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KELLEY PLACE	109 CHANEY STREET ENTERPRISE, AL 36331

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A 000	Initial Comments This is a 16 bed Specialty Care Assisted Living Facility (SCALF) with a census of 13 on March 03, 2022. There were seven (7) complaints investigated during this unannounced licensure complaint survey. LC#20210810006, LC#20200204004, LC#2019101001, LC#20190924003, and LC#20190327003 were substantiated. LC#20190812007 and LC#20190327002 were unsubstantiated. There were deficiencies written as a result of the complaint investigations. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. These widespread failures resulted in actual harm for at least seven (7) residents (three residents were discharged prior to the survey) and placed the remaining nine (9) residents at significant risk for harm.	A 000		
A 301	420-5-20-.03 (1) (a) (b) (c) (d) Administration. (1) The Specialty Care Assisted Living Facility Governing Authority. (a) A specialty care assisted living facility shall have an identified sole proprietorship, corporation, partnership, limited partnership, or other business entity that is its governing authority, or it shall have a designated individual or group of designated individuals who serve as its governing authority. A facility must give complete information to the Department identifying:	A 301		

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

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A 301	Continued From page 2 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the governing authority failed to adequately oversee the administrator to ensure the facility operated in compliance with the SBOH rules for specialty care assisted living facilities (SCALF). The administrator failed to adequately perform his duties as administrator to ensure the facility was managed responsibly. These failures resulted in retention of residents whose level of care exceeded the facility's capabilities, inadequate staffing, poorly managed staff who failed to treat residents with dignity and respect, the inability to meet residents' care and safety needs, lack of adequate health supervision, poorly developed resident care plans that were not current and did not address resident problem areas with appropriate care actions, improper medication management, and failure to maintain a safe environment. These widespread failures resulted in actual harm for at least seven (7) residents [three residents RI#11, RI#12, and RI#13 had been discharged prior to the survey). The remaining nine (9) residents were at risk for significant harm due to the administrator's failure to apply the rules for the day to day operations of the facility. THIS IS A REPEAT DEFICIENCY FROM SURVEYS COMPLETED ON DECEMBER 20, 2018, DECEMBER 14, 2016, AND AUGUST 09, 2016. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATIONS. Findings:	A 301		

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A 301	Continued From page 3 On December 20, 2018, an Alabama Department of Public Health (ADPH) surveyor conducted an onsite licensure survey and two complaint investigations. The complaints were both substantiated. Eight (8) of the 14 deficiencies cited during the December 2018 survey were cited again during this survey. The eight repeat deficiencies included governing authority, administrator, implementing/following policies and procedures, staffing, employee training, resident rights, incidents, and resident care. On March 01, 2017, an ADPH surveyor conducted an onsite licensure survey. Five (5) of eight (8) deficiencies cited during the March 2017 survey were cited again during this survey. The five repeat deficiencies include failing to follow policies and procedures, employee training, medication management, and fire safety. On December 14, 2016, an ADPH surveyor conducted an onsite licensure survey and one (1) complaint investigation. The complaint was unsubstantiated. Twelve (12) of 17 deficiencies cited during the December 2016 survey were cited again during this survey. The 12 repeat deficiencies included governing authority, administrator, implementing/following policies and procedures, RN duties, resident assessments, resident care, and resident safety. On August 09, 2016, an ADPH surveyor conducted an onsite licensure survey. Ten (10) of 11 deficiencies cited during the August 2016 survey were cited again during this survey. The 10 repeat deficiencies included governing authority, administrator, RN duties, employee training, resident rights, incidents, resident care, and resident safety.	A 301		

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A 301	Continued From page 4 Based on results from previous surveys, the governing authority failed to ensure the facility attained and maintained compliance with the SBOH rules for SCALF's. On February 02, 2022, EI#1 submitted an online report that Resident Identifier (RI)#1 was physically abused by EI#19. ADPH requested and received an immediate plan of action (IPOA) in response to the physical abuse suffered by RI#1. The facility's immediate plan of action included the following actions. 1. All residents would have skin assessments to identify any skin issues including injuries of unknown origin. 2. All residents would be interviewed regarding any possible abuse received from an employee. 3. All employees would be trained on the abuse policy and procedures, which included mandatory reporting requirements. 4. All employees would be trained on "Dealing with Difficult Behaviors". 5. The facility would implement weekly skin assessments during resident bathing. 6. Weekly skin assessments would be completed by care associates who would report findings to the Licensed Practical Nurse (LPN) on duty, who would then report the findings to the RN/Care Coordinator. 7. The alleged perpetrator would be suspended and/or terminated based on the outcome of the investigation. On February 09, 2022, a surveyor with the ADPH conducted a care inspection survey as the result of the facility's report of RI#1's physical abuse by EI#19. The surveyor requested documentation of the implementation of the immediate plan of action for RI#1's physical abuse. EI#3 told the surveyor resident skin assessments had not been	A 301		

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A 301	Continued From page 5	A 301		

documented or completed. EI#1 told the surveyor resident interviews had not been conducted. Only 16 of the 27 current employees had completed the abuse and mandatory reporters training at the time of the survey. EI#1 was unsure how many employees had completed the Relias computer training for dealing with difficult behaviors. The weekly skin assessments had not been implemented because the baseline assessments had not been completed on all the residents. EI#1 confirmed that EI#19 had been terminated upon completion of RI#1's physical abuse investigation. The result of the facility's investigation was that RI#1 suffered physical abuse by EI#19 on two separate occasions.

On March 03, 2022, a surveyor with ADPH completed a full licensure survey with five of the seven complaints substantiated. The substantiated complaints included allegations regarding the lack of resident care, lack of resident activities, lack of employee training, inadequate staffing, ineligible residents, poorly managed employees, and resident safety concerns. All of which were substantiated. Once on site, the surveyor also confirmed that at least seven (7) residents had suffered actual harm because of the widespread resident care and safety deficiencies.

The following deficiencies were identified as a result of the administrator's failure to apply the State Board of Health's rules for the day to day operations of the facility.

302 - Facility policies and procedures were not implemented or followed. THIS IS A REPEAT DEFICIENCY FROM SURVEYS COMPLETED ON DECEMBER 20, 2018, MARCH 01, 2017, AND DECEMBER 14, 2016.

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A 301	Continued From page 6 303 - The administrator did not perform required administrative duties. THIS IS A REPEAT DEFICIENCY FROM SURVEYS COMPLETED ON DECEMBER 20, 2018 (previous deficiency #413), DECEMBER 14, 2016 (previous deficiency #416, #417, #418), AND AUGUST 09, 2016 (previous deficiency #413 and #417). THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. 401 - The facility did not ensure an adequate number of employees were employed and on duty to meet the care and safety needs of all residents 24 hours a day, seven (7) days a week. The facility failed to properly manage employees to ensure resident care and safety needs were met. The facility also failed to utilize certified nurse assistants (CNAs) during an emergency staffing shortage. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON DECEMBER 20, 2018 (previous deficiency #402). THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. 405 - The registered nurse(RN)/care coordinator did not adequately perform his/her duties. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON DECEMBER 14, 2016 (previous deficiency #416, and #417). THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. 406 - The RN did not identify and provide training to all staff to meet the care and safety needs for all of the residents living in the facility. THIS IS A REPEAT DEFICIENCY FROM SURVEYS COMPLETED ON DECEMBER 20, 2018 (previous deficiency #429), MARCH 01, 2017	A 301		

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(previous deficiency #421), AND AUGUST 09, 2016 (previous deficiency #424 and #427). THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION.

504 - The facility did not honor the residents' rights of providing a safe environment, allowing residents to receive visitors without an appointment, to have a safe outdoor recreation area, to keep/use their own personal items, and to be treated with dignity and respect. THIS IS A REPEAT DEFICIENCY FROM SURVEYS COMPLETED ON DECEMBER 20, 2018, AND AUGUST 09, 2016. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION.

508 - The facility did not ensure incident reports were completed and incidents were thoroughly investigated. The facility also failed to provide interventions to prevent a reoccurrence of the incident. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON FEBRUARY 03, 2020. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION.

604 - The facility did not ensure adequate health supervision was provided to all residents to identify changes in health status and provide necessary care when needed. THIS IS A REPEAT DEFICIENCY FROM SURVEYS COMPLETED ON FEBRUARY 03, 2020 AND JANUARY 21, 2016, (PREVIOUS DEFICIENCY #602). THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION.

605 - The facility did not provide adequate health observation to identify residents who had care

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A 301	Continued From page 8	A 301		

and safety needs which exceeded the facility's capabilities. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION.

606 - The facility did not provide the necessary assistance for residents who required an increased medical or skilled nursing level of care. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION.

609- The facility failed to implement and follow its own abuse policy and procedures. The facility also failed to implement appropriate interventions to protect residents from further abuse. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION.

611 - The RN did not develop and update care plans to ensure appropriate care and safety interventions were documented to address resident care and safety needs. The RN did not accurately document resident assessments. The RN also did not ensure care plan interventions were followed by care staff and evaluated for effectiveness. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION.

612 - The facility did not provide adequate activities for all residents. The facility also did not develop individualized activity programs for residents with wandering behaviors. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION.

615 - The facility did not ensure all medications administered by facility employees were documented at the time they were administered. THIS IS A REPEAT DEFICIENCY FROM A

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A 301	Continued From page 9 SURVEY COMPLETED ON JUNE 18, 2018 (PREVIOUS DEFICIENCY #629). 616 - The facility did not ensure that resident medication in the custody of the facility was properly stored and managed. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON MARCH 01, 2017. 621 - The facility retained residents whose care and safety needs exceeded the capabilities of the facility license. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. 804 - The facility did not properly maintain resident dining tables and chairs in a safe and sanitary condition. 1002 - The facility did not provide adequate housekeeping and maintenance services to ensure a safe and decent environment for all residents. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON DECEMBER 14, 2016. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. 1203 - The furniture throughout the common areas of the facility had damaged or worn finishes that were not properly maintained or replaced to ensure the furniture could be properly sanitized. The facility failed to maintain the building and equipment in good repair. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON MARCH 01, 2017.	A 301		
A 302	420-5-20-.03 (e) Administration.	A 302		

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A 302	Continued From page 10 (e) Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). All residents shall be informed of new policies or changes in existing policies that may have bearing on the resident. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies shall cover the following: (i) Facility responsibility to protect all residents from abuse, neglect, and exploitation. (ii) How allegations of abuse, neglect, and exploitation will be handled by the facility. (iii) Resident confidentiality. (iv) Admission and continued stay criteria. (v) Discharge criteria and notification procedures for residents and sponsors. (vi) Facility responsibility when a resident's personal belongings are lost. (vii) What services the facility is capable and not capable of providing. (viii) Medication management. (ix) Infection control.	A 302		

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A 302	Continued From page 11 (x) Meal service, timing, menus and food preparation, storage, and handling. (xi) Fire safety and emergency plan, fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness. (xii) Staffing and conduct of staff while on duty. (xiii) Oxygen administration and storage if used in the facility. (xiv) Dietary Policies. The dietitian, with the approval of the administrator, shall develop written policies and procedures for the guidance of all personnel handling food as outlined by the most current Food and Drug Administration Food Code published by the U.S. Department of Health and Human Services. The facility shall develop and implement dietary policies and procedures to meet the needs of the residents in the facility. In addition to other matters deemed necessary by the facility, dietary policies shall address: (I) Sanitation of dishes, utensils, and service equipment, and sanitary food preparation and handling. (II) The attire and cleanliness of staff members who prepare, handle, or serve food. (III) A schedule of meals, which shall include between-meal nourishment or snacks, and fluids. (IV) Food substitutions or alternatives.	A 302		

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A 302	Continued From page 12 (V) Method to ensure an adequate dietary plan is implemented for any resident with a therapeutic diet or special dietary needs. (VI) Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food. (VII) Provision of necessary services to any resident requiring adaptive devices to eat. (VIII) Procedure for the handling of potentially hazardous foods such as meat, milk, ice, and eggs. (IX) Storage of food. (X) Procedure for food service in the event of a disaster. Disaster menus shall be developed. The policy shall address how food will be obtained and maintained at safe temperatures if electricity is not available. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement and staff failed to follow policies and procedures for abuse of residents, medication storage, health assessments, care plans and admission, retention, and continued stay criteria. This deficient practice resulted in actual harm for seven (7) residents, three (3) residents had been discharged prior to the survey. The remaining nine (9) residents were at risk for significant harm. THIS IS A REPEAT DEFICIENCY FROM	A 302		

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A 302	Continued From page 13 SURVEYS COMPLETED ON DECEMBER 20, 2018, MARCH 01, 2017, AND DECEMBER 14, 2016. Findings: Abuse - Facility employees did not immediately report witnessed incidents of physical abuse between residents or between residents and employees. Please refer to deficiency #609 for additional details. Medication Storage - The licensed practical nurses (LPNs) did not follow the policy and procedure for medication storage. The surveyor observed nurses leave the medication room, the medication cart, and the medication refrigerator unlocked and unsupervised at various times throughout the survey. These unlocked/unsupervised medication storage areas were observed with residents in the area and access by anyone to all medications including controlled medications. The medication cart keys, including the controlled medications key, were observed hanging on a hook in the unlocked/unsupervised medication room. Please refer to deficiency #616 for any additional information. Health Assessments - The RN did not follow the health assessments policy and procedure for timely and accurate completion of comprehensive assessments, behavior screenings, and physical self maintenance scales (PSMS). Please refer to deficiencies #604 for additional information. Care plans - The RN did not follow the care plan policy and procedure regarding the development of care plans with resident specific and appropriate care interventions to address the	A 302		

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A 302	Continued From page 14 resident's care and safety needs. The RN also did not update and evaluate the effectiveness of the care plan interventions put in place for the residents. Please refer to deficiency #611 for additional information. The facility administrator and RN did not follow the admission, retention, and continued stay criteria policy and procedure, which allowed ineligible residents to remain in the facility. Please refer to deficiencies #606 and #621 for additional information.	A 302		
A 303	420-5-20-.03 (2) (a) Administration. (2) The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the specialty care assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an administrator shall meet all applicable statutory requirements. 4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days.	A 303		

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A 303	Continued From page 15 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 actually being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement. 9. The facility administrator is responsible for ensuring that required training is provided to all staff. 10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting. 11. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when	A 303		

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A 303	Continued From page 16 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 observation, interview, and record review, the administrator failed to perform his duties to ensure the care and safety needs of all residents were met. This deficient practice resulted in actual harm for at least seven (7) residents (three residents RI#11, RI#12, and RI#13 had been discharged prior to the survey). The remaining nine (9) residents were placed at risk for significant harm from neglect and/or abuse. THIS IS A REPEAT DEFICIENCY FROM SURVEYS COMPLETED ON DECEMBER 20, 2018 (previous deficiency #413), DECEMBER 14, 2016 (previous deficiency #416, #417, #418), AND AUGUST 09, 2016 (previous deficiency #413 and #417). Findings: On February 02, 2022, EI#1 submitted an online report for physical abuse of RI#1 by EI#19. During the facility investigation EI#1 actually identified two (2) separate incidents where RI#1 suffered physical abuse by EI#19. ADPH	A 303		

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A 303	Continued From page 17	A 303		

requested and received an immediate plan of action (IPOA) from EI#1 to ensure RI#1 was safe from further abuse by EI#19. The IPOA's purpose was also to help identify any other residents who may have suffered abuse and to protect the residents living in the facility.

On February 09, 2022, an ADPH surveyor was dispatched to the facility to verify that the IPOA for the physical abuse of RI#1 had been carried out. Upon arrival the surveyor was told portions of the IPOA had not been completed including resident skin assessments, resident interviews, abuse training, and training for dealing with difficult behaviors. Weekly skin assessments for monitoring injuries of unknown origin, completed by the care associates, had not been implemented because baseline assessments were never completed. EI#1 and EI#3 agreed that the potential for abuse and continued injuries of unknown origin had not been resolved with the IPOA.

The surveyor spent a total of four days onsite at the facility (February 09, 22, 23, and 24 of 2022). During those four days, the surveyor observed the following administrative concerns.

Residents did not receive adequate personal care and supervision to prevent incidents and abuse by other residents or employees. Please refer to deficiencies #504, #606, #609, and #611.

Residents were not provided with a safe and decent environment. Please refer to deficiencies #504 and #609.

Minimal staffing requirements were not met which resulted in an unsafe environment where care and safety needs of all residents were not met.

