A 401		

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A 401	Continued From page 17 (1) An assisted living facility shall ensure personnel are employed and on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. (a) An assisted living facility shall be staffed at all times by at least one individual who has a current certification in cardiopulmonary resuscitation (CPR). (b) An assisted living facility must be staffed to ensure the safe evacuation of all residents in the event of a fire or emergency. (2) Employee Schedule. An 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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility was not staffed at all times by at least one individual who had current certification in cardiopulmonary resuscitation (CPR). Findings: On April 13, 2022, employee schedules for the months of March 2022 and April 2022 were reviewed. A review of the documents revealed the facility was not always staffed with at least one (1) individual certified in CPR on all shifts. This was brought to the attention of EI#2 who was instructed to make sure every shift was properly covered. EI#2 verbalized understanding and she	A 401		

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A 401	Continued From page 18 (EI#2) scheduled a CPR class for that evening on April 13, 2022. The surveyors were provided with a list of the nine (9) course participants that were certified by an onsite Basic Life Support (BLS) instructor.	A 401		
A 402	420-5-4-.04 (3) Personnel. (3) Employee Screening. (a) Prior to any resident contact, such as but not limited to assistance with activities of daily living, newly employed personnel shall have a physical examination certifying that the employee is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to residents through normal staff to resident contact. Employees who develop signs or symptoms of infectious skin lesions or diseases that would be capable of transmission to residents through normal staff to resident contact shall not be permitted to have resident contact until free from such signs and symptoms. (b) Not more than 30 days prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis. (c) Vaccines. Assisted living facilities shall immunize employees in accordance with current recommended Centers for Disease Control and Prevention (CDC) guidelines (www.cdc.gov/vaccines). Any particular vaccination requirement may be waived or delayed by the State Health Officer in the event of a vaccine shortage. (d) An assisted living facility shall not hire an individual whose name is on the Alabama	A 402		

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A 402	Continued From page 19 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. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON AUGUST 6, 2014. Findings: Review of employee files on April 13 and 18, 2022 revealed the following information. EI#2, EI#9, EI#10, EI#12 and EI#16 did not have a physical examination certifying the employee was free of signs and symptoms of infectious skin lesions and diseases 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#11 and EI#16 were not evaluated for tuberculosis within 30 days of resident contact. EI#11 was not screened through the Alabama Department of Public Health (ADPH) Nurse Aide Abuse Registry. Although EI#16 was screened through the ADPH Aide Abuse Registry, the screening was completed on April 13, 2022, not prior to EI#16's hire date of June 2, 2010. These findings were discussed with EI#7 on April 14 and 18, 2022 after EI#7 did not provide all required information.	A 402		

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A 403	420-5-4-.04 (4) Personnel. (4) Personnel Records. An assisted living facility shall maintain a personnel record for each employee. This record shall contain: (a) An application for employment which contains information regarding the employee's education, training, and experience. (b) Verification of current certification or licensure, if applicable. (c) Record of required physical examinations and vaccinations. (d) Verification the facility has not hired an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry. (e) Date of hire. (f) Date of initial resident contact. (g) Date employment ceased. This Rule is not met as evidenced by: Based on record 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#16 did not have an application for	A 403		

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A 403	Continued From page 21 employment. EI#2, EI#9, EI#10, EI#12 and EI#16 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 and EI#16 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	420-5-4-.04 (6) Personnel. (6) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained in the facility. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on assisted living facilities. 2. Facility policies and procedures.	A 405		

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A 405	Continued From page 22 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 environment safety. 10. Special needs of the elderly, mentally ill, and mentally retarded. 11. Safety and nutritional needs of the elderly. 12. Identifying signs and symptoms of dementia. (b) Cardiopulmonary Resuscitation. An assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of an assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within 90 days of hire. An assisted living facility equipped with an automated external defibrillator (AED) shall be	A 405		

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A 405	Continued From page 23 staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or American Red Cross in CPR or AED utilization. (c) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training. (d) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all staff completed required training. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON AUGUST 6, 2014 and MARCH 1, 2016. Findings: Review of employee files on April 13 and 18, 2022 revealed the following information. EI#2, EI#9, EI#11 and EI#16 had not completed all required initial training for ALF employees, although some employees had completed portions of the training. All four of the employees	A 405		

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A 405	Continued From page 24 had resident contact. EI#2, EI#10, EI#11 and EI#16 did not have current CPR certification at the time surveyors entered the facility. All four 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. EI#2, EI#9, EI#10, EI#11, EI#12 and EI#16 did not complete special needs training in diabetes. The facility currently had 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 405		
A 504	420-5-4-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate. 1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility.	A 504		

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A 504	Continued From page 25 2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints. 3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy. 4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time. 5. Every resident shall have freedom to participate in and benefit from social, religious, and community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. 6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the premises, an individual account record for each resident shall be maintained by the administrator and an up-to-date record shall be maintained for all transactions. 7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so. 8. Every resident shall have the right to	A 504		

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A 504	Continued From page 26 a reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals. 9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident. 10. Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to receive or reject medical care, dental care, or other health care services except those required to control communicable diseases. 11. Every resident shall have the right to at least 30 days prior written notice of involuntary relocation or termination of residence from the facility unless the resident is a patient in a facility providing a higher level of care and no longer meets the eligibility and continued stay requirements in these rules, or for medical reasons the resident is considered by a physician to require an emergency relocation to a facility providing a more skilled level of care, or unless the resident engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record. 12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person	A 504		

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A 504	Continued From page 27 without restraint, interference, coercion, discrimination, or reprisal. 13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file. 14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the facility, provided that: (i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care. (ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation; and (iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time without recourse. 15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges.	A 504		

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A 504	Continued From page 28 16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities. 17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll-free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll-free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area. 18. All state inspection reports and any resulting corrective action plan from the past 24 months shall be posted in a prominent location. If there has been no inspection in the past 24 months, then the results of the most recent inspection and any resulting corrective action plan shall be posted. 19. Every resident shall have the right to 30 days prior written notice to both resident and sponsor of any increase of fees or charges. 20. Every resident shall have the right to 30 days prior written notice of any involuntary change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents.	A 504		

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A 504	Continued From page 29 21. Every resident shall have the right to wear his or her own clothes, to keep and use his or her own personal possessions including toilet articles except for personal possessions too large to be stored in the resident's room. 22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings. 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours and to freely come and go from the home. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide a safe and decent environment for residents at all times. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received complaints which alleged the residents were living in unsafe and unsanitary conditions at the facility. Many of these complaints were substantiated during the onsite survey. The	A 504		

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following deficient practices were cited which jeopardized the safety and well-being of all residents of the facility.

