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A 000	Initial Comments	A 000		

On June 24, 2021, an unannounced licensure survey and complaint investigation was conducted for this 110 bed Assisted Living Facility (ALF) with a census of 31.

There was one (1) complaint investigated during this survey. Complaint Intake ID: 20210519004 was substantiated with deficiencies cited as a result of the investigation.

On August 16-17, 2021, the surveyors investigated two (2) incidences and one (1) complaint reported to the ALF Intake Tracking System. The census was 33 during this survey.

Intake ID20210809014 (transferred residents) and Intake ID20210812001 (death) were investigated and deficiencies were cited as a result of the investigation. Complaint Intake ID20210813021 (linked to the death as noted above) was substantiated and deficiencies were 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 420-5-4, Alabama Administrative Code, for Assisted Living Facilities. The deficiencies cited pose a potential risk of harm to the residents and requires a plan of correction.

A 301 — 420-5-4-.03 (1) (a) (b) (c) (d) Administration. — A 301

The Assisted Living Facility Governing Authority.

(a) An assisted living facility shall have an identified sole proprietorship, corporation, partnership, limited partnership, or other business

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entity that is its governing authority, or it shall have a designated individual or group of designated individuals who serve as its governing authority. A facility must give complete information to the Department identifying:

1. Each person who has an ownership interest of 10 percent or more of the governing authority.

2. Each person or entity who has an ownership interest of 10 percent or more in the real property or building used by the assisted living facility to offer its services.

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

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

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

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

(d) The governing authority is responsible for appointing and supervising the

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administrator who is responsible for overall management and the day-to-day operation of the facility. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the Governing Authority failed to properly supervise the Administrator to ensure the facility operated in compliance with the SBOH rules for ALFs. The Governing Authority's lack of adequate oversight and the Administrators' neglect to perform his duties resulted in failure to implement policies and procedures necessary to ensure the facility was managed responsibly and in compliance with SBOH rules for ALFs.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 14, 2016.

Findings:

The current Administrator, Employee Identifier (EI#1) had only been employed at the facility for approximately three months at the time of the survey. During an interview on June 24, 2021, EI#3, Regional Vice President/Governing Authority, reported he (EI#3) had terminated several Administrators due to failure to adequately perform the duties of the Administrator. Review of ADPH records confirmed EI#1 was the fifth administrator since May 2017 when the current Governing Authority began managing the facility. EI#3 further stated he (EI#3) was sure EI#1 was the right person for the job and would be able to fulfill the duties of the Administrator. EI#3 added he (EI#3) had

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plans to be present at the facility monthly but had been unable to do so due to the COVID-19 pandemic.

During an interview on the morning of June 24, 2021, EI#2, Regional Registered Nurse Consultant/Governing Authority, stated she (EI#2) had been employed as a consultant to the facility since December 2014. On June 22, 2021, EI#2 provided the surveyors with "RNC Visit" notes. EI#2 stated these documents were completed each time she (EI#2) visited the facility to provide oversight. The forms were dated March 18 and 19, 2021, May 4, 2021 and June 3, 2021.

On March 18, 2021, EI#2 reviewed the ALF resident records and documented the following non-compliance issues. Physician orders were not followed (widespread), Resident Service Plans were not updated or were missing and monthly assessments were not completed. EI#2 documented that the administrator placed the ALF nurse supervisor on an action plan related to the issues found by EI#2.

On May 4, 2021, EI#2 audited the personnel files and wrote in her (EI#2) report the ALF/SCALF staff was not in compliance with the following education; cardiopulmonary resuscitation (CPR), hospice, oxygen therapy, and diabetes. According to EI#2's, RNC Visit form, CPR, hospice and diabetes training were being scheduled by the Unit Coordinators for the assisted living and SCALF. There was no documentation to support the hospice special needs training had been completed.

On June 3, 2021, RNC Visit report documented dull and stained floors in need of striping, waxing and edging in both the ALF and the SCALF. This

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remained a deficiency at the time of the survey.

Although the above issues had been identified during visits by the Governing Authority prior to the survey, the deficient practices continued at the time of the survey. EI#2 stated, following each visit to the facility, she (EI#2) provided a copy of the visit report to the Administrator and to the Regional Vice President.