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A 303	Continued From page 18 Please refer to deficiencies #401, #504, #606, #609, and #621. Employees were not properly managed to ensure resident care and safety needs were provided. Please refer to deficiencies #401, #504, #606, #609, and #611. All scheduled employees were not properly trained. Some staff refused to provide the care required by the residents living in the facility. Please refer to deficiencies #401, #406, #504, #606, #609, #611, #615, #616, and #621. Residents were retained in the facility with unmanageable and combative behaviors which kept employees from providing necessary care to the residents . These residents exceeded the capabilities of the facility license. Please refer to deficiencies #504, #606, #609, and #621. Residents had unmet care, safety, and psychosocial needs that were not addressed by the facility in an appropriate and timely manner resulting in actual harm for seven (7) residents (three residents had been discharged prior to the survey). The nine (9) remaining residents were at risk for significant harm and death. Please refer to deficiencies #504, # #606, #609, #611, #612, and #621. Residents did not have current care plans with appropriate individualized interventions that addressed their care and safety needs. Please refer to deficiency #611. The administrator did not maintain corrections for deficient practices previously cited by the department. Please refer to deficiencies #301, #302, #401, #405, #406, #504, #508, #604, #605,	A 303		

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A 303	Continued From page 19 #606, #611, #615, #616, #1002, and #1203. On February 09, 2022, the surveyor observed the following abusive and resistive resident behaviors. RI#2 and RI#3 had a physical altercation, with both residents hitting each other. RI#3 experienced greatly increased anxiety while RI#2 sat crying on the couch. RI#2 refused a complete skin assessment by EI#3 and the surveyor. RI#2 only allowed two nurses to look at RI#2's forearms and lower legs, which did not include the laceration on RI#2's left upper arm, observed by the surveyor earlier that same day. RI#6 walked into the common living room area with the top half of his/her body exposed while refusing dressing assistance by multiple employees including the LPN, RN, caregiver, and the activity director. RI#4 even tried to convince RI#6 to allow staff to finish dressing him/her. There were at least 8 different residents in the common area at the time of the incident. On February 22, 2022, EI#1 told the surveyor no 30 day discharge notices had been issued to the sponsors of the six (6) residents who resisted care daily and had unmanageable behaviors as seen on February 09, 2022. Please refer to deficiencies #606 and #621 for additional information. On February 23, 2022, EI#1 told the surveyor he (EI#1) was responsible for the administrative duties and the business office directors duties for Kelley Place and Madison Heights, a sister SCALF across the street. Review of the job descriptions for the administrator and business office director revealed EI#1 was responsible for all events and activities in the community including ensuring residents were appropriate for the SCALF, communicating changes in residents	A 303		

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A 303	Continued From page 20 to sponsors, billing, employee payroll, monitoring/reporting expenditures, and completion and monitoring of all financial documentation. EI#1 was also responsible for employee supervision, hiring, training, completion of employee file paperwork, and safeguarding the community from abuse, damage, or deterioration. In addition, EI#1 was to establish preventive maintenance, hold meetings with all employees, directors, residents, and sponsors as needed, track move-ins and move-outs and document all communication. The Administrator/Executive Director job description did not document the need for the administrator to have knowledge of the SBOH rules and regulations for a SCALF and to ensure compliance with the rules.	A 303		
A 401	420-5-20-.04 (1) (2) Personnel. (1) A specialty care assisted living facility shall ensure adequate personnel are employed and on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. No specialty care assisted living facility shall have fewer staff on duty than specified in Table A below. Even if this minimum staffing ratio is met, the governing authority of a specialty care assisted living facility shall have additional staff on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. Facilities with resident bedroom wings separated from the remainder of the facility by a lockable door shall maintain dedicated staff to these areas adequate to meet all care and safety needs of the residents in these areas at all times.	A 401		

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A 401	Continued From page 21 Table A Staff Number 7 AM - 3 PM 3 PM - 11 PM 11 PM - 7 AM 2 1 -16 Residents 1 - 16 Residents 1 - 16 Residents 3 17 - 24 Residents 17 - 36 Residents 17 - 48 Residents 4 25 - 32 Resident 37 - 48 Residents 49 - 64 Residents 5 33 - 40 Residents 49 - 60 Residents 65 - 80 Residents 6 41 - 48 Residents 61 - 72 Residents 81 - 96 Residents 7 49 - 56 Residents 73 - 84 Residents 97 - 112 Residents 8 57 - 64 Residents 85 - 96 Residents 113 - 128 Residents 9 65 - 72 Residents 97 - 108 Residents 129 - 144 Residents 10 73 - 80 Residents 109 - 120 Residents 145 - 160 Residents 11 81 - 88 Residents 120 - 132 Residents 161 - 176 Residents 1 Additional Staff For each 8 residents, or any fraction thereof, by which the census exceeds 88 For each 12 residents, or any fraction thereof, by which the census exceeds 132 For each 16 residents, or any fraction thereof, by which the census exceeds 176 (a) A specialty care assisted living facility shall be staffed at all times by at least one individual who has a current certification in cardiopulmonary resuscitation (CPR).	A 401		

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A 401	Continued From page 22 (b) A specialty care assisted living facility must be sufficiently staffed to ensure the safe evacuation of all residents in the event of a fire or emergency. (2) Employee Schedule. A specialty care assisted living facility shall post a schedule of employees indicating names and days and hours scheduled to work. This schedule shall be retained in the facility for 6 months after use. In the event of an unplanned staff shortage which would make it otherwise impossible to meet the staffing requirements imposed by these rules, a facility may employ a certified nurse aide who has not received the training specified in these rules. For the purposes of this subsection, a certified nurse aide is defined as an individual who has been deemed or determined to be competent by the Alabama Nurse Aide Registry maintained by the Alabama Department of Public Health. This individual may not work unless accompanied at all times by an individual who is appropriately trained in accordance with these rules. Such employment shall last only until the facility has employed staff trained in accordance with the above. In no event may the period during which such staff is employed in a facility exceed 120 consecutive hours. This Rule is not met as evidenced by: Based on observations, record review, and interview, the facility failed to provide the minimum number of required employees 24 hours a day seven (7) days a week. The facility failed to utilize certified nurse aides (CNAs)	A 401		

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during an emergency staffing shortage. The facility failed to ensure employees were CPR (cardiopulmonary resuscitation)certified within 90 days of hire. The facility also failed to properly manage employees to ensure resident care and safety needs were met. This deficient practice resulted in actual harm for at least seven (7) residents [three residents (RI#11, RI#12, and RI#13) had been discharged prior to the survey] and placed the remaining nine (9) residents at significant risk for harm.

THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON DECEMBER 20, 2018 (previous deficiency #402).

Findings:

PLEASE NOTE: There were two individually licensed 16 Bed SCALF facilities owned and managed by the same company. The two buildings were located across the street from each other and were not connected by a common hallway. However, the two facilities shared a single employee who was responsible for duties that would normally be provided by at least two or more employees in similar facilities throughout the state.

The surveyor spent a total of four days onsite at the facility (February 9, 22, 23, and 24 of 2022). During those four days, the surveyor observed the following staffing concerns.

On February 09, 2022, at approximately 10:50 AM, the surveyor observed there was one care associate in the kitchen area and a second care associate went to the kitchen area after letting the surveyor in the facility. The kitchen area was where the care associates also stored their

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phones and purses. Ten (10) residents were observed in the common living room sleeping or looking around. The LPN was in the medication room with the door closed. There were no activities in progress. EI#18 had an office in the facility, but was not seen in the facility upon arrival.

On February 22, 2022, at approximately 4:15 AM, the surveyor entered the facility to find one caregiver working the 7:00 PM to 7:00 AM shift. EI#12 told the surveyor the other care associate had called off and there had been no replacement. There was no nurse onsite but a nurse was available on call. EI#12 told the surveyor she (EI#12) had worked "many" shifts alone in the facility. EI#12 told the surveyor the facility staffing issues had been a lot worse since the onset of the Covid pandemic and EI#12 had worked alone more in the past year than during the 27 year long employment with the facility. The number of actual shifts EI#12 had worked alone was unknown but had happened several times a month since the Covid pandemic had started.

On February 22, 2022, EI#1, administrator, told the surveyor EI#3 was responsible for scheduling staff. EI#1 stated he was aware there had been a call off for the night shift and that EI#3 was working on a replacement. However, EI#1 told the surveyor he (EI#1) did not follow-up with EI#3 to make sure the night shift was sufficiently covered by the two minimum required employees. EI#3 did not report to EI#1 that the night shift had not been staffed with a second employee. EI#1 told the surveyor most of the conversations between EI#1 and EI#3 were verbal and there was no documentation to explain why there was inadequate staffing on the night shift of February 21 through February 22, 2022, from 7:00 PM

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A 401	Continued From page 25 through 7:00 AM. On February 22, 2022, the surveyor was told by EI#4 there was an LPN routinely scheduled to work a 12 hour shift from 7:00 AM to 7:00 PM each day. The LPN was responsible for resident medication management which included physician and pharmacy phone calls, refilling medications, and medication administration. According to the LPN job description the LPN was also responsible for monitoring resident care and safety needs, and monitoring residents for changes in condition. The LPN was also expected to run back and forth between the two facilities administering medications and responding to resident incidents in each building. There was no LPN in the facility after 7:00 PM. EI#4 was the only LPN required to be on call 12 hours every night (7:00 PM to 7:00 AM) seven (7) nights a week. EI#4 also worked at least three (3) 12 hour day shifts in the facilities every week. The exception to this LPN staffing pattern was on Wednesdays, when there were two LPNs working because the weekly resident medication replacement cycle was delivered by the pharmacy. On February 22, 2022, EI#8, care associate, told the surveyor "a few weeks ago" EI#8 had performed the Heimlich maneuver on RI#1 who had gotten choked on pancakes. There was no documentation of the incident available in RI#1's record during the survey. EI#5, LPN, told the surveyor she (EI#5) "remembered something about the choking incident", but EI#5 didn't know about the Heimlich maneuver being performed. Then EI#5 went on to say, "things get kind of crazy here, if I don't have an incident report, it's hard to keep track of what's going on."	A 401		

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EI#18 was the activity/marketing director. EI#18 split his/her 40 hour week between the two SCALF buildings. EI#18 also split his/her time conducting activities and marketing for both facilities.

On February 23, 2022, EI#18 told the surveyor she (EI#18) was supposed to spend 20 hours a week on activities, and 20 hours a week on marketing. EI#18 said when things were slow with marketing, she was supposed to spend more time on activities. EI#18 told the surveyor care associates were responsible for conducting activities on the weekends and when EI#18 was busy handling marketing tasks. EI#18 told the surveyor there were four (4) activities scheduled in each facility every day, two (2) in the morning and two (2) in the evening.

Note: EI#18 was actually allotted 10 hours a week for activities in each facility or approximately two (2) hours per day five (5) days a week for each 16 bed SCALF.

On February 09, 2022, the surveyor was told by EI#1 that the offices for EI#1 and EI#3 were in the facility across the street and EI#1 and EI#3 made rounds in the facility "frequently". However, EI#3 told the surveyor she (EI#3) had not observed nor had any employees reported any resistive behaviors by RI#1 to EI#3. EI#1 told the surveyor he was aware that RI#1 had resistive behaviors with the care associates.

On February 22, 2022, the surveyor observed EI#2 assist EI#18 tidy up some trash and store some Christmas trees from the facility courtyard area in preparation for a tour of a potential resident sponsor. EI#2 told the surveyor there

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wasn't anyone else to help EI#18 clean up the courtyard.

On February 23, 2022, EI#1 told the surveyor he (EI#1) was responsible for the administrative duties and the business office directors duties for both facilities. After further investigation and observation of many deficient practices, the surveyor determined the administrator was unable or unwilling to perform all of the required job duties for both facilities. Please refer to deficiency #303 for additional information.

RI#3 was the care coordinator and RN for both facilities. After further investigation and multiple deficient practices observed, the surveyor determined that the RN was unable or unwilling to perform all of the required job duties for both facilities. Please refer to deficiency #405 for additional information.

The surveyor was told by various employees and agency staff during separate interviews that there were at least six (6) different residents (RI#1, RI#2, RI#6, RI#7, RI#8, and RI#15.) out of 13 residents who resisted care daily or weekly. The same employees and agency staff told the surveyor they had reported the residents' resistive behaviors to the nurse/supervisor. However, there had been no increase in the number of employees working each shift, and no sitters had been added for increased supervision or assistance with care and safety.

On February 09, 2022, the surveyor observed the following behaviors. RI#2 and RI#3 had a physical altercation, with both residents hitting each other. RI#2 refused a complete skin assessment by EI#3 and RI#2 only allowed the nurses to look at RI#2's forearms and lower legs.

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A 401	Continued From page 28 The surveyor observed the assessment did not include a cut/laceration observed by the surveyor earlier that same day. RI#6 walked into the common living room area with the top half of his/her body exposed while refusing dressing assistance or encouragement to dress by multiple employees including the LPN, RN, a caregiver, and the activity director. RI#4 also tried to convince RI#6 to let the employees help get RI#6 dressed without success. Eventually EI#18 convinced RI#6 to put on a jacket that was hanging nearby. On February 22, 2022, EI#1 told the surveyor there had been no 30 day discharge notices issued to the sponsors of the six residents who resisted care daily/weekly and had unmanageable behaviors as discussed on February 09, 2022. Please refer to deficiencies #303, #606, and #621 for additional information.	A 401		
A 405	420-5-20-.04 (6) (7) (8) Personnel. (6) Medical Director. Each specialty care assisted living facility shall have a medical director who is a physician currently licensed to practice medicine in Alabama. The medical director is responsible for implementation of resident care policies, and the coordination of medical care in the facility. The medical director shall participate in quality assurance activities in the facility. A nurse practitioner or physician's assistant shall not serve as the medical director of a specialty care assisted living facility. (7) Registered Professional Nurse. Each facility shall have at least one RN. An RN may also serve as the administrator or as the care coordinator, but not as both. In all instances	A 405		

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A 405	Continued From page 29	A 405		

where the facility's RN is assigned other duties as an administrator or care coordinator the facility must assure that the RN devotes sufficient time and effort to all clinical duties.

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

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

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

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

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

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

6. The RN shall direct the practice of any licensed practical nurse.

(8) Care Coordinator. There shall be a care coordinator who will manage the daily routine delivery of resident care. This person shall be an LPN or RN. An LPN care coordinator shall work under the supervision of the RN in the management and delivery of resident care.

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A 405	Continued From page 30 This Rule is not met as evidenced by: Based on observation, record review, and interview the RN/Care Coordinator, failed to perform required duties to ensure each resident's care needs were met. This deficient practice resulted in actual harm for at least seven (7) residents, three of the seven resident had been discharged prior to the survey. The remaining nine (9) residents living in the facility were at risk for significant harm. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON DECEMBER 14, 2016 (previous deficiency #416, and #417). Findings: The following RN/Care Coordinator concerns were identified and confirmed with EI#1 and EI#2 during separate interviews. The RN did not accurately assess residents with resistive and combative behaviors. On February 09, 2022, EI#3, RN, showed the surveyor a completed Behavior Screen for RI#1 with no behavior incidents documented between September 2021 and January 2022. EI#3 told the surveyor none of the employees had reported any behaviors for RI#1 to EI#3 and EI#3 had not observed any behaviors by RI#1. EI#3 admitted the behavior screen had just been "created" by EI#3 to replace a missing behavior screen EI#3 had previously completed. EI#3 assured the surveyor the behavior screen for RI#1 was "accurate" as written. However, the surveyor had taken a picture of a previously completed behavior screen, dated April 2021 through January 2022, for RI#1 that documented several incidents of behaviors by RI#1. RI#1's record	A 405		

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A 405	Continued From page 31 documented multiple admissions to the geriatric behavioral health hospital for unmanageable behaviors which included resistance to care and combative behaviors towards other residents. EI#1, administrator, was also participating in the meeting with EI#3 and the surveyor and told the surveyor that he (EI#1) was aware that RI#1 had resistive behaviors during care with employees. The RN did not identify and address ongoing daily/weekly care resistance behaviors by RI#1, RI#2, RI#6, RI#7, and RI#8. The RN did not document the resistive behaviors accurately on the PSMS assessments and did not report these ineligible residents to EI#1 or EI#2. EI#3 told the surveyor she (EI#3) was not aware that residents who resisted care were not eligible for continued stay in a SCALF. EI#1 and EI#20, Regional Wellness Director, both told the surveyor in separate interviews that EI#3 had been trained multiple times by EI#20. EI#3 did not ensure resident care plan interventions were developed, followed, evaluated for effectiveness, or individualized as evidenced by record review and surveyor observations. The surveyor observed residents with unwashed, unkempt hair, and long dirty finger nails. RI#3 had significant anxiety symptoms as evidenced by observations of pacing, restlessness, and a physical altercation with RI#2. The lack of an adequate activity program also contributed to resident behaviors and boredom. Please refer to deficiencies #611 and #612 for additional details. The resistive care behaviors and changes in condition were not documented or communicated to the physician, third party care provider, and resident sponsors' as required.	A 405		

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A 405	Continued From page 32 The RN did not identify and address employee training needs. Please refer to deficiency #406 and #609 for surveyor identified training needs in the areas of abuse, dealing with difficult behaviors, resident rights, reporting resident behaviors/abuse, how to provide appropriate supervision to prevent incidents, and how to report identified changes in health status. The RN did not properly supervise the LPN employees to ensure medication keys were properly managed, medications were properly secured, and controlled medications were properly accounted for by two employees on each shift. On February 22, 2022, EI#12, care associate, was observed working the 7:00 PM to 7:00 AM shift alone and told the surveyor it was not the first time she (EI#12) had worked alone. EI#12 told the surveyor the facility staffing issues had been a lot worse since the onset of the Covid pandemic and she (EI#12) had worked alone more in the past year than during the 27 year long employment with the facility. The number of actual shifts EI#12 had worked alone was unknown but had happened several times a month since the Covid pandemic had started. On February 22, 2022, EI#1 told the surveyor EI#3 was responsible for staff scheduling. EI#1 said he was aware an employee had called off, but he (EI#1) had not followed up with EI#3 to ensure there was a minimum of two (2) employees working each shift as required by the SBOH rules for a SCALF. EI#3 also did not ensure staffing agency employees, utilized by the facility, were certified nurse aides (CNAs) as required by the rules.	A 405		

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A 405	Continued From page 33 On February 23, 2022, EI#1 told the surveyor that EI#3 had resigned from the position of RN/Care Coordinator. Review of the Wellness Director (RN/Care Coordinator) job descriptions revealed the following responsibilities and duties were required, direct supervision of community based licensed nursing staff, assign and direct the work of subordinates, provide training, supervision, and monitoring of associates in the administration of medications, provide training to resident care associates on an ongoing basis, supervises the maintenance of resident charts, assess health and psycho-social status of residents and initiate individualized care plans. In addition, the RN/Care Coordinator proactively manages care and services for each resident, evaluates effectiveness, and maximizes the resident's ability to remain in their environment, participates in preadmission screening of prospective residents, ensures required documentation is completed prior to or upon resident admission, performs onsite evaluations of residents admitted in alternate care environments for treatment, performs ongoing assessments/observations of residents' physical and psychosocial needs and coordinates quality proactive care. The RN coordinator also evaluates residents and documents changes in condition and notifies executive director, physician and resident's responsible party of those changes, communicates with physicians regarding resident status changes, ensures residents are prepared for physician appointments, updates charts, facilitates continuity of care with third party health care providers, ensures in-house ancillary services such as podiatrist, doctor and dental visits, lab, x-ray, and other services are scheduled and followed through, assists in	A 405		

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A 405	Continued From page 34 keeping the environment safe for associates, shares on-call and manager on duty responsibilities and other duties as assigned. The Wellness Director (RN/Care Coordinator) job description did not document the need for the RN to have knowledge of the SBOH rules and regulations to ensure compliance with the rules.	A 405		
A 406	420-5-20-.04 (9) Personnel. (9) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. An RN shall identify staff training needs and shall provide or arrange for needed training. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that, prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on specialty care assisted living facilities. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire. 5. Identifying and reporting abuse, neglect,	A 406		

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A 406	Continued From page 35 and exploitation. 6. Basic first aid. 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environmental safety. (b) Prior to providing any resident care, all staff shall complete The Dementia Education and Training Act (DETA) Care Series Training developed by the Alabama Department of Mental Health or equivalent training approved by the State Health Officer. All licensed staff shall complete DETA Brain Series Training, The Pharmacological Management of Dementia, and the Dementia Assessment Series provided by the DETA Program or equivalent training approved by the State Health Officer prior to resident contact. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained. (c) All staff who have resident contact shall be able to demonstrate diversional methods and redirection. All staff shall be able to demonstrate an understanding of the implications of caring for residents with agnosia, amnesia, aphasia, and apraxia. All staff shall be able to demonstrate an understanding of the facility's fire and evacuation plan and all other policies regarding safety, including policies for preventing elopements, responding to elopements, and fall prevention. (d) Cardiopulmonary Resuscitation. A	A 406		

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A 406	Continued From page 36 specialty care assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of a specialty care assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within 90 days of hire. A specialty care assisted living facility equipped with an automated external defibrillator (AED) shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or the American Red Cross in CPR or AED utilization. (e) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training. (f) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to identify and provide employees with adequate training to meet the needs of the residents with dementia symptoms.	A 406		

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A 406	Continued From page 37 THIS IS A REPEAT DEFICIENCY FROM SURVEYS COMPLETED ON DECEMBER 20, 2018 (previous deficiency #429), MARCH 01, 2017 (previous deficiency #421), AND AUGUST 09, 2016 (previous deficiency #424 and #427). Findings: The surveyor identified the following employee training needs during the survey. - How to provide adequate supervision of residents with dementia to prevent incidents. - How to manage difficult behaviors in residents with dementia. - Appropriate activities and diversion techniques versus isolation in a residents room or employee demands for residents to "go sit down" when residents are agitated or anxious. - The lack of reporting by care associates for all resident behaviors to the nurse(s) immediately, to ensure proper management and prevent further harm or behaviors. - How care associates can provide beneficial activities, in addition to snacks and drinks, to distract residents and prevent additional behaviors and boredom. - Proper grooming and dressing techniques for residents with dementia. - How to treat residents with dignity and respect in all aspects of care. - Proper supervision of all employees with accountability for their actions including nurses and department directors. - Ensuring accurate assessments of residents and appropriate individualized care plan interventions to meet resident care and safety needs. - How to implement and follow policies and	A 406		

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procedures.
- Techniques for preventing and the importance of immediately reporting any abuse.