Employees were not properly screened or trained, including CPR training. The facility was not staffed at all times with at least one staff member certified in CPR.

Residents were not given an opportunity to utilize the unit dose packaging system to protect themselves from a medication error by staff.

Residents' plans of care were not updated to meet the care needs of the residents.

A resident identified as needing a higher level of care was retained in the facility. This same resident's personal hygiene was not monitored by the staff.

Activities were minimal or non-existent on some days, leaving the residents inactive and bored.

Dishes were not sanitized. The kitchen was dirty. There was no functional dishwasher. Meals were not appetizing. Food temperatures were not properly monitored. Food was not protected from contamination. Mold was present under the kitchen sink. The staff had to plunge the kitchen sink because it was stopped up. There were no paper towels available in the kitchen for the staff to dry their hands on after washing.

The building was dirty, inside and out, and in need of repairs. The call system was not functional in all rooms. The housekeeping closet in the laundry room was dirty.

Fire drills and fire alarm inspections were not

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A 504	Continued From page 31 completed as required. These deficient practices created an environment 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 would make things right.	A 504		
A 508	420.5.4-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in an assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review. 1. Incidents which require investigation are: (i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as bruising, pain, or injury that is not consistent with actions necessary in providing day to day care to a resident or for which medical treatment was sought. (ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid, including but not limited to: a physician ordered portable X-ray,	A 508		

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a visit to an emergency department, urgent care facility, clinic or physician office.

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

(iv) Elopement by a resident.

(v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules.

(vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules.

(vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules.

(viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I of Alabama Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or Staphylococcus aureus).

(ix) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility.

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A 508	Continued From page 33 (x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (xi) An unplanned occurrence that results in media attention. (xii) A medication error, overdose, or over sedation. (xiii) Ingestion by a resident of a toxic substance that requires medical attention. (xiv) Any indication of malfunction of the sprinkler system, or fire alarm system. 2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following: (i) Names of all residents involved. (ii) Names of all staff involved including person in charge at the time of the incident. (iii) When the administrator was notified (date and time). (iv) Circumstances under which the incident occurred. (v) When the incident occurred (date and time). (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken. (viii) The extent and description of	A 508		

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A 508	Continued From page 34 injury, if any, to the affected resident or residents. (ix) Immediate treatment rendered. (x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified. (xi) Names, telephone numbers, and addresses of witnesses. (xii) Date and time relatives or sponsor were notified. (xiii) Out-of-facility treatment. (xiv) Follow-up care. (xv) Outcome resolution. (xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future. (xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation. (xviii) The entire investigative file shall 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.	A 508		

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A 508	Continued From page 35 (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 as defined in these rules. (ii) Elopement by a resident. (iii) Suspected, alleged, confessed, or witnessed abuse, neglect, or exploitation of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file. (iv) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident.	A 508		

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A 508	Continued From page 36 (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 of the Alabama Administrative Code Sec. 420-4-1-.04. shall be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1-.04. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than 3 years. (x) Any indication of malfunction of the sprinkler system, or fire alarm system. 4. The report to the Department's Online Incident Reporting System shall include the following: (i) Facility name and direct phone number. (ii) Time and date of the report. (iii) Reporter's name. (iv) Name of resident(s), staff, or visitor(s) involved in the incident.	A 508		

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A 508	Continued From page 37 (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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report an outbreak of a contagious disease to the Department's Online Incident Reporting System (OIRS) within 24 hours of the diagnosis. Findings: 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. However, while on site, the surveyors learned there had been two (2) outbreaks of COVID at the ALF and SCALF facilities. The morning of April 14, 2022, the surveyors discussed this with EI#2, Administrator, and EI#3, Director of Nursing (DON). EI#2 and EI#3 stated they were not aware this was a reporting requirement to the OIRS. EI#2 provided the surveyors with a list of residents and employees that tested positive for	A 508		

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A 508	Continued From page 38 COVID-19 in November 2020 and December 2020. A total of twelve (12) residents and seven (7) employees had a confirmed case of the virus. There were six (6) residents in the ALF and six (6) residents in the SCALF during that time. The surveyor reviewed the disease reporting requirements with EI#2 and she (EI#2) verbalized understanding and agreed to comply.	A 508		
A 602	420-5-4-.06 (2) (a) (b) (c) Care of Residents. (2) Medical Examination Record. (a) Initial Physical Examination. Not more than 30 days prior to admission of any resident to an assisted living facility, the resident or prospective resident shall be examined by a physician. For purposes of the initial physical examination only, a currently licensed physician in good standing with the Medical Licensure Commission of any state may complete this physical assessment. The physician shall report his or her findings in writing to the facility. In addition to any information otherwise required by the facility's policies and procedures, and in addition to any other information the physician recommends or believes is pertinent, the initial physical examination record shall contain the following: 1. All of the physician's diagnoses, and the resident's baseline weight and vital signs. 2. Medication presently prescribed (name, dosage, and strength of drug, frequency, and route of administration). 3. A statement by the physician that the resident is free of signs and symptoms of	A 602		

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A 602	Continued From page 39	A 602		

infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact.

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

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

1. The resident's weight and vital signs.

2. Changes in diagnoses.

3. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration).

