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	P1602	A. BUILDING: _____ B. WING _____	03/03/2022

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MADISON HEIGHTS	108 CHANEY STREET ENTERPRISE, AL 36330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments This is a 16 bed Specialty Care Assisted Living Facility (SCALF) with a census of 12 on March 03, 2022. There were six (6) complaints investigated during this unannounced licensure and complaint survey. LC#20211220002, LC#20210920007, LC#20210810007, LC#20210608019, LC#20190924005, were substantiated, with deficiencies cited as a result of the complaint investigations. LC#20190530019 was unsubstantiated with no deficiencies cited. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practices resulted in actual harm for at least three (3) residents (RI#1, RI#5, and RI#6) and placed the remaining nine (9) residents at risk for significant 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, 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 three (3) residents, Resident Identifier (RI)#1, RI#5, and RI#6. The remaining nine (9) residents were at risk for significant harm due to the administrator's failure or unwillingness to apply the rules for the day to day operations of the facility. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON DECEMBER 20, 2018. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. Findings: On December 20, 2018, an Alabama Department of Public Health (ADPH) surveyor conducted an onsite licensure survey and complaint	A 301		

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A 301	Continued From page 3	A 301		

investigation. The complaint was substantiated and eleven deficiencies were cited. During the current survey, nine (9) of the eleven deficiencies cited during the 2018 survey, were cited again. The facility failed to correct past deficient practices. The nine repeat deficiencies included a governing authority citation, administrator duties not performed as required, staffing issues, lack of employee training, and deficiencies involving resident care.

On March 03, 2022, a surveyor with ADPH completed a complaint survey and a full licensure survey. Five (5) of six complaints were substantiated. The substantiated complaints included allegations of poor resident care, a lack of resident activities, mismanaged medications, a lack of employee training, inadequate staffing, ineligible residents, poorly managed employees, and resident safety concerns. All of the allegations were substantiated. During the survey, the surveyor also confirmed at least three (3) residents had suffered harm because of widespread resident care and safety deficiencient practices.

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 - The facility did not ensure policies and procedures were developed, updated, implemented, and followed by facility employees.

303 - The administrator did not perform his required administrative duties. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON DECEMBER 20, 2018 (previous deficiency #413).

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A 301	Continued From page 4 401 - 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 ensure employees were properly managed to ensure resident care needs were met. The facility failed to utilize certified nurse assistants (CNAs) during an emergency staffing shortage as required. The facility also failed to ensure employees were CPR (cardiopulmonary resuscitation) certified within 90 days of hire. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON DECEMBER 20, 2018 (previous deficiency #402). 405 - The registered nurse (RN)/Care Coordinator did not adequately perform her duties. 406 - The facility did not identify and provide employees with adequate training to meet the needs of residents with dementia symptoms. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON DECEMBER 20, 2018 (previous deficiency #429). 504 - The facility did not honor residents' rights for a safe environment and the right to receive visitors without an appointment. 508 - The facility did not ensure all positive Covid cases were reported to the ADPH online incident reporting system as required. 601 - The facility did not ensue physician orders were followed and did not document notification of the physician when medications were not given as ordered.	A 301		

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A 301	Continued From page 5 604 - The facility did not ensure adequate health supervision was provided to all residents to identify changes in health status and provide the necessary care. 605 - The facility did not provide adequate observation of residents to identify those who had care and safety needs which exceeded the facility's capabilities. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON DECEMBER 20, 2018 (previous deficiencies #605 and #635). 606 - The facility did not provide the necessary assistance for the discharge or transfer of residents who required an increased medical or skilled nursing level of care. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON DECEMBER 20, 2018 (previous deficiency #608). 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, individualized, and evaluated for effectiveness. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON DECEMBER 20, 2018 (previous deficiency #512). 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 IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON DECEMBER 20, 2018 (previous deficiency #621).	A 301		

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A 301	Continued From page 6 613 - Medications were not managed or administered in accordance with the nurse practice act and industry standards. 615 - The facility did not ensure all medications administered by facility employees were documented as given at the time they were administered. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON JUNE 18, 2018 (PREVIOUS DEFICIENCY #629). 616 - The facility did not ensure medications, including controlled medications, in the facility's custody were properly stored and managed. 621 - The facility retained residents whose care and safety needs exceeded the capabilities of the facility license. 805 - The common living room furniture was not kept in good repair so that the furniture could be properly cleaned. The carpet in the hallway by the laundry room was soiled and the employees did not have the appropriate training and supplies for cleaning the soiled carpet. 1002 - The facility did not ensure that chemicals and poisons were properly secured or supervised at all times. The facility allowed a flammable substance to be stored in the beauty shop. 1204 - The fire/smoke door by the laundry room did not close properly upon activation of the fire alarm.	A 301		
A 302	420-5-20-.03 (e) Administration. (e) Policies. The governing authority shall be responsible for establishing and	A 302		

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A 302	Continued From page 7 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. (x) Meal service, timing, menus and food	A 302		

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A 302	Continued From page 8 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. (V) Method to ensure an adequate	A 302		

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A 302	Continued From page 9 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 develop, update or implement policies and procedures for medication management, health assessments, care plans, and admission, retention, and continued stay criteria. This deficient practice resulted in harm for three (3) residents (RI#1, RI#5, and RI#6). The remaining nine (9) residents were at risk for significant harm. Findings: Medication Storage - The licensed practical nurses (LPNs) did not follow the facility's policies and procedures for medication storage. The	A 302		

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A 302	Continued From page 10	A 302		

surveyor observed nurses leave the medication room and the medication cart unlocked and unsupervised at various times throughout the survey. The unlocked and unsupervised medication storage areas, which included controlled medications, were accessible to residents, staff or visitors. The medication cart keys, including the controlled medication key, were observed hanging on a hook in the unlocked/unsupervised medication room or observed laying on top of the unsupervised medication cart. Please refer to deficiency #616 for any additional information.

The facility's policy and procedure for Medication Storage documented, "All medications store(d) by the community must be maintained in a ...locked container or area. ... Keys should not be easily accessed by other staff or residents. Controlled substances stored by the Community must be kept under double lock."

Medication Administration - Employee Identifier (EI)#7 was observed administering medications to residents without checking the medication unit dose packets against the residents' medication administration record (MAR). Medications including controlled medications were not documented contemporaneously. Please refer to deficiencies #613 and #615.

The facility's policy and procedure for Medication Administration documented that other employees were allowed to administer resident medications with "Atlas training or approved state training".

The facility's Medication Administration policy and procedure was not in compliance with the SBOH rules and did not restrict resident medication administration to licensed nurses or physicians as

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A 302	Continued From page 11 required by the SBOH Rules and Regulations for SCALF. The policy did not address that the nurse shall verify the medication unit dose package with the MAR or physician orders to ensure accuracy and prevent medication errors. The policy did not document that all administered medications shall be documented contemporaneously. The policy did not document that the resident's physician should be notified if the resident's medications were refused or unavailable for administration. Controlled medications - The facility did not ensure controlled medications, in the custody of the facility, were properly accounted for by at least two employees on each shift, which is an industry standard. The facility's Medication Administration and Medication Storage policies and procedures did not document any industry standards for the appropriate accounting for and documentation of controlled medications kept in the custody of the facility. Health Assessments - The RN did not follow the Health Assessments policy and procedure for the timely and accurate completion of monthly assessments, comprehensive assessments, behavior screening, and physical self maintenance scales (PSMS). Please refer to deficiency #604, #605 and #611 for additional information. The facility's policy and procedure for Health	A 302		

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A 302	Continued From page 12 Assessments documented a comprehensive assessment and care plan were required when a resident experienced a significant weight loss, two or more falls in 30 days, or behavioral symptoms. The facility's policy did not include that a comprehensive assessment and care plan update were required when a resident experienced a change in health status. The Health Assessments policy documented the PSMS and behavior screen were only required on admission and annually. The policy and procedure did not document that a PSMS and Behavior Screen were required when a resident experienced a change in health status as required by the SBOH rules SCALFs. Plan of Care - The RN did not follow the Plan of Care policy and procedure regarding the development of care plans with resident specific and appropriate care interventions to address the resident's care and safety needs. The RN did not update and evaluate the effectiveness of the care plan interventions for each resident. The RN also did not ensure the resident care plan interventions were followed. Please refer to deficiency #611 for additional information. The Plan of Care policy and procedure documented "the RN ...shall develop appropriate written plans of care to address the specific problems identified. The nurse shall evaluate both the (community's) implementation and the resident's response to the plan of care. (The plan of care) shall be modified when necessary to meet the needs of the resident." The facility administrator and RN did not follow the Admission, Retention, and Continued Stay Criteria policy and procedure, therefore allowing	A 302		

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A 302	Continued From page 13	A 302		

ineligible residents to remain in the facility. Please refer to deficiencies #606 and #621 for additional information.

The facility policy and procedure for Admission, Retention, and Continued Stay Criteria documented "... Individuals should NOT be admitted who: a) Are receiving or requires skilled nursing care. b) Has a wound which requires care beyond first aid (soap and water). c) Has unmanageable behaviors or behaviors that may be dangerous to themselves or others. d) Has a PSMS score greater than 23, or a score of 5 in feeding, dressing, grooming, bathing, or a score of 4 or 5 in physical ambulation. ..."

"Retention Criteria - Individuals should not be retained who a) Has a PSMS score greater than 23, or a score of 5 in feeding, dressing, grooming, bathing, or a score of 4 or 5 in physical ambulation. b) Has symptoms or behaviors that infringe on the rights or safety of residents currently residing in the community. c) Has unmanageable behaviors or behaviors that may be dangerous to themselves or others. d) Requires medical or skilled nursing care which is expected to exceed 90 days unless: the individual is capable of performing and does perform all tasks related to his or her own care; the individual is incapable of performing some or all of the 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... .e) If a resident 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 may remain in the community for a period longer than 90 days. "

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A 302	Continued From page 14 The facility's Retention Criteria Policy and Procedure did not reflect the changes required by the SBOH Rules and Regulations for SCALF that went into effect on April 6, 2019. "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, then the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for specialty care assisted living facilities." "The facility would in all cases remain responsible for ensuring the appropriate delivery of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident."	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.	A 303		

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A 303	Continued From page 15 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an administrator shall meet all applicable statutory requirements. 4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days. 5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age. 6. The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character. 7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week. 8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe 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	A 303		

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A 303	Continued From page 16 responsible for ensuring that required training is provided to all staff. 10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting. 11. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when needed. 12. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan. 13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained. This Rule is not met as evidenced by: Based on 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 harm for at least three (3) residents (RI#1, RI#5, and RI#6). The remaining nine (9) residents were placed at risk for significant harm. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM	A 303		