During all four days of the survey, the surveyor made the following observations.
- Six (6) female residents with unkempt, matted, or greasy/stringy hair (RI#1, RI#2, RI#6, RI#7, RI#8, and RI#10).
- RI#6 ambulated down the hall without any clothes on the top half of RI#6's body. There were three employees walking down the hall with RI#6 trying to convince RI#6 to put on clothes. RI#4 even tried to convince RI#6 to put on a shirt. EI#18 finally got RI#6 to put on a jacket that was hanging on a chair close by.
-The surveyor was told by RI#2 "nobody likes me" and then observed RI#2 hit and get hit by RI#3 approximately 10 minutes later. This behavioral incident had not been reported to the nurse on duty (EI#4). The behavior incident was reported to EI#4 after the incident had been discussed by the surveyor with EI#1 and EI#3.
- The surveyor heard RI#4 tell RI#3, "If RI#2 "hit me (RI#2) would be laid out on the floor for a good long while." RI#4 also told RI#3 that RI#3 should "just backhand (RI#2)" then RI#4 called RI#1 "stupid". These threatening comments were not likely heard by the employees, who were observed "hanging out" in the kitchen area instead of in the common area where most of the residents were located when the residents weren't in their rooms.

PLEASE NOTE: The care employees were not required to prepare the residents' meal, they only had to set up drinks and place eating utensils. The meals were prepared and brought in from the "sister" facility and plated by the cook.

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A 406	Continued From page 39 On February 22, 2022, the surveyor observed - RI#2 refused grooming assistance after toileting, by the caregiver, nurse, and agency caregiver. - RI#10 had greasy stringy hair. On February 24, 2022, the surveyor and EI#1 reviewed the list of current employees and the employees who were currently CPR certified. EI#3 (hired August 30, 2021) and EI#4 (hired March 08, 2021) had been employed for greater than 90 days. EI#1 did not have documentation that EI#3 or EI#4 were currently CPR certified.	A 406		
A 504	420-5-20-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission, of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate. 1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility. 2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints.	A 504		

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A 504	Continued From page 40 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 reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals.	A 504		

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A 504	Continued From page 41 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 without restraint, interference, coercion, discrimination, or reprisal. 13. Every resident shall have the right to	A 504		

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

14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the facility, provided that:

(i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care.

(ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation.

(iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time without recourse.

15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges.

16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of

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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.

21. Every resident shall have the right to wear his or her own clothes, and to keep and use his or her own personal possessions, including toilet articles, except for personal possessions

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A 504	Continued From page 44 too large to be stored in the resident's room. 22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings. 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the rights of every resident were honored and protected including the right to a safe and decent environment free from abuse, neglect, and isolation. In addition, the facility failed to treat every resident with dignity and respect, failed to provide a safe, outdoor recreational area, failed to allow residents to keep and use personal items, failed to allow residents to entertain visitors at reasonable times and failed to post the most current statement of deficiencies in a conspicuous area for all to view. These deficient practices resulted in the actual harm of at least seven (7) residents (three residents had been discharged at the time of the survey), and placed the remaining nine (9) residents at risk for significant harm or death.	A 504		

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A 504	Continued From page 45 THIS IS A REPEAT DEFICIENCY FROM SURVEYS COMPLETED ON DECEMBER 20, 2018, AND AUGUST 09, 2016. Findings: UNSAFE ENVIRONMENT Review of the ADPH Online Incident Reports documented the following abuse and behavior incidents in the facility. On June 03, 2020, RI#1 pushed RI#12. There were no injuries documented. On September 13, 2020, RI#12 grabbed RI#1's fingers, then RI#1 pushed RI#12's arm against the wall causing a skin tear. There were no other injuries documented. On December 16, 2020, RI#11 yelled and cursed at RI#1 then hit RI#1 (details of hit type and location unknown). There were no injuries documented. On April 17, 2021, RI#1 went into RI#3's room and sat on RI#3's bed. RI#1 was "too agitated to redirect (out of RI#3's room) then (RI#1) clawed at RI#3's face". RI#3 then hit RI#1 with an open hand (location unknown). There were no injuries documented. On June 09, 2021, RI#3 was upset and crying after arguing with another resident (name unknown). RI#3 was sent to RI#3's room to "calm down". An unknown amount of time later, RI#3 left his/her room and walked up to RI#5 and slapped RI#5 in the face. RI#3 was sent back to RI#3's room. There were no injuries documented.	A 504		

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The facility used isolation to manage behaviors.

The online incident reports to ADPH for resident on resident abuse stopped after June 09, 2021, even though RI#1 and RI#3 continued to live in the facility.

On February 01, 2022, EI#22 witnessed EI#19 slap RI#1 in the face. The physical abuse to RI#1 resulted in bruising to the whole left side of RI#1's face.

On February 02, 2022, EI#22 reported to EI#1 that EI#19 had physically abused RI#1 on at least two different occasions (January 25, 2022, and on February 01, 2022). On January 25, 2022, EI#19 was witnessed pulling RI#1's head back by pulling RI#1's hair.

On February 02, 2022, EI#1 submitted an online incident report for an allegation of physical abuse to RI#1 by EI#19. ADPH requested and received an immediate plan of action (IPOA) from EI#1, in an effort to protect the residents in the facility from any further abuse.

On February 09, 2022, at approximately 10:50 AM, an ADPH surveyor entered the facility for an onsite visit to ensure the facility had completed the IPOA received by ADPH on February 02, 2022. RI#2 approached and told the surveyor, "Nobody likes me." The surveyor observed that RI#2 had a healing cut/laceration on RI#2's left upper arm approximately two and a half inches long and an abrasion/skin tear to the right wrist area the approximate size of a quarter. EI#3 told the surveyor there was no incident report or investigation for the healing cut observed on RI#2's left upper arm.

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A 504	Continued From page 47 On February 09, 2022, at approximately 10:50 AM, EI#18 was not observed in her office or providing activities in the facility when the surveyor arrived. On February 09, 2022, the surveyor observed the following resident behaviors. At approximately 11:00 AM, the surveyor observed an incident of resident on resident physical abuse between RI#2 and RI#3. EI#8 and EI#9 were observed hanging out in the kitchen area. R#2 and RI#3 were hitting each other while sitting on the couch in the common living room. RI#3 was eventually removed from the situation by EI#9, while RI#2 was left sitting on the couch crying. After RI#3 was removed from the physical altercation with RI#2, RI#3 was told to "go sit down " on a couch at the opposite end of the living room next to RI#4. EI#9 went back to the kitchen area with EI#8. RI#3 remained upset, pacing, glaring at RI#2, sighing heavily, and throwing his/her hands in the air as a sign of disgust/irritation. RI#3 was still upset and kept pacing back and forth to look out the common living room window as if RI#3 was expecting someone to show up. The surveyor heard RI#4 tell RI#3, "If (RI#2) hit me (RI#2) would be laid out on the floor for a good long while." RI#4 also told RI#3 that RI#3 should just "backhand (RI#2)" then RI#4 called RI#2 "stupid". The physical abuse incident and the above behaviors were not reported to EI#4 (LPN) by EI#8 or EI#9. The surveyor reported the behaviors and the physical abuse incident to EI#1 and EI#3, who then reported the incident to EI#4 for follow-up.	A 504		

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A 504	Continued From page 48 The surveyor observed that RI#2 refused a complete skin assessment by EI#3. RI#2 only allowed the nurses to look at RI#2's forearms and lower legs, which did not include a cut/laceration on RI#2's upper left arm, observed by the surveyor earlier that same day. RI#6 walked into the common living room area with the top half of his/her body exposed. RI#6 was refusing dressing assistance and encouragement to dress by multiple employees including the LPN, RN, a care associate, and the activity director. RI#4 even encouraged RI#6 to allow the employees to finish dressing RI#6. On February 09, 2022, RI#4 told the surveyor, "Those (residents RI#1, RI#2, RI#6, RI#7, RI#8, RI#9, RI#15, and RI#16) over there sit there all day long and some of them sleep there at night. I would get so bored, I have to go to my room and read or do something, I just can't sit all day long." On February 09, 2022, upon further investigation, the surveyor determined the facility did not complete the following actions documented in the IPOA submitted to ADPH on February 02, 2022. There were no skin assessments for all residents, no resident abuse interviews, no abuse training for all employees, and no training for staff on how to deal with difficult behaviors. The only action documented in the IPOA that was implemented by the facility, was the termination of EI#19's employment. The facility IPOA also documented a plan to initiate weekly skin assessments during resident showers to identify injuries of unknown origin or possible abuse. The skin assessments were to be completed by the care associates and then given to the nurses. The surveyor reminded EI#1 and EI#2 that RI#1's abuse was at the	A 504		

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hands of a care associate. The surveyor asked EI#1 and EI#2 if it was a safe practice for care associates to be the only persons assessing residents for injuries. EI#1 and EI#2 agreed the residents' risk for injuries of unknown origin or possible abuse had not been resolved by failing to completely implement the facility IPOA.

On February 22, 2022, at 4:10 AM, the surveyor observed that the facility did not provide the minimum number of required employees seven (7) days a week 24 hours a day. The surveyor observed only one (1) care associate working in the facility from 7:00 PM through 7:00 AM, which placed all 13 residents at risk for significant harm or even death in the event of an emergency or fire.

The facility did not implement its own emergency staffing policy regarding the use of administrative, nursing, and agency staff when care associates failed to show up for work. According to separate employee interviews, none of the care associates who were scheduled to work the day shift on February 22, 2022, had been contacted by EI#3 to come into work early. Neither of the two (2) nurses had been contacted by EI#3 to work the night shift or come in early.

The surveyor was told by various employees during separate interviews that the facility shared employees and administration daily with their "sister" facility (Madison Heights) located across the street. The shared employees included the administrator/business office director, the RN/care coordinator, the LPN, the activity/marketing director, the kitchen staff, and the part-time maintenance director. EI#4 was the only nurse (LPN) scheduled to be on call 12 hours every night, seven (7) nights a week. EI#4

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also worked at least three (3) 12 hour day shifts a week in addition to being on call every night. The only time there were two nurses working the day shift was on Wednesdays because that was the day the pharmacy delivered the weekly resident medication cycle.

On February 22, 2022, the surveyor was told by various employees during separate interviews, that there were no dedicated employees for housekeeping, therefore the housekeeping tasks were to be completed by the care associates. This practice promoted inadequate supervision of residents to prevent accidents and incidents of abuse.

On February 23, 2022, EI#18 told the surveyor she (EI#18) was basically allotted two (2) hours per day for activities in the facility when EI#18 wasn't involved with marketing activities. EI#18 did not work weekends so the care associates were tasked with providing activities on the weekends and also when EI#18 was busy with marketing tasks. EI#18 told the surveyor there were four (4) activities scheduled every day. Two (2) activities in the morning and two (2) activities in the evening. Residents were not provided with adequate activities to prevent behaviors, abuse, and boredom.

The surveyor was told by various employees and agency staff (EI#4, EI#8, EI#9, EI#15, and EI#16) throughout the survey there were at least six (6) different residents who resisted care daily and/or weekly (RI#1, RI#2, RI#6, RI#7, RI#8, and RI#15). The same employees and agency staff also told the surveyor the resistive behaviors had been reported to the nurse and supervisor. However, staffing had not been increased to provide care to multiple residents who resisted

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care and no sitters were added for increased supervision and safety. EI#1 told the surveyor he had not issued 30 day discharge notices to any of the six (6) residents who resisted care and had unmanageable behaviors.

The facility did not ensure staffing agency employees (EI#15, EI#16, EI#17), utilized during a staffing shortage, were Certified Nurse Aids (CNA) as required by the SBOH rules. The agency employees were not properly trained to provide care and supervision to residents with dementia. EI#1 and EI#2 told the surveyor they were not aware of the SBOH rule that only allows CNAs to work in emergency staffing situations under limited time frames and circumstances.

On February 23, 2022, at 3:00PM, during a telephone interview with Avesta Medical Staffing, the agency representative stated she sent caregivers to the facility instead of CNAs at the request of a female staff member (name unknown) of the facility. She said the CNAs did not want to work at the facility because of the low pay. The agency representative said she had plenty of caregivers willing to work. When asked about training, she said since caregivers are not required to be certified, there is no training or CPR training. The surveyor asked the representative if she was aware the caregivers were left alone in the facility at times. She said no, that when the facility called and asked for help she assumed they were staffed as required. She said her most recent facility contact person when staffing needs arise, is EI#1.

The facility did not have adequately trained and managed employees to prevent abuse or behavior incidents. The employees were observed by the surveyor to "hang out" in the

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kitchen area of the facility, which is where their phones and purses were stored. The nurse stayed in the nurses office, (which was on the other side of the facility from the common area where the residents stayed when the residents weren't in their rooms), or the nurse was in the facility located across the street in the "sister" facility. EI#1, EI#2 and EI#3 only had offices in the "sister" facility across the street and told the surveyor during separate interviews that they made "frequent" rounds in the facility. However, EI#3 told the surveyor she (EI#3) had not seen nor had employees reported RI#1's resistive care behaviors. EI#1 told the surveyor he (EI#1) was aware RI#1 had behaviors and resisted care. The surveyor had been told by EI#4, EI#8, EI#9, and EI#10 that RI#1 resisted care daily.

On February 09, 2022, EI#3 told the surveyor she (EI#3) did not know that residents who resisted care were ineligible for retention within the facility. EI#1 and EI#20, Regional Wellness Director, both told the surveyor in separate interviews that EI#3 had been trained by EI#20.

On February 22, 2022, EI#1 told the surveyor there had been no 30 day discharge notices issued to the sponsors of the residents who resisted care and had unmanageable behaviors even after the residents' were identified and discussed with EI#1 on February 09, 2022. Please refer to deficiency#303, #606 and #621 for additional information.

On February 23, 2022, at approximately 12:48 PM, the surveyor observed the medication refrigerator and the medication room, which is also the nurse's office, was left unsecured and unsupervised. The surveyor also observed the medication cart keys were left hanging on the

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door in the nurses office or left laying on top of the medication cart. This deficient practice allowed anyone access to the residents' medications including the controlled medications. The facility also did not have a system in place to account for controlled medications.

The surveyor observed there were at least four (4) wooden chairs with loose arms in the dining room, which created a fall hazard. The wooden chairs and tables also had missing finish and exposed wood which could not be properly sanitized. The vinyl covering on the furniture in the common living room was cracked and worn and could not be properly sanitized.

The surveyor reviewed resident records and determined the administrator and the RN had not accurately documented, reported, and properly managed resident behaviors. Resident assessments were not completed accurately and the results were not discussed with administration. Facility policies and procedures were not followed for abuse, admission criteria, retention criteria, assessments, and care plans.

The administrator and the RN did not ensure investigations were completed with appropriate individualized interventions developed, documented on the care plan, implemented, and evaluated for effectiveness for all resident incidents.

SAFE OUTDOOR RECREATION

The facility's fenced in courtyard was not safe for resident use due to damaged fencing, broken and cracked chairs, and an unsecured gate to the public way. In addition, residents would have had access to trash storage, the generator, and gas

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supply lines which were located in the courtyard. The facility placed six (6) lawn chairs in the front yard within approximately 12 feet of the street. The front yard was not fenced in. The street was utilized for neighborhood traffic and was also used as a through street by people who did not live in the neighborhood. The surveyor observed that only one (1) resident, supervised by an employee or sponsor, was outside at a time. RI#3 and R#3's sponsor were observed on February 24, 2022, attempting to enter the fenced courtyard without success and ended up going back to the chairs in the front yard of the facility.

DIGNITY AND RESPECT

On June 09, 2021, RI#3 had an argument with an unknown resident and was left crying. Employees told RI#3 to "go to (RI#3's) room to calm down." An unknown time later, that same day, RI#3 left RI#3's room, walked down the hall and slapped RI#5 in the face. RI#3 was again sent to RI#3's room like an unruly child. Note: This is also an example of using isolation/physical restraint for behavior management, which is not allowed by the SBOH rules in a SCALF.

On September 27, 2021, at approximately 9:00 PM, RI#1 was found in bed with his/her left eye swollen shut. The incident report and investigation were incomplete and did not include employee statements or an investigative summary to explain the injury of unknown origin. The RN documented on the comprehensive assessment dated September 27, 2021 - "Possible fall" however, the injury was also suspicious for another incident of abuse by EI#19 who was working at the time of the injury.

On February 09, 2022, the surveyor observed an

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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 504	Continued From page 55	A 504		

incident of physical abuse between RI#2 and RI#3 that left RI#2 crying on the couch. The incident had not been reported by EI#8 or EI#9 to EI#4. EI#4 was notified after the surveyor reported the incident to EI#1 and EI#3.

On February 09, 2022, the surveyor observed five (5) female residents with unkempt, matted, or greasy/stringy hair (RI#1, RI#2, RI#6, RI#7, and RI#8).