4. Changes in treatment.

(c) Change of Condition Physician Examinations. Changes in the resident's condition that require a physician examination and result in a change in diagnoses, medications, or treatments shall be reported to the facility and documented in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed

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A 602	Continued From page 40 necessary, pertinent, or recommended by the resident's treating physician, this physical examination shall contain a listing of the following: 1. New diagnoses. 2. Changes in condition. 3. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration). 4. Changes in treatment. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility did not ensure all required resident physical examinations were complete and on file. Findings: Resident Identifier (RI)#1 was admitted to the facility on July 23, 2019, with diagnoses which included, congestive heart failure (CHF), adjustment disorder anxiety, depressed mood, Type 2 diabetes, ventricular tachycardia, atherosclerotic heart disease, hypertension, and muscle weakness. No baseline weight was documented on RI#1's Initial Physical Examination dated July 22, 2019. There were no annual physical examinations on file for RI#1 for 2020 or 2021. On the afternoon of April 18, 2022, EI#3 told the surveyor she (EI#3) would look in the thinned chart for RI#1's missing documentation. EI#3 went on to say the facility needed a better filing system and she (EI#3) had	A 602		

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A 602	Continued From page 41 contacted someone in the medical records department on April 18, 2022, for some help. The surveyor was not provided with RI#1's 2020 or 2021 annual physical examinations at the conclusion of the survey on April 19, 2022.	A 602		
A 611	420-5-4-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall be based on the initial medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be reviewed and updated based on the annual examination, and all other physician examinations, diagnoses, and recommendations of the resident's treating physician, and the resident's monthly assessments. The plan of care shall be developed and updated in cooperation with the resident and, if appropriate, the sponsor. All entries on the plan of care shall be accurately dated. 1. The plan shall at all times reflect the current condition of the resident and document the personal care and services required from the facility by the resident. In addition to other items that may be required by the facility's own policies	A 611		

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A 611	Continued From page 42	A 611		

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 assisted living facilities shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident.

(i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested.

(ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips.

(iii) Hair. Resident's hair shall be kept clean, neat, and well groomed.

(iv) Manicure. Fingernails and toenails shall be kept clean and trimmed.

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A 611	Continued From page 43 (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' plans of care were not updated and did not contain specific interventions to address the residents' care needs. In addition, the plans of care did not reflect the current condition of the residents and all entries on the plans of care were not accurately dated. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON MARCH 1, 2016 and FEBRUARY 5, 2019. Based on observations and interviews, the facility failed to assist all residents with a clean and well-kept personal appearance. Findings: PLAN of CARE: RI#1 was admitted to the facility on July 23, 2019, with significant past medical history of congestive	A 611		

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A 611	Continued From page 44 heart failure (CHF), Type 2 diabetes, ventricular tachycardia, atherosclerotic heart disease, and hypertension. None of these diagnoses were noted as problems on the plan of care. RI#3 was admitted to the facility July 5, 2018, with diagnoses to include, weakness, persistent atrial fibrillation, chronic kidney disease, Type II diabetes mellitus, gastric esophageal reflux disease (GERD), rheumatic multiple valve disease, secondary pulmonary hypertension and Meniere's disease. RI#3 was identified as a fall risk and sustained a fall in February 2022. RI#3 was also found on the floor twice in November 2021 on November 11 and 13. None of the incidents were addressed on the plan of care. According to the Monthly Assessment dated February 28, 2022, RI#3 presented to the dining room naked from the waist down and was having crying fits when she/he became frustrated. RI#3 was care planned for impaired cognitive function or impaired thought process but there was not mention of the inappropriate behaviors exhibited in February 2022. The care plan noted, "Weight Management (Loss/Gain)" as a need, however, RI#3's significant weight loss of 8.4% in February 2022 was not mentioned. RI#3 had a history of diarrhea and fecal impaction which was not listed as problem on the care plan. During the survey, RI#3 was observed to be in need of personal hygiene assistance. The care plan was not updated to include the need for increased assistance with activities of daily living (ADL). Also, there were no interventions to ensure RI#3's hands and fingernails were checked frequently and cleaned of feces immediately to prevent disease or illness. See deficiency 621 for additional information.	A 611		

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A 611	Continued From page 45 RI#4 had been residing at the facility since May 1, 2016. RI#4's care plan contained documentation that RI#4 was a high risk for falls. Five (5) falls, without injury, were recorded on RI#4's care plan for 2021. According to the Monthly Assessment dated February 28, 2022, RI#4 had a four (4) day history of missing his/her chair at night and landing on the floor. The care plan did not address RI#4's problem with his/her chair with specific interventions to prevent recurrence. RI#5 was admitted to the facility on October, 23, 2015, with diagnoses to include systemic lupus, osteoarthritis, hypertension, polyneuropathy, weakness, bradycardia, hypothyroidism, and insomnia. The plan of care did not include these as a "Problem/Needs" or provide any applicable interventions. RI#5 was identified at risk for malnutrition on the plan of care, but the plan of care was not updated with the recent significant weight loss in April 2022 (5.3%). On the morning of April 12, 2022, EI#9, was interviewed regarding her (EI#9) ALF responsibilities. EI#9 told the surveyor she (EI#9) had only been at the facility since February 1, 2022, and was completing some of the care plans. EI#9 also said EI#3 had been filing in since the last unit manager left the facility. EI#9 told the surveyor she (EI#9) was scheduled to begin as the unit manager on April 22, 2022. EI#9 said she (EI#9) reported to EI#2 and EI#3. On April 14, 2022, resident plans of care were discussed with EI#2, EI#3, and EI#20. EI#20 told the surveyor the previous unit manager was responsible for updating the ALF care plans. EI#20 stated she (EI#20) was unsure what was needed on the care plans and would like to have some training on what was expected.	A 611		