The facility was cited in 2016 for lack of oversight by the governing authority and again during the current survey. The administrator was cited in 2018 for failing to correct past deficiencies. The administrator was also cited during the current survey (2021) and the previous survey (2020) for improper management of the staffs activities. The facility has a history of not following their written policy and procedures as cited at the 2016 and 2018 surveys.

An anonymous ALF complaint was submitted to the Alabama Department of Public Health on May 19, 2021. The complaint included, oxygen safety concerns, blood glucose checks not performed as ordered, eye drops not given on time, lack of adequate staffing, ineligible residents, inadequate housekeeping and laundry services. These complaints were substantiated during the June 24, 2021 survey and most were repeat deficiencies from previous surveys.

Inadequate staffing to meet the care needs of the residents has been cited during the following surveys, July 2016, February 2020, and June 24, 2021. Medication assistance provided by the staff to residents has been out of compliance during the following surveys, July 2016, February 2018, February 2020, and June 24, 2021. The problems with the laundry room, laundry service, and

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cleanliness of the facility have been ongoing since 2018. Failure to properly perform fire drills was cited during the February 2020 survey and during the July 2016 survey and continued to be a deficient practice currently.

In February 2018, a resident required skilled nursing and the same deficient practice was found during the current survey. The facility was cited for failure to provide a safe and decent environment in February 2018 and again at the current survey. The Governing Authority's failure to ensure the Administrator adequately addressed these repeated deficiencies resulted in an unsafe, unsanitary and chaotic environment for all residents and placed the residents of the facility at risk of harm.

EI#3 reiterated to the surveyors his (EI#3's) confidence that EI#1 had the ability to regain and maintain compliance with SBOH rules for ALF at the facility. EI#3 stated he (EI#3) talks with EI#1 multiple times daily about issues and concerns as they arise at the facility.

ADPH's first contact with the owner was on July 7, 2021. The surveyor contacted EI#16, Owner, by phone on the morning of July 7, 2021. EI#16 stated he (EI#16) purchased the facility approximately four years ago and did not realize the facility was in trouble at that time. EI#16 stated he (EI#16) was made aware of the current deficiencies at the facility by EI#1 and assured the surveyor all identified deficiencies would be addressed. In regards to staffing, EI#16 stated COVID-19 had caused problems with maintaining adequate staff at the facility. In regards to the building deficiencies which had been an ongoing deficient practice, EI#16 stated he (EI#16) was sending a maintenance crew to the facility within

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the next two weeks and plans to have building issues addressed within 60 days. EI#16 verbalized a concern issues at the facility had not been communicated to him (EI#16) and, therefore, may not have been addressed. However, EI#16 added EI#1 now contacts him (EI#16) directly with concerns or needs instead of going through the Regional Vice President. Although he (EI#16) had made regular visits to the facility prior to the survey, EI#16 stated he (EI#16) now plans to visit more frequently.

The initial onsite visit for this survey was conducted from June 22-24, 2021, and resulted in the above findings. On August 16 and 17, 2021, an additional visit was conducted by surveyors for investigation of care following a fire at a skilled nursing facility (SNF), which was reported on August 9, 2021 to ADPH. The SNF was located on the same campus and owned by the same governing authority. As a result of the fire the governing authority made a decision to transfer some of the SNF residents to the assisted living facility (ALF) and to the SCALF. There were two (2) residents admitted to the ALF, increasing the census to 33. However, the admission process was incomplete and did not include required documents including, financial agreements, resident bill of rights, and inventory of personal effects. The residents had not been properly screened for tuberculosis for six (6) days after they were transferred on an emergency basis. The care plans were not devised until five (5) days after admission to the facility. The resident care assistants (RCA) did not have the necessary documentation (care plans) during that time to inform them (RCA) of the personal care and services required to care for the residents. In fact, the two (2) new residents did not receive physician ordered medications for up to six (6)

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A 301	Continued From page 7 days after the transfer. Inadequate staffing had been cited at the facility prior to admission of these two (2) additional residents. On August 16, 2021, EI#1 reported to surveyors he (EI#1) had been at the facility as long as 24 days straight due to unavailable staff. During the second onsite visit to the facility, surveyors also investigated a facility reported incident involving a resident's death, as well as, a complaint from family members about the death. The family reported the facility was negligent in caring for their family member. The complaint was substantiated and the facility was cited for not conducting wellness checks on all residents at least every two (2) hours. Deficient practices continued at the facility following the initial visit by surveyors. In fact, ten (10) of the 22 deficiencies cited pertain to resident care.	A 301		
A 302	420-5-4-.03 (1) (e) Administration. Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). All residents shall be informed of new policies or changes in existing policies that may have bearing on the residents. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies	A 302		

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shall cover the following:

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

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

(iii) Resident confidentiality.