The surveyor was told by various employees and agency staff during separate interviews that five residents resisted care daily and or weekly. The same employees and agency staff told the surveyor they had reported the residents' resistive behaviors to the nurse/supervisor. There was no response by the nurse/supervisor, to increase employees on each shift, sitters were not added to help monitor residents' for safety or to assist with difficult behaviors, and no 30 day discharge notices had been issued to the sponsors of the residents who resisted care (RI#1, RI#2, RI#6, RI#7, and RI#8).

THE ABILITY TO KEEP AND USE PERSONAL ITEMS

On March 02, 2022, during a phone interview with RI#16's sponsor the surveyor was told when RI#16's sponsor began to move RI#16 out of the facility after a very short stay, RI#16's sponsor could not find RI#16's clothes, toiletries, walker/rollator, or the cloth bed pads used for incontinence. When RI#16's sponsor asked a care associate (name unknown) where RI#16's personal items were, RI#16's sponsor was told RI#16's personal items had been removed from RI#16's room and used by staff for all the residents living in the facility at the time. RI#16's

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A 504	Continued From page 56 wheelchair was found in the sister facility. RI#16's sponsor also told the surveyor that while packing up RI#16's remaining 10 clothing items, five (5) of the shirts in RI#16's closet had other residents' names on them. RI#16's rollator was missing, both of RI#16's hearing aides were missing, all of RI#16's toiletries were missing, and most of RI#16's 30 items of clothing had disappeared. RI#16's sponsor told the surveyor RI#16 had only lived in the facility for approximately two weeks before RI#16's sponsor took RI#16 back home. VISITORS AT REASONABLE TIMES On March 02, 2022, during a phone interview with RI#16's sponsor the surveyor was told there had been a sign on the facility door for a long time telling visitors to call ahead at least two (2) hours before visiting residents. RI#16's sponsor was not turned away if the sponsor showed up without an appointment, but was consistently reminded to call for an appointment before the next visit.	A 504		
A 508	420-5-20-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in a specialty care assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review. 1. Incidents which require investigation	A 508		

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A 508	Continued From page 57 are: (i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as extensive bruising, pain, or injury that is not consistent with actions necessary in providing day-to-day care to a resident or for which medical treatment was sought. (ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid including but not limited to a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office. (iii) The onset of wandering behavior by any resident who is not fully cognitively intact. (iv) Elopement by a resident. (v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. (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	A 508		

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or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or Staphylococcus aureus).

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

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

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

(xii) A medication error, overdose, or over sedation.

(xiii) Ingestion by a resident of a toxic substance that requires medical attention.

(xiv) Any indication of malfunction of the sprinkler system, or fire alarm system.

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

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A 508	Continued From page 59 (date and time). (iv) Circumstances under which the incident occurred. (v) When the incident occurred (date and time). (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken. (viii) The extent and description of injury, if any, to the affected resident or residents. (ix) Immediate treatment rendered. (x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified. (xi) Names, telephone numbers, and addresses of witnesses. (xii) Date and time relatives or sponsor were notified. (xiii) Out-of-facility treatment. (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	A 508		

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A 508	Continued From page 60 incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation. (xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request. (xix) The entire investigative file and documentation of all corrective action taken shall be retained for a period of not less than 3 years after the resident is discharged or dies. (xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff. 3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident: (i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention. (ii) Elopement by a resident. (iii) Suspected, alleged, confessed, witnessed, or actual abuse, neglect, or exploitation of a resident or residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human	A 508		

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A 508	Continued From page 61 Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file. (iv) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (vi) An unplanned occurrence that results in media attention. (vii) Any medication error, overdose, or over sedation. The incident shall be immediately reported to the attending physician, facility medical director, or back-up physician. (viii) Ingestion by a resident of a toxic substance that requires medical attention. (ix) Notifiable diseases and health conditions listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04. shall also be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1-.04. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than three years. (x) Any indication of a malfunction of the sprinkler system, fire alarm system, or a door locking device.	A 508		

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A 508	Continued From page 62 4. The report to the Department's Online Incident Reporting System shall include the following: (i) Facility name and direct phone number. (ii) Time and date of the report. (iii) Reporter's name. (iv) Name of resident(s), staff, or visitor(s) involved in the incident. (v) Names of staff on duty at the time of the incident. (vi) Date and time of the incident. (vii) A brief description of the incident. (viii) Any injury or injuries to resident(s). (ix) Action taken by the facility in response to the incident. (i) Vital Statistics Reports. A record shall be kept of all births, deaths, and stillbirths that occur within the specialty care assisted living facility. By the fifth day of each month, the administrator shall make a report of such births, deaths, and stillbirths for the preceding month on such forms as the State Board of Health shall provide to the county health officer, or in counties without a county health officer, to the State Registrar. This report shall be in addition to the official birth, death, and stillbirth certificates. If	A 508		

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A 508	Continued From page 63 there are no births, deaths, or stillbirths in any month, a report shall be made stating that fact to the county health officer. This Rule is not met as evidenced by: Based on observation and record review, the facility failed to complete a thorough investigation for an injury of unknown origin. Employees failed to immediately report multiple incidents of resident abuse to their supervisor or administration. The facility failed to report a resident on resident abuse incident to the ADPH online incident reporting website. This deficient practice resulted in harm for at least three (3) residents and placed the remaining 10 residents at risk for significant harm. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON FEBRUARY 03, 2020. Findings: According to an incident report dated September 27, 2021, at 9:00 PM, RI#1 was found in bed with his/her left eye swollen shut. The incident report and investigation were incomplete and did not include employee statements or an investigative summary to explain the injury of unknown origin. The RN documented on RI#1's comprehensive assessment dated September 27, 2021 - "Possible fall". However, RI#1's injuries were also suspicious for physical abuse. On February 02, 2022, EI#1, administrator, submitted an online report that RI#1 had been	A 508		

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physically abused by EI#19. During the facility investigation EI#1 actually identified RI#1 suffered from at least two (2) separate incidents of physical abuse by EI#19. ADPH requested and received an immediate plan of action (IPOA) from EI#1 to identify and protect the residents in the facility from further abuse.

On February 09, 2022, an ADPH surveyor was sent to the facility to verify that the IPOA, submitted by the facility, on February 02, 2022, for the abuse incident involving RI#1 and EI#19, had been carried out. Upon arrival the surveyor was informed by EI#1 and EI#3, RN, that the facility had failed to fully implement the IPOA developed to protect residents from abuse. EI#1 and EI#3 stated the resident skin assessments had not been completed or documented as required, the resident abuse interviews had not been completed, the abuse training had not been completed for all 27 employees, and the training for dealing with difficult behaviors could not be verified as having been completed by all employees. In addition, the weekly skin assessments by care staff for monitoring for injuries of unknown origin had not been initiated because the baseline skin assessments had not been completed. The surveyor reminded EI#1 and EI#3 the abuse suffered by RI#1 was at the hands of a caregiver EI#19. EI#1 and EI#3 agreed the potential for physical abuse and ongoing injuries of unknown origin had not been resolved.

On February 09, 2022, the surveyor was told by RI#2 "nobody likes me" and then approximately 10 minutes later the surveyor observed RI#2 and RI#3 hitting each other. The surveyor heard RI#4 tell RI#3, "If (RI#2) hit me (RI#2) would be laid out on the floor for a good long while." RI#4 also told

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A 508	Continued From page 65 RI#3 that RI#3 should just "backhand (RI#2)" then RI#4 called RI#2 "stupid". These threatening comments by RI#4 were not reported by EI#8 or EI#9 to EI#4, LPN. The physical altercation/abuse between RI#2 and RI#3 was also not reported to EI#4. The surveyor was told by EI#4, EI#8, and EI#9, that RI#3 would usually walk away from a confrontation with other residents. EI#8 and EI#9 agreed that RI#3 didn't walk away during the altercation on February 09, 2022. This resident on resident abuse was not reported to the ADPH online incident reporting website, even after the surveyor reported the incident to EI#1 and EI#3 on February 09, 2022.	A 508		
A 602	420-5-20-.06 (2) (a) (b) (c) Care of Residents. (2) Medical Examination Record. (a) Initial Physical Examination. Not more than 30 days prior to admission of any resident to a specialty care assisted living facility, the resident or prospective resident shall be examined by a physician. For purposes of the initial physical examination, a physician currently licensed and in good standing with the Medical Licensure Commission of any state may complete this physical assessment. The physician shall report his or her findings in writing to the facility. This examination is not required for a resident of a facility dually licensed as an assisted living facility and as a specialty care assisted living facility in those cases when the resident is transferred from the assisted living unit to the specialty care assisted living unit in the same facility. In addition to any information otherwise required by the facility's policies and	A 602		

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A 602	Continued From page 66 procedures and in addition to any other information the physician recommends or believes is pertinent, the initial physical examination record shall contain the following: 1. All of the physician's diagnoses and the resident's baseline weight and vital signs. 2. Medication presently prescribed (name, dosage, and strength of drug, frequency, and route of administration). 3. A statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident-to-resident contact. 4. Documentation of evaluation for tuberculosis within the previous 12 months. (b) Annual Physical Examination. In addition to the admission physical examination, each resident shall be examined annually by a physician, and findings from the annual physical examination shall be documented with a copy placed in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent or recommended by the resident's attending physician, the annual physical examination shall contain the following: 1. The resident's weight and vital signs. 2. Changes in diagnoses. 3. Changes in condition.	A 602		

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A 602	Continued From page 67 4. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration). 5. Changes in treatment. (c) Change of Condition Physical Examinations. Changes in the resident's condition that require a physician examination and result in a change in diagnoses, condition, medications, or treatments shall be reported to the facility and documented in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent, or recommended by the resident's treating physician, this physical examination shall contain a listing of the following: 1. Changes in diagnoses. 2. Changes in condition. 3. Changes in medications prescribed (name, dosage and strength of drug, frequency, and route of administration). 4. Changes in treatment. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure initial physician medical exams were completed with all required components. This deficient practice had the potential to affect all 13 residents living in the facility.	A 602		

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A 602	Continued From page 68 Findings: RI#3 was admitted to the facility on approximately February 08, 2021, according to the date on RI#3's care plan. RI#3's initial physician medical examination was incomplete. RI#3's medical examination dated February 08, 2021, did not have baseline vital signs documented and did not have a documented statement that the resident was free of symptoms of communicable diseases. On February 09, 2022, RI#3's record review was verified with EI#3, who agreed the above information was missing.	A 602		
A 604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility RN or care coordinator shall screen prospective residents for eligibility for admission into the specialty care assisted living facility. The screening shall include a clinical history, a mental status examination to include aphasia screening, a geriatric depression screen, a physical self-maintenance screen, and a behavior screen. Appendix A herein, contains the Physical Self Maintenance Scale (PSMS) form and the Behavior Screening form. These forms shall be completed to screen physical functioning and behaviors. The PSMS and Behavior Screen assessments shall be completed by the RN or	A 604		

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care coordinator upon admission, annually, and when there is a change in the resident's status.

The facility RN shall perform a comprehensive assessment of each prospective resident for facility eligibility. This assessment shall document identified care needs and serve as a baseline for the RN plan of care and future assessments.

(b) Monthly Assessments. The RN shall assess each resident monthly and more often when necessary to identify changes in the resident's health status. The monthly assessment shall include a review of monthly weights, falls, incidents, elopements, behavioral symptoms, medications, changes in resident status, and appropriateness of the resident's plan of care.

(c) Comprehensive Assessment. The facility RN shall perform a comprehensive assessment and communicate with the resident's attending physician and with the resident's sponsor or responsible family member when a decline in health status or behavior occurs, or if the resident develops any of the following problems:

1. Weight loss:

(i) Each month, the facility shall accurately weigh and record the weight of each resident.

(ii) A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half percent or greater weight loss in a period of 3 months or less, or a 10 percent or greater weight loss in a

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A 604	Continued From page 70 period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician. 2. Falls (two or more falls within a 30 day period). 3. Elopement. 4. Any sign and symptom of adverse drug reaction, interaction or over sedation, or circumstances which contraindicate medications that have been prescribed for the resident. 5. Unmanageable, combative, or potentially harmful behavior(s). 6. Any accident with injury. (d) Focused Assessments. The RN or LPN shall conduct focused assessments when necessary to identify changes in resident status. (e) Any change in resident status requires immediate documentation and implementation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on observation, interview, and record review, the RN failed to accurately assess, document, and manage resident behaviors. The RN failed to complete monthly assessments	A 604		

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A 604	Continued From page 71 consistently for all residents, which included monthly weights. The RN failed to identify changes in resident health status and develop care plan interventions to address those changes. The RN also failed to evaluate resident care plans for effectiveness and make changes to the care plan as necessary. This deficient practice had the potential to affect all 13 residents in the facility. THIS IS A REPEAT DEFICIENCY FROM SURVEYS COMPLETED ON FEBRUARY 03, 2020 AND JANUARY 21, 2016, (PREVIOUS DEFICIENCY #602). Findings: RI#1 RI#1 was readmitted to the facility on April 30, 2021, from a geriatric behavioral hospital with diagnoses which included dementia and type II diabetes. RI#1 refused monthly weights for May and August, of 2021. RI#1's weight for June 2021 was left blank. RI#1 suffered a significant weight loss of 21.6 pounds or approximately 14% of RI#1's total body weight (from 154.8 to 133.2 pounds) between April 30, 2021 and July 2021 (3 months). RI#1 suffered an additional significant weight loss of 10 pounds or 7.3% of RI#1's total body weight (from 136 to 126 pounds) in one (1) month between November and December 2021. There were no care plan interventions documented to address the significant weight losses suffered by RI#1. There was no January 2022 monthly assessment or weight documented for RI#1. RI#1's care plan	A 604		

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had not been updated since September 27, 2021. RI#1's ADL care plan dated October 22, 2021, inaccurately documented that RI#1 had "no weight loss" and "cooperates with care". RI#1's inaccurate monthly assessments consistently documented RI#1 "cooperate with staff most times, good appetite, (continue current plan of care)."

On February 09, 2022, the surveyor observed RI#1's hair had not been brushed and was smashed against the back of RI#1's head.

The surveyor was onsite for a total of four days (February 09, 22, 23, 24, 2022) . The surveyor was told by various employees (EI#4, EI#8, EI#9, and EI#10) during separate interviews that RI#1 was combative and resisted care daily. The same employees described the combative behaviors as hitting, kicking, and slapping and stated the behaviors had been reported to the nurse/supervisor.

The RN did not document the combative/resistive behaviors during care on any of RI#1's PSMS assessments. This lack of documentation and subsequent lack of communication resulted in harm and the retention of a resident who was not eligible for continued stay in the facility.

RI#2
RI#2 was admitted to the facility on approximately October 22, 2021, according to the care plan date. The most current behavior screen for RI#2 was dated October 22, 2021 (admission date). RI#2's ADL care plan was left blank.

RI#2's monthly assessment for November 2021, documented RI#2's weight was 100 pounds which was a significant loss of 25 pounds or a

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20% loss of RI#2's total body weight since September 2021, just one (1) month earlier. RI#2's monthly assessment documented, "cooperates with staff most times... good appetite... (continue current plan of care)...". The RN did not identify or address the significant weight loss suffered by RI#2.

On December 22, 2021, RI#2 was admitted to a behavioral health hospital after "aggressive behavior towards (RI#2's) roommate." The hospital notes documented (EI#3) reported "(RI#2's) agitation has become increasingly worse, picking fights with and between other residents...stealing other resident's food... has history of non-compliance with medications...". RI#2's behaviors were not documented in RI#2's facility record, monthly assessments, PSMS assessment, or on RI#2's behavior log. RI#2's behaviors were not documented on RI#2's care plan with specific individualized interventions for care staff to follow when providing care to RI#2.

On December 28, 2021, RI#2 was readmitted to the facility from the behavioral health hospital. There was no comprehensive, PSMS, or behavior screen assessment completed at that time.

On February 09, 2022, the surveyor was told by RI#2 "nobody likes me" and then approximately 10 minutes later the surveyor observed RI#2 and RI#3 sitting on the couch hitting each other (it is unknown which resident started the incident). EI#9 came from the kitchen and removed RI#3 from the situation. RI#2 was left sitting on the couch crying, while EI#9 tried to get RI#3 to calm down.

On February 09, 2022, the surveyor observed resistive care behaviors by RI#2 when EI#3 and

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the surveyor attempted to complete a skin assessment. RI#2 would only allow the nurses to look at RI#2's lower legs and forearms.

On February 22, 2022, at approximately 11:20 AM, EI#15 told the surveyor RI#2 refused to have incontinence care after being incontinent of bowel in the bed. EI#15 went on to tell the surveyor she (EI#15) and other employees had been trying to provide RI#1's incontinence care for about an hour, with no success because RI#2 kept kicking the employees who tried to provide the care.

RI#2's PSMS assessment (date blank) did not document RI#2 resisted care. RI#2's monthly assessments consistently documented, "cooperates with staff most times, good appetite, (continue current plan of care)". The monthly assessments did not address RI#2's resistive care behaviors or RI#2's significant weight loss.

This lack of care and subsequent lack of communication resulted in actual harm and the retention of a resident who was not eligible for continued stay in the facility.

RI#3
RI#3 was admitted to the facility on approximately February 08, 2021, with diagnoses which included dementia, aggressive behaviors, and anxiety. RI#3 was independent with all ADL's and ambulation. RI#3's care plan documented symptoms of anxiety, but did not have any interventions or guidance for caregivers to assist RI#3 in managing his/her symptoms of anxiety. RI#3's monthly assessments consistently documented, "cooperates with staff, good appetite, (continue current plan of care)." RI#3's monthly assessments did not document RI#3's continued anxious behavior.

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A 604	Continued From page 75 On April 17, 2021, RI#1 went into RI#3's room and sat on RI#3's bed. RI#1 was "too agitated to be redirected" and clawed at RI#3's face. RI#3 then hit RI#1 with an open hand. No injuries were documented. On June 09, 2021, RI#3 was arguing with an unknown resident and RI#3 was sent to RI#3's room to "cool down". An unknown amount of time later that same day, RI#3 left RI#3's room walked down the hall and slapped RI#5. RI#3 was sent back to RI#3's room. No injuries were documented. This incident caused harm to RI#5 and was an example of the facility's use of isolation for RI#3's behavior management, which was not successful. On February 09, 2022. at approximately 11:00 AM, the surveyor observed RI#2 and RI#3 were on the couch hitting each other. Both caregivers (EI#8 and EI#9) had been sitting in the kitchen area, EI#9 went to the couch and began loudly calling RI#3's name and trying to separate RI#2 and RI#3. After the residents were separated, RI#2 was left on the couch crying while EI#9 tried to calm RI#3 down. RI#3 was still very agitated, as evidenced by RI#3 breathing hard, sighing frequently, talking in a raised voice, and glaring at RI#2. RI#3 was told to go sit on another couch at the opposite end of the room from RI#2. EI#9 went back into the kitchen area with EI#8. The surveyor observed that RI#3 continued to be in an agitated state for approximately one hour after the altercation with RI#2, as evidence by RI#3 repeatedly looking out of the front window, pacing back and forth between the couch and the window, throwing RI#3's hands in the air, shaking RI#3's head and sighing frequently while glaring	A 604		

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at RI#2. While RI#3 was still in this agitated state, RI#4 came out of RI#4's room and sat on the couch with RI#3. RI#3 told RI#4 that RI#2 had hit RI#3. RI#4 got upset and started saying "You just need to back hand (RI#2), if (RI#2) hit me, I'd lay them out and they wouldn't get up for a good long while."