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A 303	Continued From page 17 SURVEYS COMPLETED ON DECEMBER 20, 2018 (previous deficiency #413). Findings: The surveyor spent a total of three days onsite at the facility (February 22, 23, and 24, of 2022). During those three days, the surveyor observed the following administrative concerns. Residents did not receive adequate personal care and supervision to identify changes in health status. Please refer to deficiencies #504, #606, #611, and #621. Residents were not provided with a safe and decent environment. Please refer to deficiency #504, #621, #805, #1002, and #1204. Minimal staffing requirements were not provided which resulted in an unsafe environment where the care and safety needs of all residents were not met. Please refer to deficiencies #401, #504, #606, and #621. Employees were not properly managed to ensure resident care and safety needs were met. Please refer to deficiencies #401, #504, #606, #611, and #621. Scheduled employees were not properly trained or refused to provide necessary care to the residents living in the facility. Please refer to deficiencies #401, #405, #406, #504, #606, #611, #612, #613, #615, #616, and #621. Residents were retained in the facility with unmanageable and combative behaviors and other care needs that exceeded the facility's capabilities. Please refer to deficiencies #504,	A 303		

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A 303	Continued From page 18 #606, and #621. Residents had unmet care, safety, and psychosocial needs that were not addressed by the facility in an appropriate and timely manner. Please refer to deficiencies #504, #606, #611, #612, and #621. Residents did not have current care plans with appropriate individualized interventions to address their required 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, #401,#406, #605, #606, #611, and #612. PLEASE NOTE: There were two individually licensed 16 Bed SCALF buildings 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. On February 23, 2022, EI#1 told the surveyor he was responsible for the administrative duties and the business office directors duties for two facilities. Review of the job descriptions for the administrator and the business office director included the following duties. The administrator is responsible for all events and activities in the community including ensuring residents are appropriate and communicating any changes to sponsors. Additional duties include billing, employee payroll, monitoring and reporting	A 303		

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A 303	Continued From page 19 expenditures, completion/monitoring of all financial documentation, employee supervision, hiring, training, and completion of employee file paperwork. The administrator was also responsible to safeguard the community from abuse, damage, or deterioration, establish preventive maintenance, hold meetings with all employees, directors, residents, and sponsors as needed, tracking move-ins and move-outs, and documentation of all communication. The Administrator/Executive Director job description did not document the need for the administrator to have knowledge of and maintain compliance with the SBOH rules and regulations for a SCALF.	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. Table A	A 401		

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A 401	Continued From page 20	A 401		

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).

(b) A specialty care assisted living facility must be sufficiently staffed to ensure the safe

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A 401	Continued From page 21 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 assistants (CNAs) during an emergency staffing shortage. The facility failed to ensure employees were CPR	A 401		

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A 401	Continued From page 22	A 401		

(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. These deficient practices resulted in harm for at least three (3) residents (RI#1, RI#5, and RI#6) 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).

THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATIONS.

Findings:

There were two individually licensed 16 Bed SCALF buildings owned and managed by the same company located across the street from each other. They 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 three days onsite at the facility (February 22, 23, and 24, of 2022). During those three days, the surveyor observed the following staffing concerns.

On February 22, 2022, at approximately 4:45 AM, EI#17, agency care staff, was observed working the 7:00 PM to 7:00 AM shift alone. EI#17 told the surveyor the other care associate had gone home early. EI#17 told the surveyor she was CPR certified and her usual job was working in a children's day care center. EI#17 said she had not received any orientation or training to care for

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A 401	Continued From page 23	A 401		

residents with dementia symptoms. EI#17 had worked several shifts in the "sister" facility across the street, but had not worked in this facility before. EI#17 told the surveyor there was no nurse onsite but a nurse was available on call.

EI#17 told the surveyor EI#12 told her (EI#17) to call with any concerns, however EI#12 was working alone in the "sister" facility and if EI#12 left the "sister" facility to help EI#17, the "sister" facility would have been left unattended. EI#17 told the surveyor EI#12 had called and visited several times to ensure she (EI#17) was okay.

On February 22, 2022, EI#1 told the surveyor EI#3, RN, was responsible for scheduling and EI#1 was aware there had been a call -off for the night shift and EI#3 had been working on a replacement. EI#1 told the surveyor he did not follow-up with EI#3 to ensure the night shift was actually covered by the two minimum required employees. EI#3 did not report to EI#1 that the night shift had not been covered by 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 for February 21 through February 22, 2022, from 7:00 PM through 7:00 AM.

On February 22, 2022, the surveyor was told by EI#4 there was one LPN routinely scheduled to work a 12 hour day shift (7:00 AM - 7:00 PM) each day. The LPN was responsible for medication management for both 16 bed SCALF buildings which included physician and pharmacy phone calls, refilling medications, and administration and documentation of medications to the approximately 25 residents living in the two SCALF buildings. According to the LPN job

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A 401	Continued From page 24	A 401		

description the LPN was also responsible for monitoring resident care, resident safety, and changes in resident condition.

EI#4 told the surveyor 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 either 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 scheduled to work because the weekly resident medication replacement cycle was delivered by the pharmacy.

On February 22, 2022, EI#5 told the surveyor, "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."

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

On February 23, 2022, EI#18 told the surveyor she 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 (EI#18) was supposed to spend more time on activities. EI#18 told the surveyor the care associates were supposed to provide activities on the weekends when EI#18 wasn't working and also when EI#18 was busy with marketing tasks. EI#18 told the surveyor there were four (4)

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A 401	Continued From page 25 activities scheduled in each facility everyday, two (2) in the morning and two (2) in the evening. Review of the activity calendar showed only four activities scheduled for each day and the calendar did not specify which building. (Please refer to deficiency #612 for additional information.) PLEASE 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 both 16 bed SCALF's. On February 22, 2022, the surveyor observed the offices for EI#1 and EI#3 were in the front of the facility separated from the resident care areas. EI#1 and EI#3 also told the surveyor they made rounds in the "sister" facility across the street "frequently". On February 23, 2022, EI#1 told the surveyor he was responsible for the administrative duties and the business office directors duties for both facilities. After further investigation, 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. EI#3 was the care coordinator and RN for both facilities. After further investigation, the surveyor determined EI#3 was unable or unwilling to perform all of the required job duties for both facilities. Please refer to deficiency #405 for additional information. On December 06, 2021, RI#6's hospice nurse documented in her hospice notes that RI#6 was removed from the facility due to the lack of	A 401		

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A 401	Continued From page 26 adequate end of life care. The hospice nurse also documented that RI#6 did not have a sponsor or family to give him/her the 24 hour support RI#6 required during the actively dying process. Please refer to deficiency #606 for additional information. On March 03, 2022, RI#7's sponsor told the surveyor the hospice nurse wanted to train him/her to provide end of life comfort care, including medication administration of Ativan and morphine, to RI#7. RI#7's hospice nurse said facility staff were unable or unwilling to provide the care. RI#7's sponsor said he/she was not a licensed nurse or physician. Please refer to the deficiency #613 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 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 405		

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A 405	Continued From page 27 (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. This Rule is not met as evidenced by: Based on observation, record review, and interview, the RN/Care Coordinator failed to perform the required duties to ensure every	A 405		

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A 405	Continued From page 28	A 405		

residents' care needs were met. This deficient practice resulted in actual harm for at least three (3) residents (RI#1, RI#5, and RI#6) and placed the remaining nine (9) residents living in the facility at risk for significant harm.

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

Findings:

The following RN/Care Coordinator concerns were identified and confirmed with EI#1 and EI#2 during separate interviews.

EI#3, RN, did not accurately assess residents to identify combative behaviors and significant changes in health status.

On February 23, 2022, The records for RI#1 and RI#2 were reviewed with EI#1 and EI#2.

RI#1

RI#1 was admitted to the facility on February 18, 2021, with diagnoses which included Alzheimer's dementia, and type II diabetes. RI#2's physician medical examination dated February 16, 2021, documented RI#1 required "prompts to eat".

RI#1 suffered a significant weight loss of 14.9% of RI#1's total body weight (from 127 pounds to 108 pounds) in just two (2) months (between December 2021 and February 2022). RI#1's significant weight loss resulted in harm to RI#1 and was not addressed on RI#1's care plan. There was also no documentation that RI#1's physician had been notified of RI#1's significant weight loss.

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RI#1 suffered 12 falls between February 2021, and February 2022, with injuries including skin tears and head injuries which required emergency room evaluation and treatment. RI#1's care plan documented interventions for the multiple falls, however, the care plan interventions were not followed as evidence by three falls in the courtyard, and repeated falls in the facility due to RI#1's not using his/her walker or asking for assistance.

RI#2

RI#2 was admitted to the facility on November 24, 2021, with diagnoses which included dementia with behavior disturbance and Alzheimer's disease. RI#2 had such combative behaviors and erratic behaviors towards their sponsor, that on February 15, 2022, RI#2 pushed his/her sponsor causing the sponsor to hit his/her head on RI#2's dresser. The push with subsequent fall into the dresser resulted in a head injury that required emergency care. This incident was not addressed on RI#2's care plan. RI#2's record contained a written statement dated February 15, 2022, that EI#1 had agreed to allow RI#2 to return to the facility after RI#2's treatment at the behavioral health center.

EI#8 told the surveyor the RI#2 had combative behaviors of hitting when RI#2 didn't want to do something. EI#8 also told the surveyor RI#2 was aggravated by RI#2's sponsor.

RI#2's behaviors were not identified or addressed on RI#2's care plan with individualized interventions. RI#2 had a generic behavior management care plan which documented the same interventions the surveyor observed documented on nearly every resident behavior

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and a while."

RI#6 suffered actual harm as evidenced by the lack of appropriate end of life care and RI#6's symptoms of anxiety and restlessness.

On December 07, 2021, at approximately 8:00 PM, RI#6 died at the local hospital.

RI#7

EI#3, RN/Care Coordinator, did not ensure RI#7 had appropriate end of life care. EI#3 did not ensure RI#7's comfort or provide emotional support for RI#7's sponsor during RI#7's dying process.

On March 03, 2022, RI#7's sponsor told the surveyor RI#7's hospice nurse trained him/her to provide RI#7's Ativan intrabuccally (medication is put in the cheek to dissolve) and morphine sublingually (medication placed under the tongue) because the hospice nurse said he/she didn't think facility staff could be counted on to provide RI#7's medications as needed. The facility did not provide a nurse to work 24 hours a day to meet the special care needs of end of life care including assessing the dying resident for pain and medication administration.

RI#7's sponsor told the surveyor he/she was not a nurse or a physician but was willing to do "whatever was necessary to ensure (RI#7) had the care (RI#7) required." RI#7's sponsor went on to say that after RI#7 passed away and while he/she and EI#17 were waiting for the funeral home to arrive, EI#4, LPN, showed up at the nurses station in pajamas and slippers. RI#7's sponsor said he/she did not know EI#4 was even in the facility. EI#4, LPN, asked RI#7's sponsor if

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he/she needed anything and then EI#4 said, "well I'm going back to bed." RI#7's sponsor said he/she did not know where EI#4 was sleeping. EI#4 did not tell RI#7's sponsor or EI#17 she (EI#4) was in the facility and available if needed.

EI#3 did not ensure care plan interventions were developed, followed, evaluated for effectiveness, or individualized as evidenced by record review and interviews with care associates and resident sponsors. Please refer to deficiency #611 for additional information.

EI#3 did not identify and address employee training needs. Please refer to deficiency #406 for surveyor identified training needs.