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A 611	Continued From page 46 PERSONAL APPEARANCE: On April 12, 2022, the surveyor observed several residents (RI#1, RI#3, and RI#5) with unkempt hair. RI#3 also had dirty hands and filthy fingernails. The next morning on April 13, 2022, RI#1 and R#5 had neat and clean hair. However, RI#3 continued to to be in need of personal hygiene. RI#3 was eating breakfast in the dining room and the surveyor asked EI#2 to examine RI#3's fingernails. EI#2 agreed this was unacceptable and instructed EI#19 to clean RI#3's hands and fingernails immediately. On April 14, 2022, the surveyor checked on RI#3 and continued to find her/him with unbrushed hair and unsanitary fingernails. See deficiency 621 for additional information.	A 611		
A 612	420-5-4-.06 (4) (c) (d) (e) (f) Care of Residents (c) The facility shall offer appropriate activity programs to each resident, maintaining supplies and equipment as necessary to implement the activity programs. Every day the facility shall provide activities appropriate to each resident. (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	A 612		

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A 612	Continued From page 47 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 place and receive telephone calls at the facility in complete privacy. 2. Personnel of the facility shall assist residents with communications, such as writing letters or assisting with writing letters, or reading mail out loud if requested to do so. (f) Appointments. Residents shall be assisted in making and keeping appointments. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to provide activities appropriate to each resident every day. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The ADPH received complaints from a family member on March 17, 2022 and an employee on September 15, 2021, regarding the lack of appropriate activities for residents. The surveyors made observations and interviewed residents and staff about the activities provided. On April 12, 2022, in the afternoon, the surveyor observed EI#8 giving manicures to female residents. However, the other two (2) planned activities listed for the day "Lunch Tunes" and Beauty Shop" did not take place. The surveyor	A 612		

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A 612	Continued From page 48	A 612		

interviewed three (3) of the seven (7) residents and was informed they were not satisfied with the activities provided. In addition, three (3) staff members were asked about the activities provided for the residents. Staff told the surveyor there were not enough activities offered. EI#19, Personal Care Assistant (PCA), informed the surveyor the beautician did not come every Tuesday as scheduled for "Beauty Shop." The April 2022 activities planned for Saturday ("Word Search" and "Coloring Pages") and Sunday ("Read a Book or Magazine" and "Watch TV") are not designed to encourage socialization with the other residents on the weekends. The "Lunch Tunes" activity, scheduled for Monday through Friday, was just music playing during the meal and did not require engagement from the residents.

On April 13, 2022 at 9:00 AM, the surveyor overheard RI#5 tell EI#19, PCA, she/he (RI#5) wanted to do an activity. EI#19 suggested a puzzle and RI#5 replied, "I've already done those puzzles twice." EI#19 then offered to play cards with RI#5 and she/he gladly accepted.

The afternoon of April 13, 2022, the surveyor 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 20 years and accepted the activities director position in February 2022. EI#8 told the surveyors she (EI#8) works Monday through Friday and had been trying to improve the activities program. EI#8 informed the surveyors the previous activity director did not provide enough activities for the residents in the ALF and he/she did not go to the SCALF at all. EI#8 said she (EI#8) tries to engage the residents in activities but they do not show an interest in participating at times.

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A 612	Continued From page 49 On 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 resident's lives.	A 612		
A 614	420-5-4-.06 (5)(f)(g)(6)(7)(a)-(i) Care of Residents. (f) A resident may self-manage his or her medications. For the purposes of these rules, self-manage shall mean the resident is capable of maintaining possession and control of his or her medications, who does maintain possession and control of his or her medications, and self-administers his or her medications without creating an unreasonable risk to health and safety. (g) A resident that cannot self-manage his or her own medication without creating an unreasonable risk to health and safety may be assisted with self-administration of medication by any assisted living facility staff, including staff members who hold no professional licensure provided: 1. The resident can and does identify his or her name on the medication package and has a reasonable understanding of the unit dose packaging system in use by the facility such that the resident could protect himself or herself from medication errors when unit dose packages are brought to the resident by facility staff. The resident shall have the opportunity to demonstrate his or her ability to correctly utilize the unit dose package system at every opportunity for medication use. (6) Assistance with self-administration of	A 614		

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A 614	Continued From page 50 medication includes the following practices: (a) Reminding a resident that it is time to take a medication or medications, where such medications have been prescribed for a specific time of day, a specific number of times per day, specific intervals of time, or for a specific time in relation to mealtimes or other activities such as arising from bed or retiring to bed. (b) Physically assisting a resident by opening or helping to open a container holding medications. (c) Offering liquids to a resident to assist that resident in ingesting oral medications. (d) Physically bringing a container of medication to a resident. (7) Assistance with self-administration of medications shall under no circumstances include any of the following practices: (a) Medication administration as defined in these rules. (b) Determining the amount of medication to be given. If a medication is not available in unit dose packaging, unlicensed facility staff may measure the prescribed amount of medication only under the direction and control of the resident, provided that the resident is capable of determining the amount of medication to be given. (c) Giving a resident injections of any kind.	A 614		

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A 614	Continued From page 51 (d) Telling or reminding a resident that it is time to take a PRN, or as needed medication. (e) Placing medications in a feeding tube. (f) Giving enemas or suppositories. (g) Crushing or splitting medications, provided that a physician has ordered a specific medication to be crushed or split and the resident is capable of self-managing his or her own medication or the resident is capable of medication self-administration with assistance and would be capable of crushing or splitting his or her own medications but for limitations of mobility or dexterity, may be assisted with crushing or splitting medications by unlicensed staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. (h) Mixing medications with food or liquids, provided that a physician has ordered a medication to be mixed with food or liquid and the resident is capable of self-managing his or her own medications or the resident is capable of medication self-administration with assistance and would be capable of mixing his or her own medications with food or liquid but for limitations of mobility or dexterity, may be assisted with mixing medications with food or liquid by unlicensed staff so long as the assistance provided is under the total control and direction of	A 614		