The above incident between RI#2 and RI#3 was not reported to EI#3 or EI#4, and the two residents were not given anything else to do as a distraction until lunch was served over an hour later.

The surveyor reported the physical abuse incident between RI#2 and RI#3 to EI#1 and EI#3 before lunch that same day.

RI#3's care plan did not address RI#3's hitting behavior incidents. RI#3's care plan did not have any specific interventions to prevent RI#3's anxiety or ways to minimize RI#3's anxiety.

On February 22, and 24, 2022, EI#2 assessed RI#3 behaviors and documented that RI#3 was verbally abusive and physically combative when "in moments of high stress".

RI#4
RI#4 was admitted to the facility on approximately April 04, 2021, according to the comprehensive assessment. RI#4's diagnoses included neurocognitive disorder, psychotic disorder due to organic brain disease and paranoid delusions.

On February 09, 2022, the surveyor was told by RI#2 "nobody likes me" and then observed RI#2 hit and get hit by RI#3 approximately 10 minutes later. The surveyor heard RI#4 tell RI#3 that if RI#2 "hit me (RI#2) would be laid out on the floor

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for a good long while." RI#4 also told RI#3 that RI#3 should just "backhand (RI#2)" then RI#4 called RI#2 "stupid".

On February 09, 2022, RI#4 told the surveyor how RI#4's sponsor and spouse had placed RI#4 in the facility and took RI#4's car. RI#4 told the surveyor that RI#2 was "mean" and you didn't have to do anything to provoke RI#2 to be mean.

The surveyor was told by EI#4 that RI#4 had anger issues with their sponsor and made threats about other residents "but (RI#4) was harmless" and wouldn't follow through with the threats.

EI#8 told the surveyor, "You don't want to get on (RI#4's) bad side...(RI#4) will curse you and threaten (harm)."

RI#4's monthly assessments and behavior logs did not address RI#4's threatening or verbally abusive behaviors. RI#4's monthly assessments documented, "cooperates with staff... good appetite... (continue current plan of care)."

While RI#4 may not have physically harmed any resident, RI#4's verbal abuse and threatening behaviors would certainly cause mental anguish for the targeted residents. RI#4's encouragement for physical abuse would also be a cause for concern and additional supervision would be required to prevent the actual harm of other residents.

On February 22, 2022 at 1:00PM, the surveyor was in the sister facility (Madison Heights) preparing questions for an interview with EI#3, RN. However, EI#3 left the facility before the interveiw could be conducted.

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A 604	Continued From page 78 On February 23, 2022, at 3:00PM, EI#1 told the surveyor EI#3, RN, resigned on February 22, 2022. EI#3 was not available for an interview with the surveyor. On February 23, 2022, EI#2 told the surveyor she (EI#2) had told the governing authority she was having trouble ensuring EI#3 fulfilled her responsibilities and duties as the RN/Care coordinator. EI#2 had been the RN prior to EI#3 and told the surveyor she "knew how important the RN duties were."	A 604		
A 605	420-5-20-.06 (3) (f) Care of Residents. (f) Observation. Each specialty care assisted living facility shall provide general observation and health supervision of the residents to identify changes in all residents' health conditions and physical abilities, and awareness of the need for medical attention or nursing services as the changes develop. Whenever a resident requires medical attention, nursing services, or changes in personal care and assistance with activities of daily living provided by the facility, the facility shall arrange for or assist the residents in obtaining necessary services. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that residents who required a	A 605		

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higher level of care received the assistance to obtain the necessary services. This deficient practice resulted in actual harm for at least four (4) residents (two residents had been discharged at the time of the survey). The remaining 11 residents were at significant risk for harm.

Findings:

RI#1
RI#1 was admitted to the facility on approximately April 15, 2018 (based on RI#1's earliest care plan).

RI#1's care plan dated August 26, 2019, documented RI#1 had "impaired mastication" which placed RI#1 at significant risk for choking and required additional supervision during meals and snacks to ensure RI#1's safety. RI#1 had choking episodes documented in the hospice notes on December 29, 2021 (eating an orange), and on March 2022 (unknown food item). EI#8 told the surveyor she (EI#8) had to perform the Heimlich maneuver in February 2022, when RI#1 choked on pancakes.

RI#1 suffered eight (8) falls between February 21, 2020 and October, 2021. RI#1's fall on October 22, 2021, resulted in a fractured left femur. RI#1's care plan repeated the same interventions of ensuring non-slip shoes, reminding resident to use walker, and performing hourly rounds and toileting. RI#1 continued to fall.

RI#1 had episodes of hitting at least three (3) other residents (RI#3, RI#11, and RI#12) documented in RI#1's care plan for December 2019, October 20, 2020, March 2021, and April 2021. These incidents of resident on resident abuse may not have resulted in physical injuries

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but resulted in mental anguish for the residents involved.

RI#1's monthly assessments and behavior log documented resistance to care began in approximately March 2021, even though the behaviors were not documented on any of RI#1's PSMS assessments.

On October 28, 2021, RI#1 started receiving hospice services with a primary diagnosis of Alzheimer's dementia with behavioral disturbance. RI#1's hospice record documented ongoing combative behaviors with care in October and November of 2021, and January of 2022. Please refer to deficiency #621 for more details.

There was no documentation in RI#1's record that a 30 day discharge notice had been issued to RI#1's sponsor. On February 22, 2022, EI#1 told the surveyor the facility had not issued a 30 day discharge notice to RI#1'sponsor.

RI#2
RI#2 was admitted to the facility on approximately October 22, 2021, according to the care plan date. The most current behavior screen for RI#2 was dated October 22, 2021 (admission date). RI#2's ADL care plan was left blank.

RI#2's monthly assessment for November 2021, documented RI#2's weight was 100 pounds which was a significant loss of 25 pounds or a 20% loss of RI#2's total body weight in just one (1) month. RI#2's monthly assessment documented, "cooperates with staff most times... good appetite... (continue current plan of care)...". The RN did not identify or address the significant weight loss suffered by RI#2.

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A 605	Continued From page 81 On December 22, 2021, RI#2 was admitted to a behavioral health hospital after "aggressive behavior towards (RI#2's) roommate." The hospital notes documented (EI#3) reported "(RI#2's) agitation has become increasingly worse, picking fights with and between other residents...stealing other resident's food... has history of non-compliance with medications...". RI#2's behaviors were not documented in RI#2's facility record, monthly assessments, PSMS assessment, or on RI#2's behavior log. RI#2's behaviors were not documented on RI#2's care plan with specific individualized interventions for care staff to follow when providing care to RI#2. On December 28, 2021, RI#2 was readmitted to the facility from the behavioral health hospital. The RN did not complete the required assessments including a comprehensive, PSMS, or behavior screen. On February 09, 2022, the surveyor was told by RI#2, "Nobody likes me." Approximately 10 minutes later, the surveyor observed RI#2 and RI#3 sitting on the couch hitting each other (it is unknown which resident started the incident). EI#9 came from the kitchen and removed RI#3 from the situation. RI#2 was left sitting on the couch crying, while EI#9 tried to get RI#3 to calm down. On February 09, 2022, the surveyor observed resistive care behaviors by RI#2 when EI#3 and the surveyor attempted to complete a skin assessment. RI#2 would only allow the nurses to look at RI#2's lower legs and forearms. On February 22, 2022, at approximately 11:20 AM, EI#15 told the surveyor RI#2 refused to have	A 605		

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incontinence care after being incontinent of bowel in the bed. EI#15 went on to tell the surveyor she (EI#15) and other employees had been trying to provide RI#2's incontinence care for about an hour but with no success because RI#2 kept kicking the employees who tried to provide care.

RI#2's PSMS assessment (date blank) did not document RI#2 resisted care. RI#2's monthly assessments consistently documented, "cooperates with staff most times, good appetite, (continue current plan of care)". The monthly assessments did not address RI#2's resistive care behaviors or RI#2's significant weight loss.

This lack of care and subsequent lack of communication resulted in actual harm and the retention of RI#2 who was not eligible for continued stay in the facility.

RI#3
RI#3 was admitted to the facility on approximately February 08, 2021, with diagnoses which included dementia, aggressive behaviors, and anxiety. RI#3 was independent with all ADL's and ambulation. RI#3's care plan documented symptoms of anxiety, but did not list any interventions or guidance for caregivers to help RI#3 manage his/her anxiety. RI#3's monthly assessments consistently documented, "cooperates with staff, good appetite, (continue current plan of care)." RI#3's monthly assessments did not document RI#3's continued anxious behavior.

On February 09, 2022. at approximately 11:00 AM, the surveyor observed RI#2 and RI#3 on the couch hitting each other. Both caregivers (EI#8 and EI#9) had been sitting in the kitchen area. EI#9 went to the couch and began loudly calling

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RI#3's name and trying to separate RI#2 and RI#3. After the residents were separated, RI#2 was left on the couch crying while EI#9 tried to calm RI#3 down. RI#3 was still very agitated, as evidenced by RI#3 breathing hard, sighing frequently, talking in a raised voice, and glaring at RI#2. RI#3 was told to go sit on another couch at the opposite end of the room from RI#2. EI#9 went back into the kitchen area with EI#8.

The surveyor observed that RI#3 continued to be in an agitated state for approximately one hour after the altercation with RI#2, as evidenced by RI#3 repeatedly looking out of the front window, pacing back and forth between the couch and the window, throwing RI#3's hands in the air, shaking RI#3's head and sighing frequently while glaring at RI#2. While RI#3 was still in this agitated state, RI#4 came out of RI#4's room and sat on the couch with RI#3. When RI#3 told RI#4 that RI#2 had hit him/her (RI#3), RI#4 got upset and started saying "You just need to back hand (RI#2), if (RI#2) hit me, I'd lay them out and they wouldn't get up for a good long while."

The above incident between RI#2 and RI#3 was not reported to EI#3 or EI#4, and the two residents were not given anything else to do, for a distraction until lunch was served over an hour later.

The surveyor reported the physical abuse incident between RI#2 and RI#3 to EI#1 and EI#3 before lunch that same day.

RI#4
RI#4 was admitted to the facility on approximately April 04, 2021, according to the comprehensive assessment, with diagnoses which included neurocognitive disorder, psychotic disorder due to

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organic brain disease and paranoid delusions.

On February 09, 2022, the surveyor was told by RI#2, "Nobody likes me." The surveyor then observed RI#2 hit and get hit by RI#3 approximately 10 minutes later. The surveyor heard RI#4 tell RI#3 that "if RI#2 hit me (RI#2) would be laid out on the floor for a good long while." RI#4 also told RI#3 that RI#3 should just backhand RI#2. RI#4 called RI#2 stupid.

On February 09, 2022, RI#4 told the surveyor that RI#4's sponsor and spouse placed him/her in the facility and took RI#4's car. RI#4 told the surveyor RI#2 was mean and you didn't have to do anything to provoke RI#2 to be mean.

The surveyor was told by EI#4 that RI#4 had anger issues with his/her sponsor and made threats about other residents but RI#4 was harmless and wouldn't follow through with the threats.

EI#8 told the surveyor you didn't want to get on RI#4's bad side. RI#4 would curse you and threaten you.

RI#4's monthly assessments and behavior logs did not address RI#4's threatening or verbally abusive behaviors. RI#4's monthly assessments documented, "cooperates with staff... good appetite... (continue current plan of care)."

While RI#4 may not have physically harmed any resident, RI#4's verbal abuse and threatening behaviors would certainly cause mental anguish for the targeted residents. RI#4's encouragement for physical abuse would also be a cause for concern and additional supervision would be required to prevent the actual harm of other

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A 605	Continued From page 85 residents. On February 23, 2022, EI#2 told the surveyor she (EI#2) told the governing authority she was having trouble ensuring EI#3, RN, fulfilled her responsibilities and duties as the RN/Care coordinator. EI#2 was the RN prior to EI#3 and told the surveyor she (EI#2) "knew how important the RN duties were."	A 605		
A 606	420-5-20-.06 (3) (g) Care of Residents. (g) Services Beyond Capability of Specialty Care Assisted Living Facility. Whenever a resident requires hospitalization, medical, nursing, or other care beyond the capabilities of the specialty care assisted living facility, arrangements shall be made to discharge the resident to an appropriate setting, or to transfer the resident promptly to a hospital or other health care facility able to provide the appropriate level of care. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to transfer or discharge residents who required a higher level of care to an appropriate setting. This deficient practice resulted in actual harm for at least seven (7) residents (RI#1, RI#2, RI#3, RI#5, RI#11, RI#12, and RI#13) (three residents RI#11, RI#12, and RI#13 had been discharged prior to the survey). The remaining nine (9) residents were at risk for significant harm.	A 606		

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A 606	Continued From page 86 Findings: RI#1 RI#1 was admitted to the facility on approximately April 15, 2018 (based on RI#1's earliest care plan). RI#1 was readmitted from a geriatric behavioral hospital on approximately April 30, 2021, with diagnoses which included type II diabetes, dementia, depression, and chronic obstructive pulmonary disease (COPD). RI#1 had at least eight (8) falls between February 21, 2020 and October, 2021. RI#1 suffered a fractured left femur from a fall on October 22, 2021. RI#1's most current ADL care plan was dated January 28, 2019, and documented RI#1 required verbal cues for all ADL's, was incontinent of bowel and bladder, and he/she was independent with eating, transferring, and ambulation. RI#1's most current care plan dated July 13, 2020, documented "combative with staff". RI#1's care plan dated August 26, 2019, documented RI#1 had "impaired mastication" which placed RI#1 at significant risk for choking. RI#1 required additional supervision during meals and snacks to ensure RI#1's safety from choking. There was no additional supervision for RI#1 during the meals observed by the surveyor. The employees were either busy doing other tasks or just hanging out in the kitchen area or nursing office. RI#1 had episodes of hitting other residents documented in RI#1's care plan for December 2019, October 20, 2020, March 2021, and April 2021. RI#1's monthly assessments and behavior log documented resistance to care began in approximately March 2021. None of RI#1's PSMS assessments for 2021 documented RI#1's	A 606		

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resistance to care. RI#1's monthly assessments for May and June 2021 documented "combative tendencies" due to incidents of hitting other residents (RI#3, RI#11, RI#12, and RI#13). RI#1's monthly assessments for July through December 2021 documented RI#1 cooperates with staff most times, has a fair appetite and for staff to continue the current plan of care. RI#1's care plan documented "temperamental demeanor" with interventions to walk away from RI#1 and to monitor RI#1's behavior. The care plan did not contain specific interventions for the proactive protection of other residents or specific interventions to help prevent outbursts of RI#1's temperamental demeanor.

RI#1 refused monthly weights for May and August, of 2021. RI#1's weight for June 2021 was left blank. RI#1 suffered a significant weight loss of 21.6 pounds or approximately 14% of RI#1's total body weight (from 154.8 to 133.2 pounds) between April 30, 2021 and July 2021 (3 months). RI#1 suffered an additional significant weight loss of 10 pounds or 7.3% of RI#1's total body weight (from 136 to 126 pounds) in one (1) month between November and December 2021. RI#1's significant weight losses had not been reported to the physician or properly managed. There were no written interventions to address RI#1's weight loss.

On October 28, 2021, RI#1 began receiving hospice services with a primary diagnosis of Alzheimer's dementia with behavioral disturbance. The following notes were documented in RI#1's hospice record.

- On October 29, 2021, "...is cooperative until you get (RI#1) in bed to change clothes after an incontinence episode then (RI#1) becomes

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combative...".
- On November 04, 2021, "(R#1)...very combative today with staff and nurse, also tried to spit on staff..."
- November 09, 2021, "(RI#1)...refused to get up (out of bed) very combative today...uses wheelchair for ambulation...".
- On December 15, 2021, "(RI#1)...Temp 103...staff found vomit on pillow ...concerned with aspiration...". Chest x-ray was negative.
- On December 16, 2021, "(RI#1) ...bruises to bilateral upper arms...no reported falls...".
- On December 28, 2021, "...one of the (care associates) reported (RI#1) fell one day over the (past) weekend, but when (hospice nurse) asked (facility nurse) said she was unsure (of fall)...bruising noted to both arms...".
- On December 29, 2021, "...(sponsor) standing beside (RI#1) trying to walk out of room... (sponsor) said (RI#1) was eating an orange and got choked up on it and had coughing fit...".
- On January 07, 2022, "(RI#1) ...1-2 person assist for ambulation... (incontinent of bowel and bladder), needs assist with all ADL's except feeding... had a choking spell last week when eating an orange...often combative with staff and doesn't like to have glucose checked or have insulin injections."
- On January 18, 2022, "...no recent falls ...new bruise to left calf area... nurse at Kelley Place not know if (RI#1) fell or not...(RI#1) ambulates with 1-2 person assist...".
- On January 20, 2022, "(RI#1)... was a bit combative with aides while trying to get (RI#1) dressed... incontinent of bowel and bladder...".
- On February 04, 2022, (RI#1) requires assistance with all ADL's including: bathing, dressing, transfers, eating, and bowel/bladder incontinence care. RI#1 "drinks less than 4 glasses of water per day... eats few fruits,

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vegetables or milk products; decreased strength bilateral upper and lower extremities... ".
- On February 15, 2022, "(RI#1)...spends most of day in bed...".
- On March 04, 2022, "(RI#1) ..combative ...hit (care associate) on the neck...".
- On March 07, 2022, "...got a report that (RI#1) may have choked on food...".

On February 09, 2022, the surveyor was told by various employees (EI#4, EI#8, EI#9, EI#10) that RI#1 resisted care daily and baths on at least a weekly basis. Resistive behaviors included combative behavior described as hitting, kicking, and slapping. There had been no increase in the number of employees working each shift and no sitters were added for RI#1's increased supervision needs. No discharge notice had been issued due to unmanageable behaviors.

EI#3, RN, told the surveyor she did not know that residents who resisted care were ineligible for continued stay in the facility.