EI#3 did not properly supervise the LPN employees to ensure medication keys were properly managed, medications were properly managed, and controlled medications were properly accounted for by two employees on each shift. Please refer to deficiencies #601, #613, #615, and #616 for additional information.

On February 22, 2022, at approximately 4:45 AM, EI#17, agency care staff, was observed working the 7:00 PM to 7:00 AM shift alone. EI#17 told the surveyor the other care associate had gone home early. EI#17 said she (EI#17) was CPR certified and her usual job was to work in a children's day care center. EI#17 told the surveyor she (EI#17) had not received any orientation or training to care for residents with dementia. EI#17 said she had worked several shifts in the "sister" facility, but had not worked in this facility before.

EI#17 told the surveyor EI#12 told her (EI#17) to call EI#12 with any concerns. However EI#12 had been working alone in the "sister" facility. If EI#12

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left the "sister" facility to help EI#17, the "sister" facility would have been left without any employees in the "sister" facility during EI#12's absence. EI#17 told the surveyor EI#12 had called and visited her (EI#17) several times to ensure EI#17 was okay.

On February 22, 2022, EI#1 told the surveyor EI#3, RN, was responsible for scheduling and EI#1 was aware that an employee had called off that night. EI#1 said he did not follow up with EI#3 to ensure there was a minimum of at least two (2) employees working each shift as required by the SBOH rules for a SCALF. EI#3 also did not ensure appropriate agency replacement employees were certified nurse aides (CNAs). The lack of training contributed to an increased risk for abuse and neglect of residents with dementia symptoms living in the facility.

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.

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A 405	Continued From page 34 Review of the Wellness Director (RN/Care Coordinator) job description revealed the following responsibilities and duties were required: direct supervision of community based licensed nursing staff, assigns and directs work of subordinates, provides training, supervision, and monitoring of associates in the administration of medications; provides training to resident care associates on an ongoing basis; supervises the maintenance of resident charts; assess health and psycho-social status of residents initiate individualized care plans, 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; evaluates residents document 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 chart; 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, etc. are scheduled and followed through; assists in 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	A 405		

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A 405	Continued From page 35 to have knowledge of and maintain compliance with the SBOH rules and regulations for a SCALF as they pertain to the RN job duties. During the survey EI#1 and EI#2 told the surveyor during separate interviews that they had identified problems with EI#3's lack of job performance.	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, and exploitation.	A 406		

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A 406	Continued From page 36 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 specialty care assisted living facility shall be	A 406		

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A 406	Continued From page 37 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 residents with dementia symptoms. This deficient practice affected all 12 residents living in	A 406		

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A 406	Continued From page 38 the facility and placed the residents at risk for significant harm. THIS IS A REPEAT DEFICIENCY FROM SURVEYS COMPLETED ON DECEMBER 20, 2018 (previous deficiency #429). THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATIONS. Findings: The surveyor identified the following employee training needs: (please refer to the deficiency identified in parentheses for additional information) - Proper medication management including controlled medications, storage, administration, and documentation. (Deficiencies #615 and #616) - Proper management of all employees with accountability for their actions including nurses and department directors. (Deficiencies #401, #405, #604) - Ensuring accurate assessments of residents and appropriate individualized care plan interventions to meet resident care and safety needs. (Deficiency #611) - How to implement and follow policies and procedures. (deficiency #302) - How to identify ineligible residents. (Deficiencies #606 and #621) - How to identify and follow-up on significant health changes in residents. (Deficiency #611) - The importance of developing an appropriate activity program which promoted good mental health while also preventing behaviors and boredom. (Deficiency #612) - Appropriate end of life care and symptom management. (Deficiency #606)	A 406		

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A 406	Continued From page 39 On February 24, 2022, the surveyor and EI#1 reviewed the list of current employees and identified 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 and EI#1 did not have documentation that EI#3 and EI#4 were currently CPR certified. EI#3 and EI#4 were both full time nurses.	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. 3. Every resident shall have the right to be treated with consideration, respect, and due	A 504		

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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.

9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No

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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 confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice.

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A 504	Continued From page 42 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 admission, of all rules and regulations governing residents' conduct and responsibilities.	A 504		

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A 504	Continued From page 43 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 too large to be stored in the resident's room. 22. Every resident shall have the right to	A 504		

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A 504	Continued From page 44 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 provide a safe and decent environment for all residents. This deficient practice resulted in actual harm for three (3) residents (RI#1, RI#5, and RI#6) and placed the remaining nine (9) residents at risk for significant harm. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. Findings: The governing authority owned and operated two individually licensed 16 bed SCALF facilities located across the street from each other. The two buildings were not connected by a common hallway. However, the two separate facilities shared a single employee who was responsible for duties normally performed by at least two or more employees in similar facilities throughout	A 504		

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A 504	Continued From page 45 the state. The facility did not provide the minimum number of required employees 24 hours a day seven (7) days a week. The facility did not utilize certified nurse assistants (CNAs) during an emergency staffing shortage which meant the emergency employees were not properly trained to care for residents with dementia symptoms. The facility did not ensure employees were CPR (cardiopulmonary resuscitation) certified within 90 days of hire. The facility also did not properly manage employees to ensure resident care needs were provided for and safety needs were met. These deficient practices resulted in actual harm for at least three residents (RI#1, RI#5, and RI#6) and placed the remaining nine (9) residents at risk for significant harm. 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 special 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 was EI#1 for staffing needs. The facility had a single employee in the following positions who was responsible for duties in two	A 504		

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individually licensed 16 bed SCALF buildings. EI#1 was responsible for all of the duties required by the administrator's job description and the business manager's job description. EI#3 was responsible for all of the duties required by the RN job description and also the Care Coordinator job description. The LPN was responsible for all of the duties listed in the LPN job description. The LPN was expected to go between the two separate facilities throughout the day and provide quality care to all of the residents in both buildings. EI#18 was responsible for all of the duties described in the activity job description and the sales/marketing job description. The care associates were responsible to provide resident supervision to prevent accidents or behaviors, resident care, resident showers, housekeeping services, laundry services, meal service, and activities with only minimal direct supervision by nursing or administrative employees.

Medication Storage - The licensed practical nurses (LPNs) did not follow the policies, procedures, or industry standards for medication storage, controlled medication management, and medication administration. The surveyor observed the nurses left the medication room and the medication cart unlocked and unsupervised at various times throughout the survey. These unlocked/unsupervised medication storage areas were in areas where residents, staff and visitors had access to all of the medications including the controlled medications. The medication cart keys, which included the key to controlled medications,were observed hanging on a hook in the unlocked/unsupervised medication room or laying on top of the medication cart. Please refer to deficiency #616 for any additional information.

Medication administration - EI#7 was observed

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administering medications to residents without comparing the medication unit dose packets with the resident's MAR (medication administration record). Medications including controlled medications were not documented contemporaneously. Please refer to deficiencies #601, #613, #615, and #616 for additional information.

Controlled medications - The facility did not ensure controlled medications in the custody of the facility were properly accounted for by at least two employees on each shift. The facility had five different controlled medication counts that were inaccurate and documented more tablets were available than the actual number of tablets that were in the facility's custody. Please refer to deficiency #616 for additional information.

EI#3, RN, did not complete timely and accurate assessments, behavior screens, and physical self maintenance scales (PSMS) to identify resident care and safety needs. EI#3 also did not document communication with administration when residents did not meet admission or retention criteria. This deficient practice resulted in actual harm suffered by RI#1, RI#5, and RI#6. RI#6's hospice notes documented EI#3 told RI#6's hospice nurse that the hospital had sent RI#6 back to the facility before EI#3 completed an assessment of RI#6 .RI#6 was not eligible for readmission or retention in the facility due to a PSMS score of 25 which exceeded the allowable score of 23. Please refer to deficiencies #405, #606, and #611 for additional information.

EI#3 did not develop care plans with resident specific and appropriate care interventions to address the resident's care and safety needs. The RN also did not update and evaluate the

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effectiveness of the care plan interventions in place for each resident. Please refer to deficiency #611 for additional information.

The facility administrator and RN did not adhere to the admission, retention, and continued stay criteria policies and procedures, which allowed ineligible residents to be readmitted or retained in the facility. These deficient practices resulted in actual harm for RI#6 and placed the remaining 11 residents at risk for significant harm from RI#2 with known combative behaviors. Please refer to deficiencies #606 and #621 for additional information.

On February 02, 2022, EI#1 reported an allegation of physical abuse by EI#19 involving a resident of the "sister facility" (Kelley Place).

During RI#6's hospice record review, the surveyor identified a suspicious pattern of injuries suffered by RI#6. The suspicious injuries suffered by RI#6 were as follows and the information was provided to the surveyor as part of RI#6's hospice records and the facility's online incident reports to ADPH.

RI#6 was admitted to the facility on approximately September 10, 2021, with diagnoses which included dementia.
- On October 18, 2021, (RI#6) was found on the floor in RI#6's room at approximately 8:30 PM with periorbital hematoma/bruising and swelling of the right eye and abrasion on the right side of the face.
- On October 26, 2021, (eight days after the previous incident) (RI#6) was found on the floor in RI#6's room at approximately 7:28 PM with bilateral nasal bone fractures, laceration above the right eyebrow, and abdominal pain.
- On October 31, 2021, (five days after the

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previous incident) RI#6 was found on the floor in another resident's room at approximately 8:30 AM. RI#6 sustained a closed head injury, contusion, fracture, and medium hematoma on the left posterior side of RI#6's head. There was old bruising to the right eye. The local ER physician even documented that RI#6 had been in the ER with the exact same complaints the previous week.
- On November 04, 2021 - (four days after the previous incident) RI#6 fell in the dining room. A CT Scan for RI#6 documented a "large frontal scalp hematoma", an "acute right nasal bone fracture" and a left eye laceration.
- On November 29, 2021, (three days after readmission to the facility from the hospital) RI#6 was observed with a laceration above RI#6's left eye with swelling and bruising of the left eye and bruising on the left side of RI#6's abdomen. There was no online incident report for this injury.

In addition, RI#6 developed a pressure ulcer of the right, second toe (date unknown) which progressed to a Stage III pressure ulcer with cellulitis of the right foot. As a result of the wound and cellulitis, RI#6 required hospitalization between November 18 and November 26, 2021. When RI#6 returned to the facility on November 26, 2021, RI#6's PSMS score was 25 which exceeded the allowable score of 23, meaning RI#6 was ineligible for readmission to the facility. RI#6 also still had a pressure sore on the right second toe which required skilled nursing care.