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A 614	Continued From page 52 the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. (i) Assisting with self-administration of eye drops, eardrops, nose drops, inhalers, nebulizers, or topical medications, provided that a resident who is capable of self-managing his or her own medication or a resident who is capable of medication self-administration with assistance and who would be capable of self-administration of his or her own medications but for limitations of mobility or dexterity, may be assisted with eye drops, ear drops, nose drops, inhalers, nebulizers, or topical medications by unlicensed facility staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. This Rule is not met as evidenced by: Based on observation and interview, every resident was not offered the opportunity to demonstrate the correct utilization of the facility's unit dose system at each medication opportunity. THIS IS A REPEAT DEFICIENCY FROM THE PRIOR SURVEY CONDUCTED ON MARCH 1, 2016 and FEBRUARY 5, 2019. Findings: On April 12, 2022, the surveyor observed EI#9 assist residents with their 9:00 AM scheduled	A 614		

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A 614	Continued From page 53 medications. At 8:40 AM, EI#9 was in the hallway at the medication cart checking the Medication Assistance Record (MAR) for RI#2. RI#2 had nine (9) medications scheduled to be given at 9:00 AM. EI#9 placed all of the medications into a plastic cup at the cart and transported them to RI#2's room. EI#9 told RI#2, "I have your morning meds." RI#2 was not given an opportunity to demonstrate his/her ability to correctly utilize the unit dose package system. EI#9 agreed with the surveyor the opportunity for properly identifying the medications was not provided.	A 614		
A 617	420-5-4-.06 (8) Care of Residents. (8) Disposal of Medications. 1. Controlled substances and legend drugs dispensed to residents, that are expired or unused because the medication is discontinued or because the resident dies, shall be destroyed within 30 days. Unused legend drugs that are not expired may be donated to a charitable clinic pursuant to Alabama Administrative Code, Chapter 420-11-11. Under no circumstances should expired, discontinued, or unused medications be stored or housed in the facility beyond 30 days. 2. Medications of residents who are discharged or transferred to another facility shall be returned to the residents. The responsible party will sign a statement that these medications have been received. The statement shall list the pharmacy, prescription number, date, resident's name and strength of the medication, and the amount. This statement shall be maintained in a file for at least three years.	A 617		

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A 617	Continued From page 54 3. When medications are destroyed on the premises of the assisted living facility, a record shall be made and retained for at least 3 years. This record shall include: the name of the assisted living facility, the method of disposal, the pharmacy, the prescription number, the name of the resident, the name, strength, and dosage of the medication, and the amount and the reason for the disposal. This record shall be signed and dated by the individual performing the destruction and by at least one witness. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to document release of medications upon discharge of a resident. Findings: RI#7 was admitted to the facility on October 9, 2014, and was discharged from the facility on February 23, 2022 to a skilled nursing facility. The surveyor reviewed the discharged record for RI#7 on April 14, 2022. The record did not contain a Medication Disposition Form. EI#20, RN, confirmed the medication release form was not in RI#7's discharge record. On the morning of April 19, 2022, the surveyor asked EI#3, Care Coordinator, if RI#7's medications were released to the sponsor at the time of discharge or still at the facility. EI#3 told the surveyor she (EI#3) did not know.	A 617		
A 621	420-5-4-.06 (11) (b) Care of Residents. (b) Retention	A 621		

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A 621	Continued From page 55 1. An assisted living facility shall not allow any resident to return to the assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the facility is licensed to provide or the facility is capable of providing. 2. An assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility. 3. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in an assisted living facility. 4. An assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless: (i) The individual is capable of performing and does perform all tasks related to his or her own care; OR (ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity BUT the individual has sufficient cognitive ability to direct his or her own care AND the individual is able to direct others and does direct others to provide the physical assistance needed to complete such tasks, AND the facility staff is capable of providing such assistance and does provide such assistance. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe	A 621		

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A 621	Continued From page 56	A 621		

practices by facility staff.

5. If a resident of an assisted living facility is diagnosed with a terminal illness other than dementia and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90 days. If the facility is unable or becomes unable to meet the needs of a resident receiving hospice care, or if a resident receiving hospice care requires care beyond what the facility may lawfully provide pursuant to this section, then the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for assisted living facilities.

The facility would in all cases remain responsible for ensuring the appropriate delivery of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident.

6. All skilled services provided in the facility, such as but not limited to wound care or insertion of a urinary catheter, shall be provided by the staff of properly licensed or certified agencies. Skilled services shall not be delegated to facility staff.

7. Residents that develop acute infectious pulmonary disease, such as active tuberculosis, or other diseases capable of transmission to other individuals through normal person-to-person contact shall be immediately transferred to an appropriate level of care until

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A 621	Continued From page 57 certified by a physician to be free of a contagious condition. 8. No assisted living facility shall be operated in whole or in part in a manner that prevents free and unhindered egress from the facility by any of its residents. 9. An assisted living facility shall not retain any resident who cannot safely reside in the facility unless his or her egress from the facility is restricted. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility retained a resident with a decline in health and exhibited inappropriate behaviors for an ALF. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The ADPH received allegations from a family member on March 17, 2022 and an employee on September 15, 2021, reporting ineligible residents were being retained in the facility. The surveyor was able to substantiate this complaint based on the following information. RI#3 had been residing at the facility since July 5, 2018. The most recent Medical Exam dated November 15, 2021, listed the following diagnoses, weakness, persistent atrial fibrillation, chronic kidney disease, Type II diabetes mellitus, gastric esophageal reflux disease (GERD), rheumatic multiple valve disease, secondary pulmonary hypertension and Meniere's disease.	A 621		