On February 09 and 22, 2022, EI#1 told the surveyor there were no 30 day discharge notices issued to any residents.

RI#2
RI#2 was admitted to the facility on approximately October 22, 2021, according to the care plan date. The most current behavior screen for RI#2 was dated October 22, 2021 (admission date). RI#2's ADL care plan was left blank and had not been completed.

RI#2's monthly assessment for November 2021, documented RI#2's weight was 100 pounds which was a significant loss of 25 pounds or a 20% loss of RI#2's total body weight in just one

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(1) month. RI#2's monthly assessment documented, "cooperates with staff most times... good appetite... (continue current plan of care)...". The RN did not identify or address the significant weight loss suffered by RI#2.

On December 22, 2021, RI#2 was admitted to a behavioral health hospital after "aggressive behavior towards (RI#2's) roommate (resident unknown)." The hospital notes documented (EI#3) reported, "(RI#2's) agitation has become increasingly worse, picking fights with and between other residents...stealing other resident's food... has history of non-compliance with medications...". RI#2's behaviors were not documented in RI#2's facility record, monthly assessments, PSMS assessment, or on RI#2's behavior log. RI#2's behaviors were not documented on RI#2's care plan with specific individualized interventions to address the behaviors.

On December 28, 2021, RI#2 was readmitted to the facility from the behavioral health hospital. There were no comprehensive, PSMS, or behavior screen assessments completed at that time.

On February 09, 2022, the surveyor was told by RI#2, "Nobody likes me." Approximately 10 minutes later the surveyor observed RI#2 and RI#3 sitting on the couch hitting each other (it is unknown which resident started the incident). EI#9 came from the kitchen and removed RI#3 from the situation. RI#2 was left sitting on the couch crying, while EI#9 tried to calm RI#3 down.

On February 09, 2022, the surveyor observed resistive care behaviors by RI#2 when EI#3 and the surveyor attempted to complete a skin

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assessment. RI#2 would only allow the nurses to look at RI#2's lower legs and forearms.

On February 22, 2022, at approximately 11:20 AM, EI#15 told the surveyor RI#2 refused to have incontinence care after being incontinent of bowel in the bed. EI#15 went on to tell the surveyor she and other employees had been trying to provide RI#2's incontinence care for about an hour but with no success because RI#2 kept kicking the employees who tried to provide care.

RI#2's PSMS assessment (date blank) did not document that RI#2 resisted care. RI#2's monthly assessments consistently documented, "cooperates with staff most times, good appetite, (continue current plan of care)". The monthly assessments did not address RI#2's resistive care behaviors or RI#2's significant weight loss.

This lack of appropriate care and subsequent lack of communication resulted in actual harm for RI#2 and the unknown roommate. RI#2 was not eligible for continued stay in the facility due to resistive care behaviors.

RI#3
RI#3 was admitted to the facility on approximately February 08, 2021, with diagnoses which included dementia, aggressive behaviors, and anxiety. RI#3 was independent with all ADL's and ambulation. RI#3's care plan documented symptoms of anxiety, but did not contain any interventions or guidance for caregivers to help RI#3 manage his/her symptoms of anxiety. RI#3's monthly assessments consistently documented, "cooperates with staff, good appetite, (continue current plan of care)." RI#3's monthly assessments did not document RI#3's

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continued anxious behavior.

On February 09, 2022. at approximately 11:00 AM, the surveyor observed RI#2 and RI#3 sitting on the couch hitting each other. Both caregivers (EI#8 and EI#9) had been sitting in the kitchen area. EI#9 went to the couch and began loudly calling RI#3's name and trying to separate RI#2 and RI#3. After the residents were separated, RI#2 was left on the couch crying while EI#9 tried to calm RI#3 down. RI#3 was still very agitated as evidenced by RI#3 breathing hard, sighing frequently, talking in a raised voice, and glaring at RI#2. RI#3 was told to go sit on another couch at the opposite end of the room from RI#2. EI#9 left the residents and went back into the kitchen area with EI#8.

The surveyor observed that RI#3 continued to be in an agitated state for approximately one hour after the altercation with RI#2 as evidenced by RI#3 repeatedly looking out of the front window, pacing back and forth between the couch and the window, throwing RI#3's hands in the air, shaking RI#3's head and sighing frequently while glaring at RI#2. While RI#3 was still in this agitated state, RI#4 came out of RI#4's room and sat on the couch with RI#3. When RI#3 told RI#4 that RI#2 had hit him/her (RI#3), RI#4 got upset and started saying, "You just need to back hand (RI#2), if (RI#2) hit me, I'd lay them out and they wouldn't get up for a good long while."

The above abuse incident between RI#2 and RI#3 was not reported to EI#3 or EI#4, and the two residents were not given anything else to do for a distraction until lunch was served over an hour later.

The surveyor reported the physical abuse incident

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A 606	Continued From page 93 between RI#2 and RI#3 to EI#1 and EI#3 before lunch that same day. While RI#2 and RI#3 may not have experienced physical injuries during the incident above, both residents suffered actual harm as evidenced by mental anguish, crying, and heightened anxiety symptoms. Staff left the residents alone in the room together. without supervision, failing to ensure a further altercation did not occur. RI#4 RI#4 was admitted to the facility on approximately April 14, 2021, according to the comprehensive assessment. RI#4 had diagnoses which included neurocognitive disorder, psychotic disorder due to organic brain disease and paranoid delusions. On February 09, 2022, the surveyor was told by RI#2 "nobody likes me" and then observed RI#2 hit and get hit by RI#3 approximately 10 minutes later. The surveyor heard RI#4 tell RI#3 that if RI#2 "hit me (RI#2) would be laid out on the floor for a good long while." RI#4 also told RI#3 that RI#3 should just "backhand (RI#2)" then RI#4 called RI#2 "stupid". On February 09, 2022, RI#4 told the surveyor how RI#4's sponsor and spouse had placed RI#4 in the facility and took RI#4's car. RI#4 told the surveyor RI#2 was mean and you didn't have to do anything to provoke him/her for RI#2 to be mean. The surveyor was told by EI#4 that RI#4 had anger issues with his/her sponsor and made threats about other residents "but was harmless" and wouldn't follow through with threats.	A 606		

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A 606	Continued From page 94 EI#8 told the surveyor "you don't want to get on (RI#4's) bad side...(RI#4) will curse you and threaten (harm)." RI#4's monthly assessments and behavior logs did not address RI#4's threatening or verbally abusive behaviors. RI#4's monthly assessments documented, "cooperates with staff... good appetite... (continue current plan of care)." While RI#4 may not have physically harmed any resident, RI#4's verbal abuse and threatening behaviors would certainly cause mental anguish and increased anxiety for the targeted residents. RI#4's encouragement for physical abuse would also be a cause for concern and additional supervision would be required to prevent the actual harm of other residents. On February 23, 2022, EI#2 told the surveyor she told the governing authority she (EI#2) was having trouble getting EI#3, former facility RN, to complete her responsibilities and duties as the RN/Care coordinator. EI#2 had been the RN prior to EI#3 and told the surveyor she (EI#2) knew how important the RN duties were.	A 606		
A 609	420-5-20-.06 (3) (k) Care of Residents. (k) Resident Abuse, Neglect, and Exploitation. Each facility shall develop and implement a policy and procedure to protect each resident of the facility from abuse, neglect, and exploitation. The facility shall ensure that all staff can demonstrate an understanding of what constitutes abuse, neglect, and exploitation, and shall ensure that all staff understands his or her responsibility to immediately report suspected, alleged, confessed, witnessed, or actual incidents	A 609		

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A 609	Continued From page 95 of abuse, neglect, or exploitation of a resident to the administrator. When abuse, neglect, or exploitation is suspected, alleged, confessed, witnessed, or actual the facility shall conduct and document a thorough investigation and take appropriate action to prevent further abuse. All allegations, suspicions, confessions, witnessed, or actual incidents shall be reported to the Assisted Living Unit of the Alabama Department of Public Health and to the victim's sponsor or responsible family member within 24 hours. Suspected, alleged, confessed, witnessed, or actual abuse, neglect, or exploitation of a resident shall be reported to the Department of Human Resources or law enforcement in accordance with Code of Ala. 1975, Section 38-9-8. At any time that a resident has been the victim of sexual assault or sexual abuse perpetrated by a staff member or visitor, local law enforcement authorities shall be immediately notified. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to implement and follow the facility's abuse policy and procedures. This deficient practice resulted in actual harm for at least seven (7) residents [RI#1, RI#2, RI#3, RI#5, RI#11, RI#12, and RI#13 (RI#11, RI#12, and RI#13 had been discharged prior to the survey). The remaining nine (9) residents were placed at a significant risk for harm. Findings: ADPH online incident report reviews documented the following. On June 03, 2020, RI#1 pushed RI#12. No injuries were documented.	A 609		

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A 609	Continued From page 96 On September 13, 2020, RI#12 grabbed RI#1's fingers. RI#1 then pushed RI#12's arm against the wall and caused a skin tear. This incident caused mental anguish and physical injury for RI#12. On December 16, 2020, RI#11 yelled, cursed at and hit RI#1. RI#1 then grabbed RI#11's arms and slapped RI#11 in the face. No injuries were documented. This incident resulted in mental anguish and physical harm. On March 12, 2021, RI#1 threw a (Yeti) drinking cup at RI#13, which caused a "red spot" where the cup hit RI#13 in the chest. This incident resulted in mental anguish and physical harm. On April 17, 2021, RI#1 went into RI#3's room and sat on RI#3's bed. RI#1 was "too agitated to be redirected" and clawed at RI#3's face. RI#3 then hit RI#1 with an open hand. No injuries were documented. RI#1 was finally sent to a geriatric behavioral hospital for management of RI#1's combative tendencies after the April 17, 2021, incident with RI#3. On June 09, 2021, RI#3 was arguing with an unknown resident and RI#3 was sent to RI#3's room to "cool down". An unknown amount of time later that same day, RI#3 left his/her room, walked down the hall and slapped RI#5. RI#3 was sent back to his/her room. No injuries were documented. This incident caused harm to RI#5 and was an example of the facility's use of isolation for RI#3's behavior management which did not work and was an inappropriate intervention.	A 609		

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A 609	Continued From page 97 There were no further incidents of resident abuse reported even though RI#1 and RI#3 were still living in the facility. On February 02, 2022, EI#1, administrator, submitted an online report for physical abuse of RI#1 by EI#19. During the facility investigation, EI#1 identified two (2) separate incidents that involved RI#1 suffering physical abuse by EI#19. On January 25, 2022, EI#22 witnessed EI#19 pull RI#1's head back by pulling RI#1's hair. On February 01, 2022, EI#22 witnessed EI#19 hit RI#1 on the left side of RI#1's face. The hit to RI#1's face resulted in bruising to RI#1's face below the eye to the jaw line. ADPH requested and received an immediate plan of action (IPOA) from EI#1 to properly manage the physical abuse incident involving RI#1 and EI#19. In addition, the IPOA's purpose was to help identify any other abused residents and to protect the residents living in the facility from any further abuse. On February 09, 2022, at approximately 10:50 AM, an ADPH surveyor arrived at the facility to verify the IPOA submitted by the facility, for the physical abuse incident involving RI#1 and EI#19, had been carried out. However, upon further investigation, the surveyor determined the facility failed to implement the IPOA as required leaving residents unprotected from the threat of abuse. The following elements of the IPOA were not completed. The surveyor was told the resident skin assessments had not been completed or documented, the resident interviews had not been completed, the abuse training had not been completed and the training for dealing with difficult behaviors had not been completed. In	A 609		

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addition, the weekly skin assessments for monitoring injuries of unknown origin had not been initiated because the baseline skin assessments had not been performed.

EI#1 and EI#3 agreed the potential for abuse and continued injuries of unknown origin had not been resolved.

On February 09, 2022, at approximately 10:55 AM, RI#2 told the surveyor, "Nobody likes me." RI#2 was observed to be anxious as evidenced by RI#2 frequently asking questions regarding what he/she should do, where he/she should sit, and even asking if it was okay for RI#2 to sit in certain spots in the common living room.

On February 09, 2022, at approximately 11:00 AM, the surveyor observed RI#2 and RI#3 on the couch hitting each other. Both caregivers (EI#8 and EI#9) had been sitting in the kitchen area. EI#9 went to the couch and began loudly calling RI#3's name and trying to separate RI#2 and RI#3. After the residents were separated, RI#2 began to cry while EI#9 tried to calm RI#3 down. RI#3 was still very anxious and agitated, as evidenced by breathing hard, sighing frequently, talking in a raised voice, and glaring at RI#2. RI#3 was told to sit on another couch at the opposite end of the room from RI#2. EI#9 left the residents and went back into the kitchen area with EI#8.

The surveyor continued to observe that RI#3 remained in an agitated state for approximately one hour after the incident with EI#2, as evidenced by RI#3 getting up repeatedly to look out the front window, pacing back and forth, throwing RI#3's hands in the air, sighing frequently and shaking RI#3's head while glaring

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at RI#2. While RI#3 was still in this agitated state, RI#4 came out of RI#4's room and sat on the couch next to RI#3. When RI#3 told RI#4 that RI#2 had hit him/her (RI#3), RI#4 got upset and started saying "You just need to back hand (RI#2). If (RI#2) hit me (RI#4), I'd lay them out and they wouldn't get up for a good long time." Then RI#4 called RI#2 "stupid".

On February 09, 2022, the surveyor was told by EI#4 that RI#4 had anger issues with his/her sponsor and made threats about other residents. EI#4 said RI#4 was harmless and wouldn't follow through with the threats. EI#8 told the surveyor. "You don't want to get on (RI#4's) bad side... (RI#4) will curse you and threaten (harm)."

While RI#4 may not have physically harmed any residents, RI#4's verbal abuse and threatening behaviors certainly caused mental anguish and anxiety for the targeted residents. RI#4's encouragement for physical abuse to other residents would be cause for concern and additional supervision would be required to prevent the actual harm of other residents.

The facility abuse policy and procedure documented that employees who witnessed abuse should report the abuse immediately to the executive director (administrator) or supervisor on duty. The abuse policy went on to document that the facility shall implement measures to prevent further abuse. Both incidents of physical abuse involving RI#1 were not reported until February 02, 2022. The first incident of abuse occurred on January 25, 2022, and the second incident of abuse occurred on February 01, 2022, according to an interview with EI#1, on February 09, 2022.

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A 611	420-5-20-.06 (4) (a) (b) Care of Residents.	A 611		

(4) Personal Care and Services. The facility shall provide care and services consistent with community standards.

(a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times.

(b) Plan of Care. The RN shall develop written plans of care for each resident prior to or at the time of admission. The plans of care shall be based on resident's assessments, diagnoses, and recommendations of the resident's physician. The plan of care shall be developed in cooperation with the resident, if appropriate, and the sponsor. The RN shall identify resident care problem areas and formulate written interventions to address those problems. The RN shall evaluate the implementation of the interventions and the resident's response to the interventions and modify the plan of care as necessary.

1. The plan shall at all times reflect the current condition of the resident. All entries on the plan of care shall be accurately dated. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following:

2. A listing of the resident's individual needs or problems that require intervention by the facility.

3. A listing of interventions provided by the facility to address the resident's identified

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A 611	Continued From page 101 needs or problems. 4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider. 5. Activities of Daily Living. Residents of a specialty care assisted living facility shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident. (i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested. (ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips. (iii) Hair. Residents' hair shall be kept clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be provided assistance with personal safety. 6. As changes in medication and	A 611		

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A 611	Continued From page 102 personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the RN failed to develop individualized care plans, update care plans with significant changes in the residents health status, and evaluate whether or not care plan interventions were effective. This deficient practice affected all 13 residents living in the facility. Findings: RI#1 RI#1 was admitted to the facility on approximately April 15, 2018 (based on RI#1's earliest care plan). RI#1's diagnoses included type II diabetes, dementia, depression, and chronic obstructive pulmonary disease (COPD). RI#1's monthly assessments and behavior log documented RI#1's resistance to care began in March 2021. RI#1's care plan did not have individualized interventions to address RI#1's resistance to care and combative behaviors. The same interventions, approach resident in a calm manner and leave the resident and come back later, were just rewritten. RI#1's monthly assessments for May, June, and July of 2021 documented, "combative tendencies" due to incidents of hitting other residents. RI#1's care plan was not updated with appropriate interventions to address the incidents of resident abuse. The care plan repeatedly	A 611		

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documented to monitor the resident or the resident's demeanor. There were no other specific interventions to prevent RI#1 from abusing other residents.

RI#1 refused monthly weights for May and August, of 2021. RI#1's weight for June 2021 was left blank. RI#1 suffered a significant weight loss of 21.6 pounds, approximately 14% of RI#1's total body weight (from 154.8 to 133.2 pounds) between April 30, 2021 and July 2021 (3 months). RI#1 suffered an additional significant weight loss of 10 pounds, 7.3% of RI#1's total body weight (from 136 to 126 pounds) in one (1) month between November and December 2021. RI#1's significant weight losses had not been addressed on RI#1's care plan. There were no interventions put in place to prevent further weight loss.

On February 22, 2022, EI#1 told the surveyor RI#1 had not been issued a 30 day discharge notice.

RI#2
RI#2 was admitted to the facility on approximately October 22, 2021 (according to the date on the care plan). RI#2's diagnoses included senile dementia with behavior disturbance. RI#2's care plan dated October 22, 2021, for activities of daily living (ADL's) was left blank. RI#2's care plan for behavior management did not have individualized interventions for RI#2's behaviors.

RI#2 was admitted to the geriatric behavioral unit on December 22, 2021, for behaviors which included "picking fights with other residents, and taking other resident's food." RI#2's care plan did not address the behaviors that were reported to the behavioral hospital. RI#2's care plan was not updated upon RI#2's return to the facility from the

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behavioral hospital stay on December 28, 2021.

RI#2's baseline weight of 125 pounds was documented on the physician medical examination dated October 20, 2021. RI#2's monthly assessment for November 2021, documented RI#2's weight was 100 pounds which was a significant loss of 25 pounds or 20% loss of RI#2's total body weight in just one (1) month. RI#2's monthly assessment documented, "cooperates with staff most times... good appetite... (continue current plan of care)...". The RN did not identify or address the significant weight loss suffered by RI#2 in the care plan.

On December 22, 2021, RI#2 was admitted to a behavioral health hospital after "aggressive behavior towards (RI#2's) roommate.". The hospital notes documented (EI#3) reported "(RI#2's) agitation has become increasingly worse, picking fights with and between other residents...stealing other resident's food... has history of non-compliance with medications...". RI#2's behaviors were not documented in the care plan or addressed with specific interventions for care staff to follow.