The facility did not provide adequate staffing for residents who required end of life care. The facility expected families and sponsors to provide 24 hour end of life care and medications to actively dying residents with dementia symptoms, anxiety, and pain. Please refer to deficiencies

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A 504	Continued From page 50 #606 and #613, for additional information. The facility did not honor the residents' right to have visitors without having to make an appointment. On February 21, 2022, the surveyor spoke with an anonymous complainant who told the surveyor he/she was told by the facility that he/she could not visit a resident unless an appointment was made at least two (2) hours before visiting the facility. During all the days of the survey, the surveyor did not see a sign posted on the facility which required sponsors to make an appointment for resident visits. On March 03, 2022, a sponsor told the surveyor there was a sign on the facility's front door telling all visitors to make an appointment at least two (2) hours before visiting. The sponsor went on to tell the surveyor, "it was very difficult to get anyone to answer the phone to even make an appointment." On March 03, 2022, RI#7's sponsor told the surveyor that he/she and other visitors for RI#7 had to make an appointment at least two hours before coming to visit RI#7.	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	A 508		

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A 508	Continued From page 51 within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review. 1. Incidents which require investigation are: (i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as extensive bruising, pain, or injury that is not consistent with actions necessary in providing day-to-day care to a resident or for which medical treatment was sought. (ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid including but not limited to a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office. (iii) The onset of wandering behavior by any resident who is not fully cognitively intact. (iv) Elopement by a resident. (v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. (vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules. (vii) Suspected, alleged, confessed,	A 508		

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A 508	Continued From page 52 witnessed, or actual exploitation of a resident or residents as defined in these rules. (viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or Staphylococcus aureus). (ix) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (xi) An unplanned occurrence that results in media attention. (xii) A medication error, overdose, or over sedation. (xiii) Ingestion by a resident of a toxic substance that requires medical attention. (xiv) Any indication of malfunction of the sprinkler system, or fire alarm system. 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.	A 508		

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A 508	Continued From page 53 (ii) Names of all staff involved including person in charge at the time of the incident. (iii) When the administrator was notified (date and time). (iv) Circumstances under which the incident occurred. (v) When the incident occurred (date and time). (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken. (viii) The extent and description of injury, if any, to the affected resident or residents. (ix) Immediate treatment rendered. (x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified. (xi) Names, telephone numbers, and addresses of witnesses. (xii) Date and time relatives or sponsor were notified. (xiii) Out-of-facility treatment. (xiv) Follow-up care. (xv) Outcome resolution.	A 508		

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A 508	Continued From page 54 (xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future. (xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation. (xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request. (xix) The entire investigative file and documentation of all corrective action taken shall be retained for a period of not less than 3 years after the resident is discharged or dies. (xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff. 3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident: (i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention. (ii) Elopement by a resident. (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	A 508		

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abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file.

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

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

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

(vii) Any medication error, overdose, or over sedation. The incident shall be immediately reported to the attending physician, facility medical director, or back-up physician.

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

(ix) Notifiable diseases and health conditions listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04. shall also be reported by the facility to the State Health 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

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A 508	Continued From page 56 not less than three years. (x) Any indication of a malfunction of the sprinkler system, fire alarm system, or a door locking device. 4. The report to the Department's Online Incident Reporting System shall include the following: (i) Facility name and direct phone number. (ii) Time and date of the report. (iii) Reporter's name. (iv) Name of resident(s), staff, or visitor(s) involved in the incident. (v) Names of staff on duty at the time of the incident. (vi) Date and time of the incident. (vii) A brief description of the incident. (viii) Any injury or injuries to resident(s). (ix) Action taken by the facility in response to the incident. (i) Vital Statistics Reports. A record shall 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	A 508		

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A 508	Continued From page 57 such forms as the State Board of Health shall provide to the county health officer, or in counties without a county health officer, to the State Registrar. This report shall be in addition to the official birth, death, and stillbirth certificates. If there are no births, deaths, or stillbirths in any month, a report shall be made stating that fact to the county health officer. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report at least one resident who tested positive for Covid and also failed to report a resident incident with injuries. This deficient practice had the potential to affect all 12 residents living in the facility. Findings: On February 21, 2022, the surveyor reviewed the online incident reports for the facility and did not find any recent Covid reports. The facility's most recent Covid positive report to ADPH was on approximately January 14, 2021, for one employee. 1. RI#7 was admitted to the facility on approximately November 04, 2021, with diagnoses which included stage four kidney disease and dementia. On February 22, 2022, at approximately 5:13 AM, the surveyor observed an empty room with an isolation set up outside the door. EI#17 told the surveyor that (RI#7) had died earlier in the shift. EI#17 was not aware of any residents who were	A 508		

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A 508	Continued From page 58 positive for Covid. On March 03, 2022, RI#7's sponsor told the surveyor RI#7 had tested positive for Covid on February 18, 2021. There was no online incident report to ADPH from the facility regarding RI#7's positive Covid test result. 2. On November 26, 2021, RI#6 was readmitted to the facility from the local hospital. On November 29, 2021, RI#6's hospice record documented that RI#6, was observed in the facility with a laceration, swelling, and bruising of RI#6's left eye. RI#6 also had bruising on the left side of RI#6's abdomen. There was no online incident report for this injury.	A 508		
A 601	420-5-20-.06 (1) Care of Residents. (1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician. (a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her choice. If the resident is unable to designate an attending physician, or does not wish to designate an attending physician, the facility shall assist the resident in identifying an attending physician who will serve the resident. A resident shall be permitted to change the designation of his or her attending physician at any time. Whenever a resident requires medical attention, an attempt shall first be made to contact the resident's attending physician, except in medical emergencies requiring activation of the local EMS system (911 or other emergency call).	A 601		

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A 601	Continued From page 59 (b) Back-up Physician Support. Each specialty care assisted living facility shall have an agreement with one or more duly licensed physicians to serve in those instances when a resident's own attending physician cannot be reached, and to provide temporary medical attention to any resident whose attending physician is temporarily not available. A nurse practitioner or physician's assistant shall not serve as the back-up physician in a specialty care assisted living facility. (c) All physician orders shall be written in accordance with community standards. If verbal orders are used, they are to be used infrequently. A physician verbal order shall only be accepted by an RN or LPN employed by the facility and authorized to do so by facility policy and procedures and state law. All verbal orders shall be reduced to writing on the physicians' order sheet by a licensed facility nurse and shall be dated and signed by the nurse receiving the order. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, or another practitioner who is responsible for the care of the resident and authorized to write orders by facility policy. All verbal orders must be authenticated within such time period as provided by facility policy, but in no case shall exceed 30 days following entry of the order. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow physician medication orders for management of a resident's medical symptoms. This deficient practice resulted in actual harm for RI#5 and placed the	A 601		

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A 601	Continued From page 60	A 601		

remaining 11 residents at risk for significant harm.

Findings:

On February 22, 2022, at approximately 7:03 AM, the surveyor with EI#5, observed medications for RI#5 that were not unit dose packaged by a pharmacy. EI#4 told the surveyor RI#5 had run out of medications on February 21, 2022. EI#4 said RI#5's sponsor put medications in Ziplock bags for each AM and PM dose, until the sponsor could get RI#5's medications unit dose packaged by the pharmacy.

RI#5 was admitted to the facility on approximately August 21, 2021, with diagnoses which included a stroke with right side paralysis, aphasia, high blood pressure, and type II diabetes. RI#5's record documented RI#5's physician had ordered the following medications for the treatment of RI#5's medical conditions.

Eliquis 5 milligrams (mg) every day (for prevention of blood clots);
Keppra 750 mg twice a day (for prevention of seizures);
Metformin 500 mg every night at bedtime (for blood sugar control);
Gabapentin 300 mg twice a day (for nerve pain symptoms);
Tylenol 500 mg twice a day (for mild pain).

On February 22, 2022, at approximately 6:58 AM, the surveyor reviewed RI#5's MAR with EI#5. The review revealed there was no documentation that RI#5 had received any of his/her medications on February 19 and 20, 2022.

On February 22, 2022, at 7:03 AM, the surveyor and EI#5 observed three Ziplock bags labeled

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(morning) medications and four Ziplock bags labeled (evening) medications.

On February 23, 2022, at approximately 4:30 PM, the surveyor attempted to talk with RI#5. RI#5 became tearful during the conversation. The surveyor attempted to console RI#5 by patting RI#5 on the shoulder, but RI#5 pulled away and winced with pain. The surveyor asked RI#5 to show the surveyor where RI#5's pain was located. RI#5 demonstrated that he/she had pain all over RI#5's body, arms, and legs.

On February 23, at approximately 4:43 PM, the surveyor reviewed RI#5's record and MAR with EI#20. The surveyor discussed the surveyor's observations and concerns about RI#5's lack of adequate pain management with EI#20 in the facility's conference room.

On February 24, 2022, at approximately 10:57 AM, the surveyor and EI#20 observed there were two (2) Ziplock bags labeled as RI#5's morning medications and four (4) bags of medications labeled as RI#5's evening medications. There had been no other medications delivered for RI#5. It is unknown what happened to the two (2) Ziplock bags labeled as morning medications for RI#5, as EI#4 and EI#5 both told the surveyor they had not given the medications to RI#5. Due to aphasia and RI#5's frustration, RI#5 was unable to tell the surveyor if he/she had received his/her medications. RI#5 did not have any pharmacy filled, unit dose medications in the facility. There was no documentation in RI#5's record that RI#5's physician had been notified that RI#5 was not getting his/her medication.

On March 02, 2022, the surveyor spoke with RI#5's sponsor's spouse regarding RI#5 and the

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A 601	Continued From page 62 missing medications. RI#5's sponsor's spouse told the surveyor he/she had put medications in Ziplock bags until they could get RI#5's medications unit dose packaged. RI#5's insurance had been allowed to lapse, and the sponsor was working with RI#5's previous employer, insurance company, and the pharmacy to get medications filled for RI#5, "but it was a difficult process". Please refer to deficiency #302 for additional information related to the facility's policy and procedures.	A 601		
A 604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility RN or care coordinator shall screen prospective residents for eligibility for admission into the specialty care assisted living facility. The screening shall include a clinical history, a mental status examination to include aphasia screening, a geriatric depression screen, a physical self-maintenance screen, and a behavior screen. Appendix A herein, contains the Physical Self Maintenance Scale (PSMS) form and the Behavior Screening form. These forms shall be completed to screen physical functioning and behaviors. The PSMS and Behavior Screen assessments shall be completed by the RN or care coordinator upon admission, annually, and when there is a change in the resident's status. The facility RN shall perform a	A 604		

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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 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

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A 604	Continued From page 64 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 record review and interview, the facility failed to provide adequate health supervision to identify and address resident health status changes. This deficient practice resulted in actual harm for at least two (2) residents (RI#1 and RI#5) and placed the remaining 9 residents at risk for significant harm.	A 604		

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A 604	Continued From page 65 Findings: RI#1 RI#1 was admitted to the facility on February 18, 2021, with diagnoses which included Alzheimer's dementia, and type II diabetes. RI#1's physician medical examination dated February 16, 2021, documented RI#1 required "prompts" to eat. In December 2021 RI#1's monthly weight was 127 pounds. In January 2022, RI#1 weighed 112 pounds and had suffered a significant weight loss of 14.6 pounds or 11.8% of RI#1's total body weight in just 30 days. In February 2022, RI#1 lost an additional four pounds and weighed just 108 pounds. RI#1 sustained a significant weight loss of 18.6 pounds or a 14.9% of RI#1's total body weight in just 60 days. RI#1's weight loss had not been identified by the RN, documented as reported to RI#1's physician, and had not been documented with individualized interventions to prevent further weight loss on RI#1's care plan. On February 22, 2022, EI#8 told the surveyor RI#1's behaviors included being "combative" with care at times, incontinent at times, and that RI#1 would take things out of other residents' rooms. These behaviors were not documented on RI#1's care plan and no interventions had been formulated to address these issues. RI#2 RI#2 was admitted to the facility on November 24, 2021, with diagnoses which include dementia with behavioral disturbance. RI#2's behavior screen documented RI#2 was taking medications for behaviors. RI#2's physician medical examination	A 604		

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and care plan did not specify the type of behaviors and no interventions were formulated to address RI#2's behaviors.