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A 621	Continued From page 58 Refer to deficiency 611 for additional information on RI#3. The morning of April 12, 2022, RI#3 was observed sitting on a rollator at a dining room table. RI#3 was very thin and frail. RI#3 was noted to have a poor breakfast intake. Later in the afternoon the surveyor examined RI#3's skin and extremities. RI#3's fingernails were stained and had an accumulation of a brown substance underneath the nails. The surveyor learned RI#3 had a history of fecal impaction and attempted to manual remove the stool herself/himself. According to the documentation on the Daily Reports dated April 9, 10, and 11, 2022, RI#3 had stool all over the floor, bed, and her/his hands. In addition, RI#3 was being changed every two (2) hours. This information was confirmed with EI#17, PCA, during an interview on April 13, 2022. EI#17, PCA, told the surveyor RI#3 had been declining and it was difficult to keep RI#3's hands clean of stool. The February 2022 Monthly Summary documented the following behaviors, "Presented to dining room naked from waist down. Not wanting staff to help clean up after diarrhea. Crying fits when she/he gets frustrated." A review of the weight logs revealed RI#3 had a significant weight loss of 8.4% from January 2022 (107 pounds) to February 2022 (98 pounds). On April 13, 2022, EI#9, Registered Nurse (RN), told the surveyor she (EI#9) had been monitoring RI#3's eating and her/his dietary intake was poor. On November 15, 2021, EI#20, RN, notified the sponsor RI#3 was requiring extra assistance. However, a discharge notice had not been issued. On April 18, 2022, the surveyor discussed RI#3's eligibility for an ALF with EI#2. EI#2 agreed RI#3's behaviors were not appropriate for an ALF and she (EI#2) had spoken with the family and arrangements were being made to transfer RI#3 to the nursing home as soon as possible.	A 621		

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A 702	Continued From page 59	A 702		
A 702	420-5-4-.07 (2) Food Service (2) Food Handling Procedures. (a) Dish and Utensils Washing, Disinfection, and Storage. 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 manufacturer's 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 30 seconds in 12.5 ppm of iodine or the amount of time set 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.	A 702		

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A 702	Continued From page 60 3. Dishes and utensils shall be allowed to air dry. 4. After washing, rinsing, sanitizing, and air-drying, all repeated use service ware (utensils 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 may be stored in 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 back flow, 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,	A 702		

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detergents, and cleaning supplies shall not be kept in the refrigerator or 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 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 be maintained 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 3 days from the date it 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 to ensure that food is not contaminated in transport and that foods that are transported are held and served at the appropriate temperatures at all times.

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

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A 702	Continued From page 62 9. Frozen food items (raw and cooked) shall be thawed under refrigeration or under running water prior to preparation. Frozen food 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	A 702		

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cream. Ice cream dippers, spatulas, and other serving utensils shall be cleaned between uses.

(e) Kitchen Garbage and Trash 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.

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A 702	Continued From page 64 (g) Live Fowl or Animals. Live fowl or animals shall not be allowed in the food service area. (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 IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON MARCH 1, 2016 and FEBRUARY 5, 2019. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The ADPH received complaints from a family member on March 17, 2022 and two (2) employees on September 15, 2021, regarding the	A 702		

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A 702	Continued From page 65 poor food service provided to residents, dirty utensils, mold under sink in kitchen and dishwasher not functional. Surveyors substantiated these allegations during the onsite survey and found numerous other areas of non-compliance related to food handling procedures. In the morning hours between 6:30 AM through 8:00 AM, on April 12, 2022, the surveyor along with EI#19, PCA, and EI#21, Dietary Aide, observed the following concerns in the facility's kitchen. The dishes were not being sanitized. EI#19 was hand washing dishes and utensils from breakfast. When asked how he (EI#19) sanitized the dishes, EI#19 said he washed the dishes with Dawn detergent in the sink and then rinsed them. The dishes were placed in a drainer on the countertop to air dry. EI#19 stated he was not trained on how to sanitize the dishes. EI#19 said the dishwasher did not work when he started working in the facility in February 2022. On April 13, 2022, the surveyor observed the repeated service and multi-service utensils and dishes were not used. The food was served on disposable plates. There were canisters on the counter top containing cereal and sugar. The sugar canister contained a plastic scoop inside and the cereal canister had a Styrofoam cup inside which was stored on top of the food ingredients. In the refrigerator were three (3) gallon pitchers and five (5) uncovered Styrofoam cups containing a dark colored liquid which appeared to be tea. The containers were not labeled and did not contain a "use by date".	A 702		

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A 702	Continued From page 66 The breakfast meal was prepared in the SNF kitchen and brought over to the facility at approximately 7:00 AM on April 12, 2022, by EI#21, Dietary Aide. The food was inside a warming box during transport, however, EI#21 did not check the temperature of the food prior to plating it in the kitchen. On April 13, 2022 at 7:36 AM, EI#6, Dietary Manager was observed checking the temperatures of the food being served for breakfast. EI#6 said she (EI#6) was aware the food temperatures were not checked on April 12, 2022, and she would retrain the dietary staff on how to check the food for the proper temperatures before serving to the residents. Food was transported from the kitchen to resident's rooms without being covered. EI#19 transported breakfast to resident's rooms (RI#1 and RI#6) on plates that were not protected from contamination. On April 13, 2022, EI#19 transported the food to the resident's rooms in covered disposable plates. The PCA did not wear an apron while serving food to the residents in the dining room on April 12, 2022. EI#19 provided direct resident care and was not aware he (EI#19) was to wear a clean covering before serving food. The surveyor observed EI#19 wearing a white plastic apron on April 13, 2022. EI#19 told the surveyor he (EI#19) found some aprons in the 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	A 702		

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A 702	Continued From page 67 Manger 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. They were reminded 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		
A 703	420-5-4-.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	A 703		

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between the evening meal and breakfast. The time schedule of meals shall be posted with the menu. The facility shall make evening snacks available after service of the evening meal. The facility shall provide fluids throughout the day and shall make between-meal nourishment (snacks) available.

(c) Menu. The menu shall be planned and written at least 1 week in advance. The current week's menu shall be posted in the food service area and shall be kept on file for the following 2 weeks. For any resident with a physician's order for a therapeutic diet, the facility shall have a copy of the diet and the facility shall document the adjustment of its menu to accommodate the resident's needs.