On February 24, 2022. the surveyor heard RI#2 and RI#5 arguing in the room they shared. EI#8 told the surveyor RI#2 and RI#5 argue all the time and they need to be separated. EI#8 said she told the nurse (name and date unknown) but nothing changed.

RI#3
RI#3 was admitted to the facility on February 08, 2021, with diagnoses which included dementia and anxiety.

On June 09, 2021, RI#3 slapped RI#5. RI#3's

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care plan did not address this aggressive behavior.

On February 09, 2022, the surveyor observed RI#2 and RI#3 hitting each other while sitting on the couch in the common living room.

The surveyor was told by EI#4, EI#8, and EI#9, that RI#3 would usually walk away from confrontation with other residents. EI#8 and EI#9 agreed that RI#3 didn't walk away during the altercation with RI#2 on February 09, 2022. EI#8 told the surveyor RI#3 would usually walk away when confronted by another resident but RI#3 could be combative if the other resident continued to bother RI#3.

RI#3's care plan did not address RI#3's behaviors or provide interventions for staff to follow to prevent incidents of aggression toward other residents.

RI#4
RI#4 was admitted to the facility on approximately April 04, 2021. According to the comprehensive assessment, RI#4's diagnoses included neurocognitive disorder, psychotic disorder due to organic brain disease and paranoid delusions.

On February 09, 2022, the surveyor was told by RI#2, "Nobody likes me." Ten minutes later the surveyor observed RI#2 hit and get hit by RI#3. The surveyor heard RI#4 tell RI#3, "If (RI#2) hit me (he/she) would be laid out on the floor for a good long while." RI#4 also told RI#3 that RI#3 should just backhand RI#2. RI#4 proceeded to call RI#2 stupid. RI#4 told the surveyor RI#2 was mean and you didn't have to do anything for RI#2 to be mean.

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A 611	Continued From page 106 On February 09, 2022, RI#4 told the surveyor about how his/her sponsor and spouse placed RI#4 in the facility and took his/her car. The surveyor was told by EI#4 that RI#4 had anger issues with his/her sponsor and made threats about other residents but "(RI#4) was harmless" and wouldn't follow through with threats. EI#8 told the surveyor "you don't want to get on (RI#4's) bad side...(RI#4) will curse you and threaten (harm)." RI#4's care plan did not address RI#4's threatening or verbally abusive behaviors. There were no written care actions for staff to follow to help handle RI#4's behaviors. On February 23, 2022, EI#1 told the surveyor he had spoken with EI#3 about the residents' hair not being brushed, but had not followed up with staff to ensure the care was actually provided on a daily basis. EI#1 did not provide any documentation where EI#1 followed up with staff to ensure resident care was provided and behaviors were properly managed.	A 611		
A 612	420-5-20-.06 (4) (c) (d) (e) (f) Care of Residents. (c) Activity Program. There shall be an activity program designed to meet the individual needs of each resident. The facility shall maintain supplies and equipment as necessary to implement the activity programs. Every day the facility shall provide activities appropriate to residents with dementia. Residents who have wandering behaviors shall have a documented	A 612		

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A 612	Continued From page 107 activity program to manage this behavior. (d) Pets residing at the facility or used in activity programs shall be in good health and shall have current vaccinations as required by law. Vaccination certificates, or copies of vaccination certificates, shall be kept on file at the facility to demonstrate compliance with this requirement. (e) Mail, Telegrams, and Other Communications. 1. Incoming mail, telegrams, and other written communications addressed to the resident shall be delivered to the resident unopened. Outgoing mail shall be promptly delivered to regular postal channels upon receipt from the resident. Residents shall be permitted to receive telephone calls at the facility in complete privacy. 2. Personnel of the facility shall assist residents with communications, such as writing letters or assisting with writing letters, or reading mail out loud if requested to do so. (f) Appointments. Residents shall be assisted in making and keeping appointments. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide an appropriate activity program that promoted mental and physical wellness. This deficient practice affected all 13 residents living in the facility.	A 612		

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A 612	Continued From page 108 Findings: On February 09, 2022, at approximately 10:50 AM, when the surveyor arrived there were two care associates in the kitchen area and eight (8) residents sitting in the common living room sleeping or just looking around the room. Six of the eight female residents had unkempt, matted, or greasy, stringy hair. Five of the eight residents were sitting with their eyes closed and not interacting with anyone in the room. The LPN was in the medication room with the door closed. There were no activities in progress. EI#18 had an office in the facility, but was not seen in the facility when the surveyor arrived. On February 09, 2022, RI#4 told the surveyor, "Those (residents RI#1, RI#2, RI#6, RI#7, RI#8, RI#9, RI#15, and RI#16) over there sit there all day long and some of them sleep there at night. I would get so bored, I have to go to my room and read or do something, I just can't sit all day long." On February 23, 2022, the surveyor asked EI#18 if there were activity plans for residents with wandering behaviors. EI#18 told the surveyor she provided activities for everyone not just the residents who wandered. On March 02, 2022, the surveyor was told during a telephone interview with RI#16's sponsor there were never any activities for the residents that he/she observed during the sponsor's frequent visits to the facility. The sponsor visited various times of the day and various days of the week. During the four days onsite (February 09, 22, 23, and 24, 2022) the surveyor observed only two activities lead by any employee. When the	A 612		

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A 612	Continued From page 109 weather was nice outside the surveyor observed RI#5 sitting outside on the porch with EI#16. RI#3 was observed outside with RI#3's sponsor. The surveyor observed that residents spent most of their days siting in front of the television, sitting and looking around, or asleep when they weren't involved with care or meals. On February 23, 2022, EI#18 told the surveyor her 40 hour work week was 8:00 AM until 5:30 PM Monday through Friday. EI#18 told the surveyor there were two (2) activities scheduled for the morning and two (2) activities scheduled for the evening. EI#18 told the surveyor she had been allotted two (2) hours per day five (5) days a week in each facility. EI#18 was responsible for activities and marketing duties for both facilities (Kelley Place and Madison Heights). The care associates were responsible for providing activities on the weekend and when EI#18 was busy with marketing tasks.	A 612		
A 615	420-5-20-.06 (5) (h) Care of Residents. (5) Medications. (h) All medications administered to residents in a specialty care assisted living facility, shall be contemporaneously recorded on a standard medication administration record. "Contemporaneously recorded" means recorded at the same time or immediately after medications are administered. The medication administration record shall include at least the following: 1. The name of the resident to whom the medication was administered.	A 615		

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A 615	Continued From page 110 2. The name of the medication administered. 3. The dosage of the medication administered. 4. The method of administration. 5. The site of injection or application, if the medication was injected or applied. 6. The date and time of the medication administration or assisted. 7. Any adverse reaction to the medication. 8. The printed name, initials, and written signature of the individual administering the medication or assisting the resident with self-administration of the medication. This Rule is not met as evidenced by: Based on record review and interview, the nurse failed to contemporaneously document medications on the resident's medication administration record. This deficient practice affected at least two (2) residents. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON JUNE 18, 2018 (PREVIOUS DEFICIENCY #629). Findings: On February 09, 2022, at approximately 12:00 PM, the surveyor, with EI#3, observed the	A 615		

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A 615	Continued From page 111 following medications had not been signed as given to the residents. The medications were not observed in the medication cart. RI#3's evening and bedtime medications for February 08, 2022 were not initialed as given. RI#3's undocumented medications were as follows. Nasamist 1 spray in each nostril due in evening and bedtime, Seroquel 25 mg (milligrams) and 50 mg for a total of 75 mg due in the evening and Donepezil 10 mg due at bedtime. RI#4's evening and bedtime medications for February 08, 2022 were not initialed as given. RI#4's undocumented medications were Melatonin 5 mg due at bedtime, Risperidone 0.25 mg due at bedtime, Atorvastatin 40 mg due at bedtime, Buspar 7.5 mg due in evening and Donepezil 10 mg due at bedtime. On February 09, 2022, EI#3 agreed the medications had not been initialed as given.	A 615		
A 616	420-5-20-.06 (5) (i) (j) (k) (l) (m) Care of Residents. (i) Medications kept under the control or custody of a specialty care assisted living facility shall be packaged by the pharmacy and shall be maintained by the facility in unit dose packaging. Medications kept under the control or custody of the specialty care assisted living facility that are not available in unit dose packaging must be packaged by the pharmacy and administered by a physician, RN, or LPN. (j) Unless a resident can and does self-manage his or her own medications, a specialty care assisted living facility shall require	A 616		

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each resident to use a single pharmacy. This does not apply to emergency pharmacy services. All residents need not use the same pharmacy that is used by other residents unless express policy of the specialty care assisted living facility provides otherwise and all residents are informed of such policy and provided a copy of such policy prior to or at the time of admission. The specialty care assisted living facility shall require pharmacies used for medication supply for residents not self-managing their medications to review all ordered medication regimens for possible errors or adverse drug interactions and to advise the facility and the prescribing health care provider when these are detected.

(k) If controlled substances prescribed for residents of any specialty care assisted living facility are kept in the custody of the specialty care assisted living facility, they shall be stored in a manner that is compliant with state and federal laws, the requirements of the Alabama State Board of Pharmacy, and any requirements prescribed by the Alabama State Board of Health. At a minimum, controlled substances in the custody of the facility shall be stored using a double lock system, under proper temperature and humidity controls and permit only authorized personnel access. The facility shall maintain a system to account for all controlled substances in its possession. All other medications in the custody of the facility shall be stored using at least a single lock, under proper temperature and humidity controls and permit only authorized personnel access. This shall include medications stored in a resident's room when the staff and not the resident have access to the medications. Medications may be kept in the custody of an individual resident who can safely manage his or

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A 616	Continued From page 113 her medications. Such medications may be stored in a locked container accessible only to the resident and staff, or may be stored and secured in the resident's living quarters, if the room is single occupancy and has a locking entrance. (l) Medication administration records and written physician orders for all over-the-counter drugs, legend drugs, and controlled substances shall be retained for a period of not less than 3 years. They shall be available for inspection and copying on demand by agents of the State Board of Health. They shall be made available for inspection at reasonable times by residents, anyone authorized by the resident, and by the sponsors of residents. (m) Labeling of Drugs and Medicines. All containers of prescribed medicines and drugs shall be labeled in accordance with the rules of the Alabama State Board of Pharmacy and shall include appropriate cautionary labels, such as, "Shake Well," or "For External Use Only." This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure medications kept in the custody of the facility were properly secured and stored at all times. This deficient practice affected all 13 residents living in the facility. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON MARCH 01, 2017. Findings:	A 616		

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A 616	Continued From page 114 On February 23, 2022 at approximately 12:48 PM, the surveyor, with EI#2, observed that the medication/nurses office was unlocked and unsupervised. The medication refrigerator was also unlocked and unsupervised. The medications stored in the unlocked refrigerator included three insulin pens (two Lantus and one Novolin) and liquid Ativan, a controlled medication. All of the residents were outside the nurses office eating lunch or meandering around. EI#2, RN, agreed the medications and the office/medication room should have been locked or supervised.	A 616		
A 621	420-5-20-.06 (9) (b) Care of Residents. (b) Retention. 1. A specialty care assisted living facility shall not allow any resident to return to the specialty care assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the specialty care assisted living facility is licensed to provide or the facility is capable of providing. 2. A specialty care assisted living facility shall not retain a resident that has a PSMS score greater than 23 or a score of five in feeding, dressing, grooming, bathing or a score of four or five in physical ambulation. 3. A specialty care assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility. 4. Residents who have unmanageable	A 621		

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A 621	Continued From page 115 behaviors or behaviors that may be dangerous to themselves or others shall not be retained in a specialty care assisted living facility. 5. A specialty care assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless: (i) The individual is capable of performing and does perform all tasks related to his or her own care; OR (ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity but the individual has sufficient cognitive ability to direct his or her own care and the individual is able to direct facility staff and does direct facility staff to provide the physical assistance needed to complete such tasks, and the facility staff is capable of providing such assistance and does provide such assistance. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. 6. If a resident of a specialty care assisted living facility is diagnosed with a terminal illness and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90 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	A 621		

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A 621	Continued From page 116 discharge or transfer the resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for specialty care assisted living facilities. The facility would in all cases remain responsible for ensuring the appropriate delivery of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility retained residents whose care and safety needs exceeded the capabilities of the facility license. This deficient practice resulted in harm to at least seven (7) residents (three of the seven residents had been discharged prior to the survey), and placed the other nine (9) residents at risk for significant harm. Findings: RI#1 RI#1 was admitted to the facility on approximately April 15, 2018 (based on RI#1's earliest care plan). RI#1 was readmitted from a geriatric behavioral hospital on approximately April 30, 2021, with diagnoses which included type II diabetes, dementia, depression, and chronic obstructive pulmonary disease (COPD). RI#1 suffered at least eight (8) falls between February 21, 2020 and October, 2021. RI#1 suffered a fractured left femur from the fall in October 22, 2021.	A 621		

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A 621	Continued From page 117 RI#1's most current ADL care plan was dated January 28, 2019, and documented RI#1 required verbal cues for all ADL's, and he/she was incontinent of bowel and bladder. Documentation also revealed RI#1 was independent with eating, transfers, and ambulation. RI#1's facility care plan dated July 13, 2020, documented RI#1 was "combative with staff". RI#1's care plan dated August 26, 2019, documented RI#1 had "impaired mastication". RI#1 had incidents of hitting other residents documented in his/her care plan for December 2019, October 20, 2020, March 2021, and April 2021. RI#1's monthly assessments and behavior log documented RI#1 began resisting care in approximately March 2021. None of RI#1's PSMS assessments documented RI#1 was resistant to care. Monthly assessments for May, June, and July of 2021 documented "combative tendencies" due to incidents of hitting other residents. RI#3, RI#11, RI#12, and RI#13 suffered mental and/or physical harm due to RI#1's "combative tendencies". On October 28, 2021, RI#1 began receiving hospice services for a primary diagnosis of Alzheimer's dementia with behavioral disturbance. The following notes were documented in RI#1's hospice record. - On October 29, 2021, "...is cooperative until you get (RI#1) in bed to change clothes after an incontinence episode then (RI#1) becomes combative...". - On November 04, 2021, "(R#1)...very combative today with staff and nurse, also tried to spit on staff..."	A 621		

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A 621	Continued From page 118 - November 09, 2021, "(RI#1)...refused to get up (out of bed) very combative today...uses wheelchair for ambulation...". - On December 15, 2021, "(RI#1)...Temp 103...staff found vomit on pillow ...concerned with aspiration...". Chest x-ray was negative. - On December 16, 2021, "(RI#1) ...bruises to bilateral upper arms...no reported falls...". - On December 28, 2021, "...one of the (care associates) reported (RI#1) fell one day over the (past) weekend, but when (hospice nurse) asked, (facility nurse) said she was unsure (of fall)...bruising noted to both arms...". - On December 29, 2021, "...(sponsor) standing beside (RI#1) trying to walk out of room... (sponsor) said (RI#1) was eating an orange and got choked up on it and had coughing fit...". - On January 07, 2022, "(RI#1) ...1-2 person assist for ambulation... (incontinent of bowel and bladder), needs assist with all ADL's except feeding... had a choking spell last week when eating an orange...often combative with staff and doesn't like to have glucose checked or have insulin injections." - On January 18, 2022, "...no recent falls ...new bruise to left calf area... nurse at Kelley Place not know if (RI#1) fell or not...(RI#1) ambulates with 1-2 person assist...". - On January 20, 2022, "(RI#1)... was a bit combative with aides while trying to get (RI#1) dressed... incontinent of bowel and bladder...". - On February 04, 2022, (RI#1) requires assistance with all ADL's including bathing, dressing, transfers, eating, and bowel and bladder incontinence care. RI#1 "drinks less than 4 glasses of water per day... eats few fruits, vegetables or milk products; decreased strength bilateral upper and lower extremities... ". - On February 15, 2022, "(RI#1)...spends most of day in bed...".	A 621		

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A 621	Continued From page 119 - On March 04, 2022, "(RI#1) ..combative ...hit (care associate) on the neck...". - On March 07, 2022, "...got a report that (RI#1) may have choked on food...". On February 09, 2022, the surveyor was told by various employees (EI#4, EI#8, EI#9, EI#10) that RI#1 resisted care daily and resisted bathing on at least a weekly basis. However, there had been no increase in the number of employees working each shift and no sitters were added for RI#1's increased supervision and safety needs. No discharge notice had been issued. On February 22, 2022, EI#8 told the surveyor "a few weeks ago" EI#8 had performed the Heimlich maneuver on RI#1 who had gotten choked on pancakes. EI#5 told the surveyor she remembered something about the choking incident but she (EI#5) didn't know the Heimlich maneuver was performed. EI#5 went on to say, "things get kind of crazy here, if I don't have an incident report, it's hard to keep track of what's going on." There was no documentation of the incident in RI#1's record regarding the family or physician being notified of the incident during the survey. RI#2 RI#2 was admitted to the facility on approximately October 22, 2021 (according to the date on care plan). RI#2 had diagnoses which included senile dementia with behavior disturbance. RI#2 was admitted to the geriatric behavioral hospital on December 22, 2021 for behaviors which included "picking fights with other residents and taking other resident's food." The incidents of resident abuse by RI#2 were not reported, therefore, there was no way to know the number	A 621		

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of residents who suffered mental and physical abuse by RI#2.

RI#2's monthly assessments for November 2021, December 2021, and January 2022, repeatedly documented RI#2 was "cooperative with staff most times, ambulates with walker, good appetite, (continue with current plan of care)."

On February 09, 2022, the surveyor was told by various employees (EI#4, EI#8, EI#9, EI#10) that RI#2 resisted care daily and bathing on at least a weekly basis. However, there had been no increase in the number of employees working each shift and no sitters were added for RI#2's increased supervision and safety needs. No discharge notice had been issued.

On February 09, 2022, the surveyor observed an incident of resident abuse involving RI#2 and RI#3 hitting each other. RI#3 appeared very anxious and RI#2 was observed crying. The facility nurse documented, in the incident report, that there were no injuries noted after the resident on resident abuse. However, the nurse to not address the signs of mental anguish and increased anxiety suffered by both residents. The failure of the nurse to identify the emotional injuries added RI#2 and RI#3 to the list of at least seven (7) residents who suffered harm while living in the facility.

On February 22, 2022, at approximately 11:25 AM, EI#15 told the surveyor RI#2 had been refusing bowel incontinence care for approximately an hour. EI#15 told the surveyor each caregiver on duty, as well as, the nurse had tried to get RI#2 to allow care, but RI#2 continued to refuse. The surveyor observed RI#2 lying in bed crying. RI#2 refused to talk with the

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surveyor about why RI#2 was crying.