(iv) Admission and continued stay criteria.

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

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

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

(viii) Medication management.

(ix) Infection control.

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

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

(xii) Staffing and conduct of staff while on duty.

(xiii) Oxygen administration and storage if used in the facility.

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(xiv) Dietary Policies. The dietitian, with the approval of the administrator, shall develop written policies and procedures for the guidance of all personnel handling food as outlined by the most current Food and Drug Administration Food Code published by the U.S. Department of Health and Human Services. The facility shall develop and implement dietary policies and procedures to meet the needs of the residents in the facility. In addition to other matters deemed necessary by the facility, dietary policies shall address:

(I) Sanitation of dishes, utensils, and service equipment, and sanitary food preparation and handling.

(II) The attire and cleanliness of staff members who prepare, handle, or serve food.

(III) A schedule of meals, which shall include between-meal nourishment or snacks, and fluids.

(IV) Food substitutions or alternatives.

(V) Method to ensure an adequate dietary plan is implemented for any resident with a therapeutic diet or special dietary needs.

(VI) Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food.

(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,

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ice, and eggs.

(IX) Storage of food.

(X) Procedure for food service in the event of a disaster. Disaster menus shall be developed. The policy shall address how food will be obtained and maintained at safe temperatures if electricity is not available.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to follow its own policies and procedures.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON FEBRUARY 28, 2018 AND ON JULY 14, 2016.

Findings:

Staffing

According to the facility's Staffing-ALF Policy and Procedure, "...The facility must be sufficiently staffed to ensure the evacuation of residents in the event of a fire or emergency...". The facility failed to ensure they were staffed to meet the safety needs of the residents on the 7 PM to 7 AM shift. Refer to deficiency 401 for additional information.

Screening of Employees

According to the facility's Employment Process Policy and Procedure, "...All prospective applicants are appropriately screened, reviewed and interviewed by Meadowood Retirement

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Village administrative staff. Only qualified applicants are selected for hire to Meadowood Retirement Village...Applicants will be screened prior to employment...Alabama Department of Public Health Nurse Aide Abuse Registry...T.B. Screening...Physician examination with physician certification that the individual is free of communicable diseases...". Employees were not properly screened prior to hire and prior to resident contact. Refer to deficiency 402 for additional information.

Medical Examination

According to the facility's Medical Exam and Physician's Plan of Care Policy and Procedure, "...The Medical Exam and Plan of Care shall include the following documentation:...A statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases....". At least one (1) resident did not have an infectious disease statement from the physician on the Medical Exam. Refer to deficiency 602 for additional information.

Discharge Criteria

According to the facility's Admission, Continued Stay & Discharge Criteria-ALF Policy and Procedure, "...Any resident that experiences an...acute condition requiring...skilled nursing care for more than ninety (90) days shall have arrangements made by the facility to discharge or transfer him/her to a safe and appropriate placement..". The facility retained a resident with known aspiration and who required thickened liquids. Refer to deficiency 606 for additional information.

Personal Care

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According to the facility's Personal Care-Activities of Daily Living Policy and Procedure, "...Residents shall be assisted and encouraged to maintain a clean well-kept appearance. The facility care staff shall provide all needed assistance, with activities of daily living to each resident...Personal Grooming Includes:...Cleansing and trimming nails...Nail care includes cleaning and regular trimming of the fingernails... they may require a nail brush or soaking...for stains to be removed. THIS IS ALWAYS PART OF THE BATH AND SHOULD ALWAYS BE CHECKED ON BATH DAYS...". The fingernails of all residents were not kept clean and trimmed. Refer to deficiency 611 for additional information.

Medication Administration

According to the facility's Medication Administration Policy and Procedure, "...Any resident who is not aware of his or her medications shall have medications administered only by an individual who is currently licensed......as a...RN or LPN...All medications shall be contemporaneously documented on the resident's medication administration record (MAR). (Contemporaneously means "occurring at the same time")...The MAR shall include ...the printed name and written signature of the individual administering the medication...". A visually impaired resident was given medications by a non-licensed employee. The nurses did not contemporaneously record medications administered or include their printed name and signature on the MAR. Refer to deficiencies 613 and 615 for additional information.