(d) Alternate food selections or 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, record reviews, and

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A 703	Continued From page 69	A 703		

interviews, the facility failed to consistently provide the residents with palatable and visually appealing meals. In addition, the facility did not post the current week's menu in the food service area.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MARCH 1, 2016.

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

Findings:

The ADPH received complaints from a family member on March 17, 2022, regarding the quality of the food served to the residents. The family member also provided numerous pictures of the food for ADPH's review. The surveyor made observations and interviewed some of the residents and staff about the food provided. The following deficient practices were found.

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 was not appealing to the eye. RI#5 requested

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A 703	Continued From page 70	A 703		

some honey or syrup but was told by EI#19 there was none available. RI#5 told the surveyor the food was horrible and the facility had run out of coffee and butter at times. This was confirmed by EI#19. EI#4 informed the surveyor the food was bad and the kitchen was dirty. 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. There was no garnish as listed on the menu (Week 2) or any attempt to make the food appear palatable.

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 our food taste better than it looks. The surveyor explained to EI#6 if a resident was not interested in the looks of the food at first glance they are not going to eat it and EI#6 agreed.

WEEKLY MENU:

On the morning of April 12, 2022, the surveyor was told by EI#19 they did not have a weekly menu available. EI#19 said someone from dietary brings the menu to the ALF from the skilled nursing facility (SNF). However, during the five (5) day survey a current week's menu was never posted in the ALF. The surveyor did observe a dietary staff person bring a menu listing the daily "Lunch Specials" and "Dinner Specials" around mid-morning but it did not list the menu for breakfast. On April 13, 2022 at 10:10 AM, EI#6, Dietary Manager, provided the surveyor with

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A 703	Continued From page 71 copies of the "Week-At-A-Glance" (Week 1 and Week 2) menus but they were never posted in the ALF. On April 13, 2022, EI#6 told the surveyor the menus had been reviewed and approved by the registered dietitian.	A 703		
A 804	420-5-4-.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. (d) Lighting. The kitchen, dishwashing area and the dining room shall have adequate light. (e) Ventilation. Vent/exhaust hoods,	A 804		

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vented to the outdoors, shall be provided over cooking surfaces to aid in removing cooking odors. Existing recirculating vent hoods in Family facilities may remain in use when filters are cleaned or replaced regularly to prevent excess grease accumulation. Group assisted living facilities 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 and shall be well lighted and ventilated.

(g) Hand Washing Facilities. Each Group and Congregate 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. Existing Group and Congregate facilities that enlarge or renovate kitchens shall install a hand wash sink.

(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

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A 804	Continued From page 73	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 74 the kitchen shall include the following: 1. Range. In a Family or Group assisted living facility, a residential use range is permitted. A Congregate assisted living facility shall have a heavy-duty range suitable for institutional use with double oven, or equivalent. 2. Refrigerator. A Family or Group assisted living facility may use a residential refrigerator. A Congregate assisted living facility shall have a heavy duty refrigerator suitable for institutional use. 3. Fire extinguisher. A five-pound type BC for residential hoods, and K type for commercial hoods. 4. Dishwashing. The dishwashing equipment for Family and 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 75 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. 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 automatic type. This Rule is not met as evidenced by: Based on observations and interview the facility failed to properly maintain the food service area (dining room and kitchen) and provide adequate supplies for the staff. This deficient practice affected all 7 residents living in the facility. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON AUGUST 6, 2014 and FEBRUARY 5, 2019. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings:	A 804		

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A 804	Continued From page 76 The ADPH received complaints from a family member on March 17, 2022 and an employee on September 15, 2021, alleging the kitchen was dirty. The morning of April 12, 2022, the surveyor along with EI#18, Housekeeping, EI#19, PCA, and EI#21, Dietary Aide, observed the following concerns in the facility's food service area. DINING ROOM: There were no paper towels available in the dining room for EI#19 after he washed his hands. EI#9 told the surveyor housekeeping needed to refill the dispenser. Until then, he (EI#19) just steps over to the bathroom to get a paper towel for drying his hands. The dining room floor tile was sticky with a black film from built-up wax and dirt. In fact, the surveyor's shoes stuck to the floor. EI#18 told the surveyor the floor needs stripping to remove the old wax. EI# 18 said she (EI#18) mops after every meal but the floor will not come clean. KITCHEN: There were no paper towels available in the kitchen for hand washing by EI#19 and EI#21 during the preparation and serving of breakfast. EI#19 said they had paper dinner napkins to dry their hands. On April 13, 2022 at 7:20 AM, EI#6, Dietary Manager entered the kitchen and washed her hands but there were no paper towels available to dry her hands. The floors needed to be swept and mopped. There was thick dust in the corners and on the baseboards. The kitchen was dingy and dark. The overhead	A 804		

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A 804	Continued From page 77 lighting was dim. The kitchen window had a thick coating of dust and grime. The kitchen sink was stopped up. EI#19 was attempting to unclog the sink with his hand. A plunger was also noted near the sink. A sign was posted above the sink "The garbage disposal is broken." The lower shelf in the refrigerator was bent with old spills and stains. The kick plate grille was rusty. The dishwasher did not work. The microwave had chipped enamel on the base and it was covered with food spills from top to bottom. EI#19 told the surveyor only the staff used the microwave and he (EI#19) attempted to clean the inside. The counter tops were sticky with an accumulation of dust and grease. The cabinet doors were peeling and sticky. The cabinet underneath the sink was covered in black mold with signs of water damage in the back. 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. 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	A 804		

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A 804	Continued From page 78 from underneath the sink.	A 804		
A1001	420-5-4-.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 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	A1001		

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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 that 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, and toiletry articles. The use of a common towel and common bar soap is prohibited.

(f) Garbage Disposal.