On February 15, 2022, RI#2's spouse arrived at the facility to visit. RI#2 pushed his/her spouse which caused RI#2's spouse to hit his/her head on a dresser resulting in a head injury that required emergency care.

RI#2's record contained a written statement dated February 15, 2022, that EI#1 had agreed to allow RI#2 to return to the facility after treatment in the behavioral health care center.

On February 22, 2022, EI#8 told the surveyor RI#2 had "combative" behaviors. EI#8 also told the surveyor RI#2's spouse was constantly telling RI#2 what to do and it "aggravated" RI#2. RI#2's care plan did not document RI#2's combative behaviors and did not have individualized care plan interventions to address RI#2's combative behaviors. RI#2's combative behaviors placed the other 11 residents living in the facility at risk for significant harm.

On February 22, 2022, EI#1 told the surveyor there were no residents who had been issued a 30 day discharge notice from the facility.

RI#5

RI#5 was admitted to the facility on August 21, 2021, with diagnoses which included cerebrovascular accident with right side paresis, aphasia, and type II diabetes.

On February 22, 2022, EI#4 told the surveyor RI#5 had run out of medications on February 21, 2022. RI#5 required medications throughout the

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A 604	Continued From page 67 day for management of seizures, blood pressure control, blood clot prevention, blood glucose levels, and pain. (please refer to deficiency #601 for additional details). On February 23, 2022, the surveyor observed RI#5 was still out of unit dose packaged medications and was suffering from pain all over his/her body. RI#5 could not even tolerate the surveyors gentle touch on RI#5's shoulder in an attempt to console RI#5 who had become tearful during an interview with the surveyor. Later that same day, the surveyor reviewed RI#5's record and MAR with EI#20 to discuss the surveyor's concerns of RI#5's lack of adequate pain management. The surveyor and EI#20 reviewed RI#5's record and MAR in the conference room. EI#20 told the surveyor he would look into RI#5's pain situation. On February 24, 2022, at approximately 10:20 AM, the surveyor observed and spoke with RI#5, who was still having pain. EI#20 verified RI#5's record and MAR were still in the conference room and that RI#5 had not received his/her evening medications (including Tylenol, Eliquis, Keppra, Gabapentin, and Metformin) for February 23, 2022, or RI#5's morning medications (including Amlodipine, Tylenol, Vitamin D, Gabapentin, Eliquis and Keppra) for February 24, 2022. On March 02, 2022, RI#5's sponsor's spouse told the surveyor RI#5's insurance had accidentally been allowed to lapse which meant RI#5 was having to pay privately for all of his/her medications and care services. RI#5's sponsor's spouse also told the surveyor they were having difficulty dealing with RI#5's previous employer to get RI#5's medications and the insurance situation resolved.	A 604		

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A 604	Continued From page 68 Please refer to deficiency #302 for additional information related to the facility's policy and procedures.	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, EI#3, RN, did not accurately assess residents to identify combative behaviors and significant changes in health status. This deficient practice resulted in actual harm for RI#1 and placed the remaining 11 residents at risk for significant harm. Findings: On February 23, 2022, the records for RI#1 and	A 605		

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A 605	Continued From page 69 RI#2 were reviewed with EI#1 and EI#2. RI#1 was admitted to the facility on February 18, 2021, with diagnoses which included Alzheimer's dementia and type II diabetes. RI#1 suffered a significant weight loss of 14.9% of RI#1's total body weight (from 127 pounds to 108 pounds) in just two (2) months (between December 2021 and February 2022). RI#1's significant weight loss resulted in actual harm and was not identified in the RN's monthly assessment or documented on RI#1's care plan with appropriate individualized interventions. RI#2 was admitted to the facility on November 24, 2021, with diagnoses which included dementia with behavior disturbance and Alzheimer's disease. RI#2 had such erratic behaviors towards his/her sponsor that on February 15, 2022, RI#2 pushed his/her sponsor causing RI#2's sponsor to hit his/her head on RI#2's dresser resulting in a head injury that required emergency care. This incident was not addressed with individualized interventions on RI#2's care plan. On February 22, 2022, EI#8 told the surveyor RI#2 had combative behaviors of hitting when RI#2 didn't want to do something. EI#8 also told the surveyor RI#2 was aggravated by RI#2's sponsor. RI#2 did not have a 30 day discharge notice from the facility. In fact, there was a written statement dated February 15, 2022, in RI#2's record that EI#1 had agreed to allow RI#2 to return to the facility after RI#2's treatment at the behavioral health center. RI#2's combative behaviors placed the other 11 residents at risk for significant harm.	A 605		

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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 605	Continued From page 70 Please refer to deficiency #302 for additonal information related to the facility's policy and procedures.	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 record review and interview, the facility readmitted a resident who had care and safety needs which exceeded the facility's admission criteria. This deficient practice resulted in actual harm for RI#6 as evidence by RI#6's symptoms of pain and anxiety. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON DECEMBER 20, 2018. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATIONS. Findings: RI#6 was admitted to the facility on approximately	A 606		

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A 606	Continued From page 71 September 10, 2021, with diagnoses which included dementia. RI#6 developed a pressure ulcer of the right second toe (date unknown) while living in the facility. RI#6's pressure ulcer progressed to a Stage III ulcer with tendons and connective tissue observed and documented by the hospital physician on November 18, 2021, as well as cellulitis of RI#6's right foot which required hospitalization between November 18 through November 26, 2021. On November 26, 2021, the facility readmitted RI#6 from the local hospital with diagnoses which included dementia, and a pressure ulcer on the right second toe. On November 26, 2021, RI#6's PSMS assessment score totaled 25 and RI#6 was ordered hospice care services that same day. There was no 30 day discharge notice documented in RI#6's closed record even though RI#6 did not meet continued stay criteria by having a PSMS score greater than 23. On November 29, 2021, RI#6's hospice RN documented, EI#3, RN, told RI#6's hospice nurse that RI#6 had been sent back to the facility without EI#3 assessing RI#6 for readmission. RI#6 was also readmitted to the facility with a Foley catheter. RI#6 was unable to sit up without support, RI#6 was lethargic and was considered NPO (nothing by mouth) due to aspiration risk determined by the hospital's speech therapist (ST), according to RI#6's hospice records. RI#6's hospice records documented on November 30, 2021, RI#6 had a physician's order for soft/pureed diet due to aspiration risk. RI#6 remained in the facility until December 06, 2021, when RI#6's hospice RN had RI#6 transferred to a local hospital for appropriate end	A 606		

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A 606	Continued From page 72 of life care. On December 06, 2021, RI#6's hospice RN documented in RI#6's hospice record that RI#6 was found non-responsive, legs drawn up in fetal position, noticeably pale fingers, hands cool and cyanotic, mottling on knees. The facility nurse was unaware of RI#6's condition. RI#6 "moaned when position (was) changed, wearing two (2) briefs and wet (incontinent of urine), lethargic with five (5) second apneic periods. RI#6's mouth was very dry with cracked skin on lips." RI#6's hospice nurse was unable to monitor RI#6's blood oxygen saturation due to RI#6's cyanotic fingers. RI#6 did not have any family to provide comfort medications and the facility nurse said that he/she could come to the facility once in a while. On December 07, 2021, at approximately 8:00 PM, RI#6 died at the local hospital. RI#6 - On February 22, 2022, at approximately 10:20 AM, RI#6's hospice aide told the surveyor the hospice aide had arrived at the facility and found RI#6 lying in bed with no sheets, no clothes, anxious and restless. RI#6's hospice aide also told the surveyor RI#6 required total assistance with all ADL's and was incontinent of bowel and bladder. The hospice aide went on to say that RI#6's hospice nurse had found RI#6 in that same condition a few days later and the hospice RN had RI#6 transferred to the local hospital for appropriate end of life care. RI#6 suffered actual harm as evidenced by the lack of appropriate end of life care and RI#6's symptoms of anxiety and restlessness. Please refer to deficiency #302 for additional	A 606		

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A 606	Continued From page 73 information related to the facility's policy and procedures.	A 606		
A 611	420-5-20-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. The RN shall develop written plans of care for each resident prior to or at the time of admission. The plans of care shall be based on resident's assessments, diagnoses, and recommendations of the resident's physician. The plan of care shall be developed in cooperation with the resident, if appropriate, and the sponsor. The RN shall identify resident care problem areas and formulate written interventions to address those problems. The RN shall evaluate the implementation of the interventions and the resident's response to the interventions and modify the plan of care as necessary. 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.	A 611		

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A 611	Continued From page 74 3. A listing of interventions provided by the facility to address the resident's identified needs or problems. 4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider. 5. Activities of Daily Living. Residents of a specialty care assisted living facility shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident. (i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested. (ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips. (iii) Hair. Residents' hair shall be kept clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be	A 611		

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A 611	Continued From page 75 provided assistance with personal safety. 6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on record review and interview, EI#3, RN, failed to accurately assess residents to identify combative behaviors and significant changes in health status. This deficient practice resulted in actual harm for RI#1 and placed the remaining 11 residents at risk for significant harm. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON DECEMBER 20, 2018. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATIONS. Findings: RI#1 On February 23, 2022, RI#1's record was reviewed with EI#1 and EI#2. RI#1 was admitted to the facility on February 18, 2021, with diagnoses which included Alzheimer's dementia, and type II diabetes. RI#2's physician medical examination dated February 16, 2021, documented RI#1 required "prompts to eat". RI#1 suffered a significant weight loss of 14.9% of RI#1's total body weight (from 127 pounds to	A 611		

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A 611	Continued From page 76	A 611		

108 pounds) in just two (2) months (between December 2021 and February 2022). RI#1's significant weight loss was not addressed in RI#1's plan of care. There were no interventions implemented to prevent RI#1 from sustaining further weight loss which caused harm to RI#1.

RI#1's care plan documented approximately 12 falls between February 18, 2021, and February 01, 2022. RI#1 was identified as a fall risk on February 18, 2021.

-On February 20, 2021 - RI#1 was ambulating without his/her walker. RI#1's care plan documented staff were to remind RI#1 to use his/her walker. This intervention was not appropriate for a resident with symptoms of dementia.

- On February 25, 2021 - RI#1 fell while unsupervised in the courtyard. RI#1 hit his/her head and suffered a "large open hematoma" to the back of the head. RI#1's care plan documented RI#1 was to be supervised by staff when RI#1 was in the courtyard. RI#1's injuries were not addressed on RI#1's care plan.

- On April 01, 2021 - RI#1 fell in his/her room - RI#1's care plan documented staff were to encourage RI#1 to keep his/her room door ajar.