Medication Assistance

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According to the facility's Medication Assistance Policy and Procedure, "...Any resident requiring staff assistance with self-administration of medication must have a reasonable...understanding of the unit dose packaging system in use by the facility such that the resident could likely protect himself or herself from medication errors if unit dose packages are brought to the resident by facility staff...". A visually impaired resident was not provided a method to correctly identify the unit dose packaging system used by the facility. Refer to deficiency 614 for additional information

Laundry, Housekeeping and Maintenance

According to the facility's General Physical Plant Maintenance Policy, "...Housekeeping and maintenance services shall be provided to maintain a sanitary, orderly and comfortable interior...". Housekeeping, laundry and maintenance services were inadequate. Refer to deficiencies 901 and 1002 for additional information.

Fire Drills

According to the facility's Fire Drills, Fire Alarm System, Sprinkler and Fire Extinguisher Checks Policy and Procedure, "...Fire drills shall be conducted at least once per month, quarterly on each shift...A thorough evaluation of every fire drill shall be maintained by the administrator...". Fire drills were not conducted and documented as required. Refer to deficiency 1101 for additional information.

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A 303	Continued From page 14	A 303		
A 303	420-5-4-.03 (2) (a) Administration. The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an administrator shall meet all applicable statutory requirements. 4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences. 5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age. 6. The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character. 7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week. 8. The administrator shall manage and direct staff activities in a manner that results in	A 303		

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maintenance of a neat, clean, orderly, and safe environment and adequate care being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement.

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

10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting.

11. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when needed.

12. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan.

13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, EI#1, Administrator, failed to adequately

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perform his (EI#1) duties to ensure the proper and safe management of the day to day operations of the facility. EI#1 also failed to ensure the facility operated in accordance with the rules of the SBOH for ALFs and failed to ensure previously cited deficiencies were corrected and compliance with SBOH rules for ALFs was maintained. These failures placed all 33 residents of the facility at significant risk of harm.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON FEBRUARY 13, 2020 AND FEBRUARY 28, 2018

Findings:

On June 22-24, 2021, surveyors with the ADPH conducted an onsite survey and complaint investigation at the facility. One (1) complaint was investigated for the ALF as well as three (3) complaints for the SCALF. The surveyors found that several of the SCALF concerns were impacting the ALF unit as well . The complaints contained allegations including blood glucose checks (Accu-Chek) not being performed as ordered, eye drops not being administered on time, oxygen assistance not being provided, inadequate staffing, ineligible residents, inadequate housekeeping and laundry services, and resident rooms not cleaned properly. Surveyors substantiated these complaints while onsite and identified other deficient practices as well.

The following is an overview of deficiencies found during the survey. There was not a process in place to meet the emergency safety needs of the residents on the 7 PM to 7 AM shift. The nurses did not give insulin injections and eye drops as

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ordered (medication errors). The nurses did not initial the Medication Administration Record (MAR) when medications were given nor did all the nurses include their signature on the MAR. The morning medications were given an hour late. Staff were not properly screened prior to hire and prior to resident contact. Staff members were not trained in special needs of residents. The Unit Care Coordinator, had only been at the facility three (3) months and had no previous experience in an ALF. One (1) resident required care beyond the capabilities of the facility. Resident monthly assessments were not performed. The Resident Service Plans were not updated and did not reflect the current condition of the residents. Not all residents had a statement from their physician certifying the resident was free of infectious diseases prior to admission.

EI#1 became Administrator at the facility on March 15, 2021, three months prior to the survey. EI#1 informed the surveyors he (EI#1) was working on bringing the facility into compliance with SBOH rules but had not been at the facility long enough to address all deficient practices which were in place when he (EI#1) began as Administrator.

Multiple repeated deficiencies were cited during this survey. Refer to deficiency 301 for additional information. Several deficiencies had been cited at least two times previously and as early as 2016. EI#3, Governing Authority, stated he (EI#3) had been through five administrators, prior to hiring EI#1. EI#1 informed the surveyors multiple times that he (EI#1) was committed to bringing the facility into full compliance with SBOH rules for ALFs as long as he (EI#1) had the support and assistance of the Governing Authority.

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The following deficiencies were cited as a result of the Administrator's failure to apply the SBOH rules to the day to day operations of the facility and the lack of oversight provided by the Governing Authority.