On February 24, 2022, at 11:45 AM, the surveyor heard two people arguing and yelling at each other. EI#9 told the surveyor it was RI#2 and RI#5. EI#9 said they do that all the time and need to be separated. EI#9 said the nurses and EI#1, administrator, know about the constant arguing and yelling because she has reported it to them. EI#9 said, "They won't do anything." (RI#2 and RI#5 shared the same room).

RI#3
RI#3 was admitted to the facility on February 08, 2021, with diagnoses which included dementia and anxiety. RI#3's physician's medical examination documented RI#3 required assistance with grooming, dressing and personal safety.

On April 17, 2021, RI#1 went into RI#3's room and sat on RI#3's bed. RI#1 was "too agitated to be redirected" and clawed at RI#3's face. RI#3 then hit RI#1 with an open hand. No injuries were documented.

On June 09, 2021, RI#3 was arguing with an unknown resident and RI#3 was sent to his/her room to cool down. An unknown amount of time later RI#3 left his/her room, walked down the hall and slapped RI#5. RI#3 was sent back to his/her room. No injuries were documented.

On February 09, 2022, at approximately 11:00 AM, the surveyor observed RI#2 and RI#3 sitting on a couch in the common living room hitting each other. The surveyor did not observe who initiated the altercation. EI#9 removed RI#3 from the couch where RI#2 was seated and told RI#3 to sit on the couch at the opposite end of the

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common living room. RI#2 was left crying on the couch after the incident with RI#3.

The surveyor observed RI#3 with increased symptoms of anxiety and frustration for approximately one hour after the altercation with RI#2. The surveyor observed there were no attempts by staff or nurses to calm RI#3, redirect RI#3 or distract RI#3 with an activity. RI#3's symptoms of anxiety and frustration included pacing back and forth to the window, breathing hard and sighing frequently, shaking RI#3's head from side to side while glaring at RI#2 from across the room, and throwing RI#3's hands up in the air after looking out the window and not seeing whoever RI#3 was looking for.

On February 09, 2022, the surveyor was told by EI#4, EI#8, and EI#9, that RI#3 would usually walk away from confrontation, but he/she would become combative if the confrontation from another resident persisted. EI#8 and EI#9 both agreed during separate interviews that RI#3 did not walk away from the confrontation with RI#2 on February 09, 2022.

RI#3's reassessments completed on February 22 and 24, 2022, by EI#2, RN, documented RI#3's behaviors were "verbally aggressive and in moments of high stress."

RI#6
RI#6 was admitted to the facility on March 09, 2021, with diagnoses which included dementia and depression. RI#6's care plan documented RI#6 began resisting care and was "aggressive with staff" in April 2021.

On February 09, 2022, RI#10, who used a wheelchair for mobility, told the surveyor RI#6

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was "like a (pro wrestler) and would throw you across the room when (RI#6) got mad."

On February 09, 2022, the surveyor observed that RI#6 was unkempt. RI#6's hair was not brushed or neatly styled. Various employees (EI#4, EI#8, EI#9, EI#10) told the surveyor RI#6 resisted care daily, "bites with toileting", and resisted hair care and bathing on at least a weekly basis. RI#6 was observed walking from his/her room down the hall to the common living room with the top half of RI#6's body exposed as he/she resisted dressing assistance from the LPN, RN, caregiver, and activity director. There were approximately eight residents sitting in the common living room at the time of the incident when RI#6 was exposed and resisted dressing assistance after a shower.

RI#6's PSMS and behavior screen completed on February 22 and 24, 2022, by EI#2 documented, no resistance to care. RI#6's only behaviors documented were "wanders and paces".

On February 22, 2022, EI#1 told the surveyor there had not been any 30 day discharge notices issued. EI#2 completed a PSMS for RI#6 and did not document any resistive behaviors for RI#6. On February 24, 2022, EI#2 did not document any behaviors except "wanders and paces".

RI#7
RI#7 was readmitted to the facility on September 15, 2021, after hospitalization and a rehabilitation stay for a fractured left hip with surgical repair. The hospital notes documented RI#7 had severe dementia, congestive heart failure and a left femur fracture from a fall at the facility on August 06, 2021.

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A 621	Continued From page 124 RI#7's hospital record documented, "(according to RI#7's sponsor) patient is slightly aggressive and combative at night, but typically responds to redirection." RI#7's hospice notes documented RI#7 was "combative" and frequently refused care by the nurse and hospice aide. The hospice aide was discontinued due to combative behavior (hitting) and resistance to care in October 2021. Hospice services were discontinued due to a failure to decline in February 2022. The hospice nurse documented refusal of care by RI#7 for every month while hospice services were provided between September 2021 and February 2022. On February 09, 2022, EI#8, and EI#10 told the surveyor during separate interviews that RI#6 resisted care daily and bathing on at least a weekly basis. On February 22, 2022, EI#1 told the surveyor none of the residents who had been reported to the surveyor as resisting care daily or weekly had been issued a 30 day discharge notice from the facility prior to the survey.	A 621		
A 804	420-5-20-.08 (4) Physical Facilities. (4) Food Service Facilities. (a) Floors. Floors in food service areas shall be of such construction as to be easily cleaned, sound, smooth, non-absorbent, without cracks or crevices, and shall be provided with approved and conveniently located facilities for the disposal of floor wash water. (b) Walls and Ceilings. Walls and	A 804		

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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, vented to the outdoors, shall be provided over cooking surfaces to aid in removing cooking odors. Group homes with residential stoves may use a residential hood sized for the stove. Commercial exhaust hoods shall be installed when commercial cooking equipment is used. Congregate facilities shall use a commercial exhaust hood system.

(f) Employee Toilet Facilities. Toilet rooms, if provided, shall not open directly into any room or space in which food is prepared, stored, displayed, or served, nor into any room in which utensils are washed or stored. Toilet rooms shall include a lavatory with a soap dispenser and disposable towels, and shall be well lighted and ventilated.

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A 804	Continued From page 126 (g) Hand washing Facilities. Each Group and Congregate specialty care assisted living facility shall provide a hand washing lavatory in the kitchens which shall be equipped with a soap dispenser and a supply of soap, disposable towels, and hot and cold running water through a mixing valve or combination faucet. The use of a common towel and common bar soap is prohibited. Hands shall not be washed in sinks where food is prepared. (h) Refrigeration Facilities. Adequate refrigeration facilities, automatic in operation for the storage of perishable foods, shall be provided Refrigeration shall be maintained at 41 degrees Fahrenheit or less. All refrigerators shall be 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	A 804		

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A 804	Continued From page 127 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 the kitchen shall include the following: 1. Range. In a Group specialty care assisted living facility, a residential use range is permitted. A Congregate specialty care assisted living facility shall have a heavy duty range suitable for institutional use with double oven, or equivalent. 2. Refrigerator. A Group specialty care assisted living facility may use a residential refrigerator. A Congregate specialty care assisted living facility shall have a heavy-duty refrigerator suitable for institutional use. 3. Fire extinguisher. Five-pound type BC for residential hoods and K type for commercial hoods. 4. Dishwashing. The dishwashing equipment for Group assisted living facilities shall be either residential type using cold water sanitizers or commercial type with a booster	A 804		

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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, and raised platforms shall be provided and kept clean. Perishable food shall be stored at least six inches above the floor. The storeroom shall be of such construction as to prevent the invasion of rodents and insects, the seepage of dust and water, leakage, or any other source of contamination.

(q) Dining Room.

1. A resident dining room, or rooms, shall be provided which is large enough to seat not less than 100 percent of the bed capacity.

(r) Water Heating Equipment. Equipment for heating an ample supply of water, under pressure, for all washing purposes shall be provided. Hot water shall be piped to all hand-washing facilities, and to each compartment of all dishwashing and laundry sinks. Water heaters shall be of the automatic type.

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A 804	Continued From page 129 This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain wooden tables and chairs, located in the dining area, in good repair. This deficient practice placed all 13 residents at risk for harm from food borne illness. Findings: On February 24, 2022, the surveyor observed that the wooden dining room tables and chairs had exposed wood and were missing the protective finish. The missing finish did not allow the wooden tables and chairs to be properly sanitized. The facility used cloth table covers for two of the five tables. EI#4 agreed that the tables and chairs needed refinishing or needed to be replaced.	A 804		
A 805	420-5-20-.08 (5) Physical Facilities. (5) Recreational. (a) Living and Recreational Room(s). Each specialty care assisted living facility shall provide adequate living and recreational room(s) for group activities, and for social events, such as holiday celebrations, without crowding. The following shall be included: 1. Small living room(s) of a personal or family type so that residents may read or visit with relatives and friends in private. This requirement	A 805		

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A 805	Continued From page 130 may be met when private bedrooms are large enough for use as small sitting rooms and are furnished for this use. Furniture for small living rooms and sitting spaces in bedrooms shall include clean comfortable chairs, tables, and lamps of good repair. 2. Central living or recreational room in which group activities can take place. This requirement may be met by combining the resident dining room with a central living or recreational room. (i) The living and recreational room shall be furnished according to the activities offered. Furniture shall include clean comfortable chairs, tables, and lamps of good repair. (b) Yards and Gardens. Each specialty care assisted living facility shall provide safe space for outside activities. (c) Hobbies or Leisure Activities. Each specialty care assisted living facility shall provide adequate space(s) for hobbies and leisure activities. This Rule is not met as evidenced by: Based on observation and interview the facility failed to maintain the common living room furniture in good repair. This deficient practice affected all 13 residents living in the facility. Findings: On February 24, 2022, the surveyor observed the common living room furniture's vinyl covering was cracked exposing cloth underneath. The furniture	A 805		

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A 805	Continued From page 131 could not be properly cleaned. EI#4 agreed the furniture needed to be replaced or reupholstered.	A 805		
A1002	420-5-20-.10 (2) Sanitation and Housekeeping. (2) Housekeeping and Physical Plant Maintenance. The facility must provide a safe, functional, decent, sanitary, and comfortable environment for residents, staff, and the public. (a) Equipment and Supplies. The home shall maintain an adequate quantity of housekeeping and maintenance equipment and supplies. (b) Bathtubs and Lavatories. Bathtubs and lavatories shall be kept clean and in proper working order, and shall not be used for laundering. (c) Resident Bedrooms. Resident bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance. (d) General Storage. 1. Broken beds, extra mattresses, mop buckets, and dust rags shall not be kept in hallways, closets, corners, or occupied resident rooms. Such items must be stored neatly and orderly in designated storage rooms. 2. The use of attics for storage of combustible materials shall be prohibited unless protected by an automatic sprinkler system and then only in small quantities so as not to create a	A1002		

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A1002	Continued From page 132 hazardous condition. 3. Basements used for storage shall meet acceptable standards for storage and shall be designed and constructed in a manner that protects against fire hazards. 4. Flammable materials such as gasoline, motor fuels, lighter fluid, turpentine, acetone, and oil based paint shall not be stored in the facility. Unless prohibited by a facility's own policies, however, a cognitively intact resident who uses lighter fluid to fill a personal cigarette lighter, or one who uses flammable materials such as paint or glue in connection with a personal hobby, may store small quantities of those materials in a safe and secure manner within his or her own room. 5. Poisonous or External Use Substances. Facility cleaning supplies and poisons shall be attended at all times or shall be kept in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to have adequate housekeeping and maintenance services to maintain a safe and sanitary environment for all residents. This deficient practice had the potential to affect all 13 residents living in the facility. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON DECEMBER 14, 2016. Findings:	A1002		

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A1002	Continued From page 133 On February 22, 2022, the surveyor observed EI#2 assist EI#18 to tidy up some trash and store Christmas trees from the facility courtyard in preparation for the tour of a potential resident sponsor. EI#2 told the surveyor there wasn't anyone who could help EI#18 clean up the courtyard. On February 24, 2022, at approximately 11:00 AM, the surveyor and EI#1 observed the following. A strong urine odor in RI#1's room especially around the two (2) cloth covered chairs. There was dried feces observed on the toilet in RI#1's bathroom. There was a broken toilet paper holder in RI#6's bathroom. There was a broken outlet cover with partially exposed wires by RI#8's bed. There was a missing towel bar in RI#14's bathroom. On February 24, 2022, at approximately 11:00 AM, EI#1 told the surveyor there were no dedicated housekeeping employees. The care associates were responsible to perform all of the housekeeping chores in the facility when they weren't busy with resident care. The maintenance employee worked part time and was also responsible for the maintenance duties in the "sister" facility across the street.	A1002		
A1203	420-5-20-.12 (5) Physical Environment.	A1203		

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A1203	Continued From page 134 (5) General Building Requirements - Group and Congregate. (a) Structural Soundness and Repair. The building shall be structurally sound, free from leaks and excessive moisture, in good repair, and painted with sufficient frequency to be reasonably attractive inside and out. The interior and exterior of the building shall be kept clean and orderly. (b) Temperature to be Maintained. The facility shall maintain a comfortable temperature. A comfortable range is between 71-81 degrees Fahrenheit. (c) Lighting. Each resident's room shall have artificial light adequate for reading and other uses as needed. All entrances, hallways, stairways, inclines, ramps, cellars, attics, storerooms, kitchens, laundries, and service units shall have sufficient artificial lighting to prevent accidents and promote efficiency of service. Night lights shall be provided in all hallways, stairways, and bathrooms. (d) Screens. All screen doors and operable windows shall be equipped with tight-fitting, full-length 16 mesh screens. Screen doors shall be equipped with self-closing devices. (e) Emergency Lighting. 1. All specialty care assisted living facilities shall provide an emergency artificial lighting system to adequately illuminate halls, corridors, and stairwells in case of electrical power failure. As a minimum, dry cell battery-operated lighting shall be provided to light such spaces.	A1203		

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A1203	Continued From page 135 2. Emergency lighting must provide illumination in accordance with the currently adopted Life Safety Code for at least 90 minutes. (f) Floors. 1. All floors shall be level, smooth and free of cracks, and finished so as to be easily kept clean. The basic requirement for floor finishes shall be wall-to-wall with such finishes as paint, stain, sealer, carpet, sheet vinyl, vinyl tile, hard tile, or other appropriate floor finish. 2. Any differences in floor levels shall not prevent a resident from navigating safely throughout the facility. (g) Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface and shall be kept clean and in good repair. (h) Windows. Operable windows shall be so constructed and maintained so that they fit snugly, and are capable of being opened and closed easily. Windows in specialty care facilities may have devices which prevent full opening of the window. (i) Ceiling Height. Each room occupied by residents shall have a ceiling height of eight feet or more. Existing facilities with ceiling heights less than eight feet shall be acceptable when the height complies with the codes. (j) Handrails. If handrails are installed in halls or corridors, the handrails shall be mounted at	A1203		

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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
A1203	Continued From page 136 30 - 36 inches above the floor and returned to the wall at each end. (k) Stairways. Stairways shall be well lighted, kept in good repair, and have handrails. Open space under stairs shall not be used for storage purposes. All walls and doors under stairs shall meet the same fire rating as the stairwell. (l) Doors. 1. In each new specialty care assisted living facility, doors of resident bathrooms connected to resident bedroom shall swing into the bedroom. 2. Bedroom and bathroom doors may be equipped with hardware that will permit a resident to lock himself within the room, provided a master key is readily accessible for the staff at a central location. 3. Resident bedroom and other exit access doors in specialty care assisted living facility shall be at least three feet wide. 4. Exterior egress doors except the main entry/exit door, may be equipped with a delayed egress locking system installed in accordance with NFPA 101. Other exterior egress doors may be arranged to prevent free and unhindered egress from specialty care assisted living facilities, in accordance with the Special Requirements portion of this section. 5. Exit doors swinging outward shall swing out over a landing having a minimum length and width equal to the door's width at the	A1203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P1601	A. BUILDING: _____ B. WING _____	03/03/2022

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A1203	Continued From page 137	A1203		

same level as the floor level, except existing doors shall not have more than a four inch step down.

(m) Ventilation. The building shall be well ventilated at all times to prevent accumulation of objectionable odors. Kitchens, laundries, service rooms, toilets, and bathrooms shall be ventilated by windows, gravity vents, or mechanical means as necessary to prevent offensive odors from entering other parts of the facility.

(n) Fire Extinguishers. Fire extinguishers shall be provided for each hall, kitchen, and laundry, of type and capacity appropriate to the need.

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

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

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

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A1203	Continued From page 138 (p) Manufactured homes/mobile homes are not permitted. (q) Fireplaces and inserts shall be inspected and cleaned annually, and shall comply with the currently adopted building code. Openings shall be protected with screens or doors. (r) Exit marking. In all facilities, a sign bearing the word "EXIT" in plain legible block letters shall be placed at each exit. Additional signs shall be placed in corridors and passageways wherever necessary to indicate the direction of exit. Letters of signs shall be at least four inches high. All exit and directional signs shall be kept clearly legible by continuous internal electric illumination and have battery back-up or emergency power. (s) Heating, Lighting, and other Service Equipment. 1. Central or individual room gas heating systems shall be of the enclosed flame type equipped with automatic flame shut-off control and shall be vented directly to the outside. Heating units of any type shall be located to avoid direct contact with any combustible material and shall be maintained in accordance with manufacturer's recommendation. 2. Open flame and portable heaters are prohibited in specialty care assisted living facilities. This does not apply to a fire place with gas logs protected as noted elsewhere in these rules. 3. Lighting shall be restricted to	A1203		

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A1203	Continued From page 139 electricity. Electric wiring, motors, and other electrical equipment in all specialty care assisted living facilities shall be in accordance with local electrical codes and the NFPA National Electrical Code. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain the building and equipment in good repair. This deficient practice affected all 13 residents living in the facility. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON MARCH 01, 2017. Findings: On February 24, 2022, at approximately 11:00 AM, the surveyor with EI#1, observed the following environmental concerns. The EXIT light by the dining room was not continuously lit which could cause a delay in evacuation in the event of a fire. The EXIT light by room #108 was not continuously lit. There were approximately 11 out of 16 handrails that were loose in the facility. One handrail next to the dining room had been removed and had not been replaced. RI#10 had paralysis of one arm, used a wheelchair for mobility, and was observed to utilize the handrails to improve RI#10's mobility while in the hallways. There were two floor tiles with missing tile pieces. One tile had a tile piece missing that was the	A1203		

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A1203	Continued From page 140 approximate size of a quarter creating a trip and fall hazard especially for a resident using a wheeled walker. The second tile had two pieces missing that were the approximate size of a dime, which could be a possible fall hazard for a resident using a wheeled walker. On February 24, 2022, EI#1 agreed the above items needed to be repaired or replaced. TONYA AVENATTI, REGISTERED NURSE	A1203		