- On June 02, 2021 - RI#1 fell in the courtyard a second time. (RI#1's care plan was not followed by staff). RI#1's care plan documented staff were to ensure RI#1 had his/her walker at all times when in the courtyard.

- On August 03, 2021 - RI#1 fell in the courtyard a third time.(RI#1's care plan was not followed). RI#1's fall resulted in a "small" laceration to

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A 611	Continued From page 77 RI#1's forehead. RI#1's care plan documented staff were to remain at RI#1's side while RI#1 was in the courtyard. RI#1's injuries were not addressed on RI#1's care plan. - On August 07, 2021 - RI#1 fell. There were no injuries documented. RI#1's care plan documented staff were to ensure RI#1 had his/her belongings close. - On September 06, 2021 -RI#1 fell. There were no injuries documented. RI#1's care plan documented RI#1 was educated to call out if he/she was walking without his/her walker. This intervention was not an appropriate intervention for a resident with symptoms of dementia. - On October 08, 2021 - RI#1's physician was notified that RI#1 had a skin tear to the left upper arm. RI#1's injury was not addressed on RI#1's care plan. - On October 09, 2021 - RI#1's home health nurse notes documented it took four (4) people to provide wound care to RI#1's skin tear. A facility nurse used a regular gauze dressing instead of a non-stick dressing on RI#1's skin tear and the gauze stuck to RI#1's wound. Removing the gauze dressing was painful and added to RI#1's combative behavior. RI#1 threatened to hit the home health nurse. RI#1's home health nurse documented EI#3, RN, "tried to calm" (RI#1) and "actually caused (RI#1) to become (more) angry and combative." - On October 14, 2021 - RI#1 fell. There were no injuries documented. RI#1's care plan documented staff were encouraged to leave RI#1's bathroom light on at night.	A 611		

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A 611	Continued From page 78 - On November 07, 2021 - RI#1 was found on the floor in his/her room. RI#1 was bleeding from back of his/her head. RI#1's care plan documented RI#1 would be assessed for foot problems and proper foot care. - November 29, 2021 - RI#1 fell. There were no injuries documented. RI#1's care plan documented RI#1 would call out for help if walking without his/her walker. Again, this was not an appropriate intervention for a resident with symptoms of dementia. - February 01, 2022 - RI#1 fell. There were no documented injuries. RI#1's care plan documented staff would ensure RI#1 had non-skid footwear. RI#1's home health nurse repeatedly documented RI#1 was observed wearing a short sleeve shirt, even after the home health nurse's repeated requests for facility staff to place a long sleeve shirt on RI#1. The home health nurse stated a long sleeve shirt could help prevent reoccurring skin tears on RI#1's arms. This intervention was not implemented or documented on RI#1's care plan, even though the home health nurse documented she had spoken with EI#3 about adding the long sleeve shirt as an intervention. RI#1's behavior screen dated February 15, 2022, documented "verbally aggressive, hitting, destructive to self and property, wanders/paces. RI#1's care plan did not identify RI#1's behaviors and there were no interventions to address RI#1's behaviors. RI#2	A 611		

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A 611	Continued From page 79 RI#2 was admitted to the facility on November 24, 2021, with diagnoses which included dementia with behavior disturbance and Alzheimer's disease. RI#2 had such erratic and combative behaviors towards his/her sponsor, that on February 15, 2022, RI#2 pushed RI#2's sponsor and caused the sponsor to hit his/her head on RI#2's dresser which resulted in a head injury that required emergency care. This incident was not addressed on RI#2's care plan. On February 22, 2022, EI#8 told the surveyor RI#2 had combative behaviors of hitting when RI#2 didn't want to do something. EI#8 also told the surveyor RI#2 was aggravated by RI#2's sponsor. RI#2's behaviors were not identified or addressed on RI#2's care plan with individualized interventions. RI#2 had a generic behavior management care plan with the same interventions seen documented on nearly every resident behavior care plan in the facility. RI#3 RI#3 was admitted to the facility on February 03, 2020, with diagnoses which included neurocognitive disorder, dementia, gout, psychosis, and PTSD (post traumatic stress disorder). On February 22, 2022, EI#8 told the surveyor RI#3 would wander into other resident rooms and sleep in other resident's beds. These behaviors were not described or addressed on RI#3's care plan.	A 611		

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A 611	Continued From page 80 RI#5 RI#5 was admitted to the facility on August 21, 2021, with diagnoses which included aphasia, cerebrovascular accident with right side paresis/weakness, type II diabetes, and high blood pressure. RI#5's was admitted to the facility on multiple types and routes of pain medication, including Fentanyl patches, Tylenol, Gabapentin, and Vitamin D (can help with some types of pain). The Fentanyl patches had been discontinued by the facility physician on an unknown date. On February 22, 2022, the surveyor observed that RI#5 was in so much pain that he/she could not tolerate a gentle touch on RI#5's shoulder. RI#5 demonstrated he/she was experiencing pain all over RI#5's body. On February 23, 2022, the surveyor with EI#20, discovered that RI#5 had not been receiving his/her routinely scheduled medications for pain including Gabapentin twice a day, Tylenol twice a day, and Vitamin D once a day since at least February 21, 2022. RI#5 had a care plan for pain, which included an intervention to give medications as ordered by the physician. This care plan intervention had not been followed between February 21, and February 23, 2022. RI#6 RI#6 was admitted to the facility on September 10, 2021, with diagnoses which included dementia. RI#6's physician medical examination dated September 08, 2021, documented RI#6 had "severe dementia" and required assistance	A 611		

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A 611	Continued From page 81	A 611		

with all ADL's except ambulation and transfers. RI#6's care plan documented RI#6 had four falls between September 10, 2021 and November 04, 2021. There were no injuries from RI#6's falls documented on RI#6's care plan.

RI#6 had the following injuries documented in RI#6's hospice and hospital records. None of the following injuries were documented on RI#6's care plan.

- On October 18, 2021, periorbital hematoma, bruising and swelling of the right eye and abrasion on the right side of the face.
- On October 26, 2021, (eight days after the previous incident) bilateral nasal bone fractures, laceration above the right eyebrow, and abdominal pain. The local ER physician even documented that RI#6 had been in the ER with the exact same complaints the previous week.
- On October 31, 2021, (five days after the previous incident) RI#6 had a closed head injury, contusion, fracture, and medium hematoma on the left posterior side of RI#6's head, with old bruising to the right eye.
- On November 04, 2021 - (four days after the previous incident) a CT Scan for RI#6 documented a "large frontal scalp hematoma", an "acute right nasal bone fracture" and left eye laceration.
- On November 29, 2021, (three days after readmission to the facility from the hospital) a laceration above RI#6's left eye with swelling and bruising of the left eye and bruising on the left side of RI#6's abdomen.

RI#6 also developed a pressure ulcer of the right second toe (date unknown) which progressed to cellulitis of the right foot and required hospitalization between November 18 and

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A 611	Continued From page 82 November 26, 2021. When RI#6 returned to the facility on November 26, 2021, RI#6's PSMS score exceeded 23 which meant that RI#6 was ineligible for readmission to the facility. RI#6 also still had a pressure sore on the right second toe which required skilled nursing care. RI#6 started receiving hospice services on November 26, 2021. The pressure ulcer and hospice services were not documented on RI#6's care plan. On February 23, 2022, when asked about the problems with the RN care plans and assessments, EI#1 and EI#2 both told the surveyor during separate interviews, they had problems with EI#3's poor job performance. Please refer to deficiency #302 for additional information related to the facility's policy and procedures.	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 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	A 612		

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A 612	Continued From page 83 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 to prevent or deter wandering behaviors while also promoting mental and physical wellness. This deficient practice affected all 12 residents living in the facility. THIS IS A REPEAT DEFICIENCY FROM A SURVEY COMPLETED ON DECEMBER 20, 2018.	A 612		

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A 612	Continued From page 84 THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATIONS. Findings: During the three days onsite (February 22, 23, and 24, 2022), the surveyor did not observe any activities led by employees. The surveyor observed that residents spent most of their day sitting in front of the television, looking around the room, or asleep when they weren't involved with care or meals. On February 23, 2022, the surveyor asked EI#18 if there were specific activity plans developed for residents with wandering behaviors. EI#18 told the surveyor she had "activities for everyone, not just the residents who wandered". 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 said there were two (2) activities scheduled for mornings and two (2) activities scheduled for evenings. 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 to provide activities on the weekends and when EI#18 was busy with marketing tasks.	A 612		
A 613	420-5-20-.06 (5) (a) (b) (c) (d) (e) Care of Residents. (5) Medications. (a) Medications, as defined in these rules, shall be prescribed specifically for the	A 613		

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A 613	Continued From page 85 resident by an individual currently licensed to prescribe medications in Alabama. A currently licensed physician in good standing with the Medical Licensure Commission of any state may prescribe medications to a resident of an assisted living facility only during the initial physical examination. (b) A physician order is required for a resident to manage and have custody of his or her own medications. (c) A resident may have custody of and manage over the counter topical medications with the written approval of a physician. A physician order is not required for over the counter topical medications that are self-administered by residents and approved by the physician for resident possession. (d) Medication administration, as defined in these rules, shall be conducted only by a physician or an RN or LPN. An RN or LPN shall administer medications to residents in the specialty care assisted living facility only in accordance with physician orders and the Nurse Practice Act. (e) A current copy of A Short Practical Guide for Psychotropic Medications in Dementia Patients or the equivalent shall be in each specialty care assisted living facility as a reference guide. This Rule is not met as evidenced by: Based on observations, record review, and	A 613		

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A 613	Continued From page 86	A 613		

interview, the facility failed to ensure resident medications were only administered by a nurse or physician. The facility also failed to ensure resident medications were managed and administered in accordance with the nurse practice act and facility policies and procedures. This deficient practice affected six residents and placed the remaining six (6) residents at risk for significant harm.

Findings:

On February 22, 2022, at 7:11 AM, the surveyor completed a controlled medication count with EI#6. There were four different controlled medications that had not been properly accounted for. EI#6 verified with the surveyor that the pill counts did not match the sign-out sheets for the medication. EI#6 told the surveyor she had been out sick the previous week and this was her (EI#6) first day back. The shift to shift count sheets were only signed by one nurse except for three or four days a month when both nurses were scheduled to work.

RI#3's Haldol 5 mg count sheet showed 30 half tablets were received, then two half tablets were administered. The Haldol count sheet documented the count increased to 58 tablets with no explanation for the increase. The next entry showed the number of tablets decreased to 55 tablets with no explanation for the decrease. RI#3's Haldol count was adjusted by the nurse without any explanation. RI#3's Haldol count adjustment also only documented a single nurse signature instead of two signatures which is how controlled medication adjustments are typically documented to ensure there is no no drug diversion.