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

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A1001	Continued From page 80 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, the premises were not kept neat and clean. In addition, the property dumpster was not kept free of rubbish that could create a sanitation hazard Findings: 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 large 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. As the surveyor approached the front entrance of the facility on the morning of April 12, 2022, the surveyor noted the concrete and brick was dusty and in need of pressure washing. The front door was dirty and needed to be painted. The windows were dirty and had spiderwebs.	A1001		

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A1001	Continued From page 81 The back patio was covered in dust and also in need of pressure washing. There was a recliner, mattress, bed-springs, bedrails, empty box, and 2x4 lumber lying around on the patio. The surveyor observed the staff using the patio table and chairs as a smoking area. On April 13, 2022 at 12:30 PM, EI#5, told the surveyor he did not know how the mattress got on the patio but he (EI#5) would get it removed. On April 14, 2022, EI#2 was informed of the dirty areas located on the outside of the premises. EI#2 verbalized agreement and stated the deficiencies would be addressed. On April 19, 2022, EI#1 told the surveyors he (EI#1) and EI#2 would make a plan that day to address the issues.	A1001		
A1002	420-5-4-.10 (2) Sanitation and Housekeeping. (2) Housekeeping and Physical Plant Maintenance. The facility must provide a safe, functional, sanitary, decent, 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.	A1002		

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A1002	Continued From page 82 (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 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:	A1002		

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A1002	Continued From page 83 Based on observations and interviews, the facility's housekeeping services failed to provide a functional, sanitary and comfortable interior environment for residents. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The ADPH received complaints from a family member on March 17, 2022 and an employee on September 15, 2021, alleging the facility (ALF and SCALF) was not kept clean and comfortable for the residents. This complaint was investigated and substantiated for the SCALF, as well as the ALF, during the onsite survey. The surveyors toured the facility on the morning of April 12, 2022 with EI#17. The following housekeeping issues were identified at that time and during the onsite survey. RI#2's furniture needed to be dusted, the floors swept and mopped. RI#3's room had an odor of bowel movement. There was feces on the floor, on the wall next to the toilet, and on the toilet seat. The bathroom rug had brown spots on it and needed washing. RI#4's wooden louvered closet door was not functional and could not be opened. On April 12, 2022, EI#4 told the surveyor the doors were installed about a month ago and had not set yet. EI#19 said he (EI#19) leaves the closet doors partially opened so RI#4 can open the doors unassisted. The hallways had spiderwebs in the corners.	A1002		

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A1002	Continued From page 84 The baseboards in the hallways were dirty. The hallway floors were sticky and in need of sweeping and mopping. 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 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	420-5-4-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift of Group and Congregate facilities. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide	A1101		

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staff and residents with experience in exiting through all exits required by the currently adopted Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years.

(c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs.

(d) Roller latches are prohibited on doors separating corridors from adjacent spaces.

(e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that:

1. Minimizes leaks and spills.

2. Adequately protects against inappropriate access.

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

(f) Fire Alarm and Sprinkler System.

1. Fire Alarm System. Where fire alarm systems are required, a corridor smoke detection system shall be installed on each floor, including areas open to the exit access corridor, to comply with NFPA 72, connected to the facility's fire alarm system. In lieu of corridor smoke detection,

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A1101	Continued From page 86 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. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON AUGUST 6, 2014 and MARCH 1, 2016. Findings:	A1101		

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A1101	Continued From page 87 The facility's fire and safety documentation was reviewed on April 14, 2022, with EI#4, Maintenance Director. The following deficiencies were found: There were no fire drills documented for the months of February 2020, 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, third, fourth quarters 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 the fire drills must be conducted monthly at varying times and days and quarterly on each shift.	A1101		
A1203	420-5-4-.12 (5) Physical Environment. (5) General Building Requirements - Family, 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.	A1203		

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A1203	Continued From page 88 (b) Temperature to be Maintained. The facility shall maintain a comfortable temperature. A comfortable range is between 71-81 degrees Fahrenheit. (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 insect screens. Screen doors shall be equipped with self-closing devices. (e) Emergency Lighting. 1. All assisted living facilities shall provide emergency artificial lighting to adequately illuminate halls, corridors, kitchens, dining areas, 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	A1203		

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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.

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.

(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 purpose. All walls and doors under stairs shall meet the same fire rating as the stairwell.

(l) Doors.

1. In each new assisted living facility, doors of resident bathrooms connected to

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resident bedrooms 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 each assisted living facility shall be at least three feet wide. Bedroom doors in Family assisted living facilities shall not be less than 32 inches 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 special locking arrangements are permitted only in specialty care assisted living facilities.

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. Exit doors of Family facilities may swing inward.

(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 extinguishers

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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 designated staff of the facility and documented on the attached extinguisher tag by the designated staff person.

(o) Call System. Except in Family facilities, 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 Group and Congregate 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

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A1203	Continued From page 92 necessary to indicate the 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 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 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 facility failed to provide a functional call system for every resident. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings:	A1203		

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A1203	Continued From page 93 The ADPH received allegations from a family member on March 17, 2022 and an employee on September 15, 2021, that a resident's call light was zip tied to the wall so she/he (RI#4) couldn't use it. On April 12, 2022 at 4:50 AM, the surveyors entered the facility and checked the call lights in each resident's bedroom and bathroom. The surveyors were accompanied by EI#17, PCA. The surveyor found no concerns with the call light in RI#4's room, however, there was not a functional call light in the bathroom for RI#1. There was no pull string attached to the metal lever to activate the call system. During an interview with RI#1 later in the morning, the surveyor learned RI#1 had a recent fall in her/his bathroom and could not call for assistance due to the missing string on the call light. RI#1 told the surveyor it had been like that since she/he moved in (2019). RI#1 said she/he was not hurt but needed someone to help her/ him get up from the floor. The surveyor informed EI#2 of the safety issue and she (EI#2) said she (EI#2) would have EI#4 repair the call light immediately. CONNIE CHERRY, REGISTERED NURSE DEBRA FREEMAN, REGISTERED NURSE	A1203		