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A 613	Continued From page 87 RI#7's Ativan 0.5 mg count sheet documented 29 tablets available, however the medication card contained only 26 tablets (3 Ativan tablets were unaccounted for). - RI#7's Perocet 5/325 mg tablets documented 27 tablets available, however the medication card contained only 25 tablets (2 Percocet tablets were unaccounted for). - RI#10's Xanax 0.5 mg count sheet documented there were 19 tablets available, however the medication card contained only 18 tablets (one Xanax tablet was unaccounted for). During the three days of the survey (February 22, 23, and 24, 2022), the surveyor observed the nurses leave the medication room and the medication cart unlocked and unsupervised at various times throughout the survey. These unlocked/unsupervised medication storage areas, which included controlled medications, were accessable to residents and any other person in the facility. The surveyor observed the medication cart keys, including the controlled medication key, hanging on a hook in the unlocked/unsupervised medication room or laying on top of the medication cart. On February 22, 2022, between 8:07 AM and 8:40 AM, the surveyor observed EI#7 administer medications to residents without checking the medication unit dose packets against the resident 's MAR. Medications including controlled medications were also not documented contemporaneously during observations of EI#7. (Please refer to deficiency # 615 for more details) The facility did not ensure RI#7 had appropriate end of life medication support, provided by a	A 613		

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A 613	Continued From page 88 licensed nurse, to promote RI#7's comfort during the dying process. On March 03, 2022, RI#7's sponsor told the surveyor RI#7's hospice nurse trained him/her to provide RI#7's Ativan intrabuccally (medication is put in the cheek to dissolve) and morphine sublingually (medication placed under the tongue). RI#7's hospice nurse told RI#7's sponsor that she (RI#7's hospice nurse) didn't think the facility staff could be counted on to provide RI#7's medications as needed. The facility did not provide a nurse to meet the special care needs, including medication administration, of the RI#7 during the dying process. The facility did not ensure RI#7's sponsor was supported during this difficult time. RI#7's sponsor went on to tell the surveyor he/she was not a nurse or a physician but was willing to do "whatever was necessary" to ensure RI#7 reveived the care he/she needed. RI#7's sponsor went on to say that after RI#7 passed away, while he/she and EI#17 were waiting for the funeral home to arrive, EI#4, LPN, showed up at the nurses station in pajamas and slippers. RI#7's sponsor said he/she did not know that EI#4 was even in the building. RI#7's sponsor said, EI#4, LPN, asked him/her if he/she needed anything, and then EI#4 said, "well I'm going back to bed." RI#7's sponsor said he/she did not know where EI#4 had been sleeping, but EI#4 had not told RI#7's sponsor or EI#17 that (she) EI#4 was in the facility and available if needed. Please refer to deficiency #302 for additonal information related to the facility's policy and procedures.	A 613		

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A 615	Continued From page 89	A 615		
A 615	420-5-20-.06 (5) (h) Care of Residents. (5) Medications. (h) All medications administered to residents in a specialty care assisted living facility, shall be contemporaneously recorded on a standard medication administration record. "Contemporaneously recorded" means recorded at the same time or immediately after medications are administered. The medication administration record shall include at least the following: 1. The name of the resident to whom the medication was administered. 2. The name of the medication administered. 3. The dosage of the medication administered. 4. The method of administration. 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.	A 615		

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A 615	Continued From page 90 This Rule is not met as evidenced by: Based on observation and record review, the facility failed to ensure nurses contemporaneously recorded all medications administered to residents. Findings: On February 22, 2022, between approximately 8:30 AM and 8:40 AM, the surveyor observed EI#7, LPN, administer medications to RI#4, RI#10, RI#11, and RI#12 without utilizing the residents' MAR. The surveyor also observed that EI#7 did not individually record each resident's medication administration. After EI#7 administered medications to all four residents, EI#7 then returned to the MARs to record that the medications had been given. EI#7 did not contemporaneously record medication administration as required. On February 22, 2022, EI#1 and EI#2 agreed EI#7 should have documented the medications for each resident at the time the medications were given. Please refer to deficiency #302 for additional information related to the facility's policy and procedures.	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	A 616		

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A 616	Continued From page 91	A 616		

maintained by the facility in unit dose packaging. Medications kept under the control or custody of the specialty care assisted living facility that are not available in unit dose packaging must be packaged by the pharmacy and administered by a physician, RN, or LPN.

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

(k) If controlled substances prescribed for residents of any specialty care assisted living facility are kept in the custody of the specialty care assisted living facility, they shall be stored in a manner that is compliant with state and federal laws, the requirements of the Alabama State Board of Pharmacy, and any requirements prescribed by the Alabama State Board of Health. At a minimum, controlled substances in the custody of the facility shall be stored using a double lock system, under proper temperature and humidity controls and permit only authorized personnel access. The facility shall maintain a

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A 616	Continued From page 92 system to account for all controlled substances in its possession. All other medications in the custody of the facility shall be stored using at least a single lock, under proper temperature and humidity controls and permit only authorized personnel access. This shall include medications stored in a resident's room when the staff and not the resident have access to the medications. Medications may be kept in the custody of an individual resident who can safely manage his or her medications. Such medications may be stored in a locked container accessible only to the resident and staff, or may be stored and secured in the resident's living quarters, if the room is single occupancy and has a locking entrance. (l) Medication administration records and written physician orders for all over-the-counter drugs, legend drugs, and controlled substances shall be retained for a period of not less than 3 years. They shall be available for inspection and copying on demand by agents of the State Board of Health. They shall be made available for inspection at reasonable times by residents, anyone authorized by the resident, and by the sponsors of residents. (m) Labeling of Drugs and Medicines. All containers of prescribed medicines and drugs shall be labeled in accordance with the rules of the Alabama State Board of Pharmacy and shall include appropriate cautionary labels, such as, "Shake Well," or "For External Use Only." This Rule is not met as evidenced by: Based on observation, record review, and	A 616		

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A 616	Continued From page 93	A 616		

interview, the facility failed to properly manage all resident medications under the facility's custody. This deficiency had the potential to affect all 12 residents living in the facility.

THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATIONS.

Findings:

On February 22, 2022, the surveyor observed RI#5's medications were not in unit dose packages labeled by the pharmacy. EI#4 told the surveyor RI#5 had run out of medications and RI#5's sponsor put RI#5's medications in Ziploc bags. There was one large Ziploc bag with RI#5's name on it that contained four other Ziplock bags with "AM" or "PM" written on the bags in black marker. EI#4 told the surveyor RI#5 ran out of medications on February 21, 2022.

The surveyor observed the shift to shift controlled count sheets contained only one nurse signature for all but three (3) or four (4) days during the month.

On February 22, 2022, the surveyor with EI#6, observed the following resident controlled medication counts were inaccurate.

- RI#3's Haldol 5 mg count sheet showed 30 half tablets were received from the pharmacy. Two half tablets were documented as administered to RI#3. The next entry documents RI#3's Haldol increased to 58 tablets with no explanation as to where the additional tablets came from. Next, a decrease to 55 tablets was documented. RI#3's Haldol count sheet did not contain an explanation as to where the three tablets went. The count

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A 616	Continued From page 94 was adjusted without any explanation. Only one nurse's signature was documented for each "adjustment" instead of two nurse signatures which is the industry standard to ensure there is no drug diversion. - RI#7's Ativan 0.5 mg count sheet documented 29 tablets available, however the medication card contained only 26 tablets (3 Ativan tablets were unaccounted for). - RI#7's Perocet 5/325 mg tablets documented 27 tablets available, however the medication card contained only 25 tablets (2 Percocet tablets were unaccounted for). - RI#10's Xanax 0.5 mg count sheet documented there were 19 tablets available , however the medication card contained only 18 tablets (one Xanax tablet was unaccounted for). EI#6, LPN, told the surveyor she had been out sick for the past week and had no idea why the controlled medication counts were inaccurate. EI#6 said maybe someone forgot to sign the medications out last week. Please refer to deficiency #302 for additional information related to the facility's policy and procedures.	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	A 621		

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A 621	Continued From page 95 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 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	A 621		

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A 621	Continued From page 96 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 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 record review and interview the administrator retained residents who were ineligible for retention or continued stay. This deficient practice resulted in harm to at least three (3) residents (RI#1, RI#2, and RI#6), and placed the remaining nine (9) residents at risk for significant harm.	A 621		

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A 621	Continued From page 97 THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATIONS. Findings: RI#1 RI#1 was admitted to the facility on February 18, 2021, with diagnoses which included Alzheimer's dementia, and type II diabetes. RI#1's physician medical examination dated February 16, 2021, documented RI#1 required "prompts to eat". RI#1 suffered a significant weight loss of 14.9% of RI#1's total body weight (from 127 pounds to 108 pounds) in just two (2) months between December 2021 and February 2022. The facility's failure to address RI#1's significant weight loss with a plan of care resulted in harm to RI#1. RI#1's care plan documented approximately 12 falls between February 18, 2021, and February 01, 2022. RI#1 was identified as a fall risk on February 18, 2021. RI#1 suffered harm from numerous falls and injuries due to inadequate supervision. RI#1's injuries included skin tears and head injuries. - On February 20, 2021 - RI#1 was ambulating without his/her walker. RI#1's care plan documented staff were to remind RI#1 to use his/her walker. This was not an appropriate intervention for RI#1 who had dementia symptoms. - On February 25, 2021 - RI#1 fell while unsupervised in the courtyard. RI#1 hit his/her head and suffered a "large open hematoma" to the back of the head. RI#1's care plan	A 621		

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documented RI#1 was to be supervised by staff when in the courtyard. RI#1's injuries were not addressed on RI#1's care plan.

- On April 01, 2021 - RI#1 fell in his/her room. RI#1's care plan documented staff were to encourage RI#1 to keep RI#1's room door ajar.

- On June 02, 2021 - RI#1 fell in the courtyard for a second time. RI#1's care plan was not followed, there was no supervision of RI#1. RI#1's care plan documented staff were to ensure RI#1 had his/her walker at all times when in the courtyard.

- On August 03, 2021 - RI#1 fell in the courtyard for a third time.(RI#1's care plan was not followed). RI#1's fall resulted in a "small" laceration to RI#1's forehead. RI#1's care plan documented staff were to remain at RI#1's side while RI#1 was in the courtyard. RI#1's injuries were not addressed on RI#1's care plan.

- On August 07, 2021 - RI#1 fell. There were no injuries documented. RI#1's care plan documented staff were to ensure RI#1 had his/her belongings close by.

- On September 06, 2021 -RI#1 fell. There were no injuries documented. RI#1's care plan documented RI#1 was educated to call out if he/she was walking without a walker. This intervention was not appropriate for a resident with memory problems related to dementia.

- On October 08, 2021 - RI#1's physician was notified that RI#1 had skin tear to his/her left upper arm. RI#1's injury was not addressed on RI#1's care plan.

- On October 09, 2021 - RI#1's home health

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nurse notes documented it took four (4) people to provide wound care to RI#1's skin tear. The facility nurse used a regular gauze dressing instead of a non-stick dressing on RI#1's skin tear causing the gauze to stick to RI#1's wound. The gauze was painful to remove. RI#1 threatened to hit the home health nurse. RI#1's home health nurse documented EI#3, RN, "tried to calm" (RI#1) and "actually caused (RI#1) to become (more) angry and combative."

- On October 14, 2021 - RI#1 fell. There were no injuries documented. RI#1's care plan documented staff were encouraged to leave RI#1's bathroom light on at night.

- On November 07, 2021 - RI#1 was found on floor of RI#1's room. RI#1 was bleeding from the back of his/her head. RI#1's care plan documented RI#1 would be assessed for foot problems and proper foot care.

- November 29, 2021 - RI#1 fell. There were no injuries documented. RI#1's care plan documented RI#1 should call out for help if walking without RI#1's walker. This same intervention was documented after a fall on September 6, 2021, and was no appropriate for a resident with a diagnosis of dementia.

- February 01, 2022 - RI#1 fell. There were no documented injuries. RI#1's care plan documented staff would ensure RI#1 had non-skid footwear.

RI#1's home health RN repeatedly documented RI#1 was observed wearing a short sleeve shirt. The home health nurse documented she repeatedly requested that facility staff place a long sleeve shirt on RI#1 to prevent reoccurring

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skin tears on RI#1's arms. This intervention had not been documented on RI#1's care plan, even though the home health nurse documented he/she had spoken with EI#3, RN, regarding the request for RI#1 to wear a long sleeve shirt.

RI#1's behavior screen dated February 15, 2022, documented "verbally aggressive, hitting, destructive to self and property, wanders/paces. RI#1's care plan did not identify RI#1's behaviors and there were no interventions to address RI#1's behaviors.

RI#2

RI#2 was admitted to the facility on November 24, 2021, with diagnoses which included dementia with behavior disturbance and Alzheimer's disease.

RI#2 had such erratic and combative behaviors towards his/her sponsor, that on February 15, 2022, RI#2 pushed his/her sponsor causing the sponsor to hit his/her head on RI#2's dresser. The incident resulted in a head injury to the sponsor that required emergency care. This incident was not addressed on RI#2's care plan. RI#2's record contained a statement, dated February 15, 2022, which documented EI#1 had agreed to allow RI#2 to be readmitted to the facility following RI#2's treatment at the behavior health facility.

On February 22, 2022, EI#8 told the surveyor RI#2 had combative behaviors of hitting when RI#2 didn't want to do something. EI#8 also told the surveyor RI#2 was aggravated by RI#2's sponsor.

RI#2's behaviors were not identified or addressed

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on RI#2's care plan with individualized interventions. RI#2 had a generic behavior management care plan with the same interventions seen documented on nearly every resident behavior care plan in the facility.

RI#2's combative behaviors placed the remaining 11 residents at risk for significant harm.

RI#6

RI#6 was admitted to the facility on approximately September 10, 2021, with diagnoses which included dementia. RI#6 developed a pressure ulcer of the right, second toe (date unknown) while living in the facility. RI#6's pressure ulcer progressed to cellulitis of RI#6's right foot which required hospitalization between November 18 through November 26, 2021.

On November 26, 2021, the facility readmitted RI#6 from the local hospital with diagnoses which included dementia, and a pressure ulcer on the right second toe. On November 26, 2021, RI#6's PSMS assessment score totaled 25 and RI#6 was started on hospice care services that same day. There was no 30 day discharge notice documented in RI#6's closed record even though RI#6 no longer met continued stay criteria with a PSMS score greater than 23. RI#6 remained in the facility until December 06, 2021, when RI#6's hospice RN had RI#6 transferred to a local hospital for appropriate end of life care.

On December 06, 2021, RI#6's hospice RN documented in RI#6's hospice record that RI#6 was found non-responsive, legs drawn up in fetal position, noticeably pale fingers, hands cool and cyanotic and mottling on his/her knees. The facility nurse was unaware of RI#6's condition.

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RI#6 "moaned when position (was) changed, wearing two (2) briefs and wet (incontinent of urine), lethargic with five (5) second apneic periods. RI#6's mouth was very dry with cracked skin on lips." RI#6's hospice nurse was unable to monitor RI#6's blood oxygen saturation due to RI#6's cyanotic fingers. RI#6 did not have any family to provide comfort medications and the facility nurse said that she could only come to the facility once in a while.

On December 07, 2021, at approximately 8:00 PM, RI#6 died at the local hospital.

RI#6 - On February 22, 2022, at approximately 10:20 AM, RI#6's hospice aide told the surveyor he/she arrived at the facility and found RI#6 lying in bed with no sheets, no clothes, anxious and restless. RI#6's hospice aide also told the surveyor RI#6 required total assistance with all ADL's and was incontinent of bowel and bladder. The hospice aide went on to say that RI#6's hospice nurse had found RI#6 in that same condition a few days later. RI#6's hospice nurse had RI#6 transferred to the local hospital for appropriate end of life care.

RI#6 suffered harm as evidenced by the lack of appropriate end of life care and RI#6's symptoms of anxiety and restlessness.

RI#7

The facility did not ensure RI#7 had appropriate end of life medication support by a licensed nurse to promote RI#7's comfort during RI#7's end of life and dying process.

On March 03, 2022, RI#7's sponsor told the surveyor RI#7's hospice nurse trained him/her to

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A 621	Continued From page 103 provide RI#7's Ativan intrabuccally (medication is put in the cheek to dissolve) and morphine sublingually (medication placed under the tongue). RI#7's hospice nurse told RI#7's sponsor he/she didn't think the facility staff could be counted on to provide RI#7's medications as needed. The facility did not provide a nurse to work 24 hours a day to meet the special care needs of RI#7 and his/her sponsor at the end of life. RI#7's sponsor told the surveyor he/she was not a nurse or a physician but was willing to do "whatever was necessary" to ensure RI#7 had what he/she needed. RI#7's sponsor went on to say that after RI#7 passed away, and while he/she and EI#17 were waiting for the funeral home to arrive, EI#4, LPN, showed up at the nurses station in pajamas and slippers. RI#7's sponsor said he/she didn't even know that EI#4 was in the building. EI#4 asked RI#7's sponsor if he/she needed anything. RI#7's sponsor said EI#4 then said, "well I'm going back to bed." He/she (sponsor) did not know where EI#4 had been sleeping, but EI#4 had not told RI#7's sponsor or EI#17 that she (EI#4) was in the facility and available if needed. Please refer to deficiency #302 for additional information related to the facility's policy and procedures.	A 621		
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)	A 805		

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A 805	Continued From page 104 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 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 ensure the furniture in the common living room was maintained in good repair so that it	A 805		

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A 805	Continued From page 105 could be properly cleaned. The carpet in the hallway by the laundry room was soiled with feces. This deficient practice affected all 12 residents living in the facility. Findings: On February 22, 2022, the surveyor observed a brown stain on the carpet in the hallway by the laundry room. EI#17 told the surveyor she cleaned up a bowel movement from the hallway carpet the best she (EI#17) could with the supplies available. The furniture in the common living room had vinyl covering that was cracked and worn which could not be properly cleaned. EI#17 told the surveyor she had placed a sheet on the couch to sit on to keep her uniform clean.	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	A1002		

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A1002	Continued From page 106 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 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.	A1002		

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This Rule is not met as evidenced by:
Based on observation and interview, the facility failed to ensure all poisons and chemicals were properly secured or supervised at all times. The facility also failed to provide adequate housekeeping and maintenance services to ensure a safe and sanitary environment. This deficient practice had the potential to affect all 12 residents.

Findings:

There was a brown stain on the hallway carpet by the laundry room. EI#17 told the surveyor she cleaned up a resident's bowel movement the best she (EI#17) could with the supplies that were available to her.

On February 22, 2022, at approximately 6:42AM, the surveyor with EI#1, observed the panic hardware on the two courtyard doors was rusty. The surveyor observed the courtyard was accessible to the residents throughout the day.

On February 22, 2022, the surveyor with EI#1, observed the beauty shop was unsecured and unsupervised. The beauty shop contained various bottles and cans of poisons and chemicals including one partially filled can of Aquanet hairspray with a warning label that documented the contents were flammable.

EI#1 agreed the beauty shop should have been secured. EI#17 told EI#1 the beauty shop was unlocked when EI#17 arrived at the facility at 7:00 PM.

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A1204	Continued From page 108	A1204		
A1204	420-5-20-.12 (6) Physical Environment. (6) Building Requirements - Group Specialty Care Assisted Living Facilities. (a) General. Group specialty care assisted living facilities licensed, constructed, or renovated shall be limited to one story buildings and shall comply with the currently adopted building code and National Fire Protection Association, Life Safety Code. Facilities, or portions of facilities, built under the currently adopted codes shall comply with the Life Safety Code Chapter for New Residential Board and Care Occupancies (excluding NFPA 101A Alternative Approaches to Life Safety). Facilities, or portions of facilities, built under previously adopted editions of the codes shall comply with the currently adopted Life Safety Code Chapter for Existing Residential Board and Care Occupancies (excluding NFPA 101A Alternative Approaches to Life Safety). (b) Required Fire Exits. 1. At least two exits, remote from each other and so located that there will be no dead-end corridors in excess of 20 feet, shall be provided. 2. Exits shall be so located that the distance of travel from the corridor door of any occupied room to an exit shall not exceed 100 feet. 3. Each bedroom or suite shall have at least one doorway opening directly to the outside, or to an exit corridor leading directly to the outside.	A1204		

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A1204	Continued From page 109 4. Exit doors shall swing to the exterior. 5. Panic hardware shall be installed on all exit doors, except where electrically controlled door hardware is used in accordance with other provisions of these rules. (c) Corridors and Passageways. Corridors and passageways used as a means of exit, or part of a means of exit, shall be at least 36 inches wide, shall be unobstructed, and shall not lead through any room or space used for a purpose that may obstruct free passage. (d) Smoke Barrier Separations. 1. Buildings exceeding 3,000 square feet in area shall be divided into separate areas by smoke barriers so located as to provide ample space on each side for approximately one-half the beds. Smoke barriers shall have a fire-resistive rating of not less than one hour or minimum one-half hour for existing sprinkled facilities. 2. Doors provided in smoke barriers shall be smoke-resistive, so installed that they may normally be kept in the open position, but will close automatically upon fire alarm activation. 3. Duct penetrations in smoke barriers shall be properly protected with smoke dampers. 4. Penetrations of smoke barriers with wiring, conduits, pipes, etc., shall be sealed to maintain the fire and smoke rating.	A1204		

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A1204	Continued From page 110 This Rule is not met as evidenced by: Based on observation and interview the facility failed to properly maintain doors mounted in smoke barriers to be smoke resistive and close upon activation of the fire alarm. This deficient practice placed all 12 residents at significant risk for harm in the event of fire. Findings: On February 24, 2022, at approximately 9:43AM, EI#1 activated the pull station and sounded the fire alarm. The surveyor and EI#1 observed that one of four smoke/fire doors did not properly close to resist the passage of smoke in the event of a fire. The smoke/fire door was located next to the laundry room. The smoke/fire door did not close because the door did not fit squarely in the door frame. The door left a gap approximately six (6) inches wide between the door frame and the door. The surveyor and EI#1 observed scratched paint on the door frame where the door had been rubbing. EI#1 agreed the door needed to be adjusted to fit properly in the door frame so the door would close. TONYA AVENATTI, REGISTERED NURSE	A1204		