302 - The facility failed to follow its own policies and procedures. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON FEBRUARY 28, 2018 AND ON JULY 14, 2016.

401 - There was inadequate staffing at the facility during the second shift. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 13, 2020 AND ON JULY 14, 2016.

402 - Employees were not properly screened prior to hire and prior to resident contact.

405 - The staff did not receive training for those residents with special needs. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 13, 2020.

503 - Required forms were not completed and resident records were not established for new admissions.

504 - The facility failed to maintain a safe and decent environment for residents. Also, the residents did not receive medications consistent with community standards nor were wellness checks conducted according to community standards. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE

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A 303	Continued From page 19 SURVEY CONDUCTED ON FEBRUARY 13, 2020. 505 - Financial agreements were not completed for new admissions. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 28, 2018. 601 - Residents did not receive insulin injections and eye drops as ordered, THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 13, 2020 AND ON FEBRUARY 28, 2018. 602 - The physician did not certify a resident was free of infectious diseases prior to admission. 604 - Monthly assessments were not completed for residents. 605 - A resident was not appropriately observed for health status changes. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. 606 - A resident required services beyond capability of facility. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON FEBRUARY 28, 2018. 611 - Residents' care plans were not current and appropriate to address the needs of the residents. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON FEBRUARY 13, 2020. 613 - A non-licensed staff person administered medications to a visually impaired resident. THIS	A 303		

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A 303	Continued From page 20 IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON FEBRUARY 13, 2020. 614 - A visually impaired resident was not provided with a means to correctly use the unit dose packing system. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON FEBRUARY 13, 2020. 615 - The MAR was not initialed contemporaneously by the nurses and the nurses did not provide a written signature on the MAR. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON FEBRUARY 13, 2020. 618 - Resident oxygen use was not documented appropriately. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 13, 2020. 901 - Laundry services were inadequate. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 13, 2020. 1002 - The facility failed to provide a clean, sanitary environment. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON JULY 14, 2016 AND ON FEBRUARY 13, 2020. 1101 - Fire drills were not performed and documented correctly. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON JULY 14, 2016 AND ON	A 303		

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A 303	Continued From page 21 FEBRUARY 13, 2020.	A 303		
A 401	420-5-4-.04 (1) (2) Personnel. Personnel. (1) An assisted living facility shall ensure personnel are employed and on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. (a) An assisted living facility shall be staffed at all times by at least one individual who has a current certification in cardiopulmonary resuscitation (CPR). (b) An assisted living facility must be staffed to ensure the safe evacuation of all residents in the event of a fire or emergency. (2) Employee Schedule. An assisted living facility shall post a schedule of employees indicating names and days and hours scheduled to work. This schedule shall be retained in the facility for 6 months after use. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure personnel were employed and on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 13, 2020 AND JULY 14, 2016.	A 401		

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Findings:

A review of the "2nd Shift" staffing schedule for June 2021 revealed only one (1) Med Tech (MT) was scheduled for the hours of 7 PM until 7 AM. The one (1) MT was responsible for fifteen residents residing on the first floor and sixteen residents living on the second floor. EI#1 told the surveyors the facility had moved to 12 hour shifts in May 2021 due to problems with staffing. EI#9 verified there was only one (1) MT on second shift and the MT called the memory care nurse if assistance was needed.

On the morning of June 23, 2021, the surveyor interviewed EI#12, MT and EI#13, MT, regarding staffing on the 7 PM - 7 AM shift. The surveyor inquired what would they do if an emergency situation (cardiac arrest or fall) happened on the first floor and they needed help. EI#12 explained she (EI#12) would have to go to the second floor to get help from someone working in memory care, which would mean leaving the injured resident alone until she (EI#12) returned. EI#12 said the staff used to have walkie talkie radios at one time but the walkie talkies radios were not currently being used.

EI#13 told the surveyor if she (EI#13) had an emergency occur on the first floor she (EI#13) would use the call light system but there was no one on the second floor to hear it at night. Also, the staff in the memory care unit (second floor) can not hear the audible sound made when the call light system is activated on the ALF unit. The surveyor asked EI#13 if she (EI#13) felt confident she (EI#13) could evacuate all the ALF residents out of the building if it was on fire. EI#13 said she (EI#13) was not completely certain she (EI#13) could safely evacuate the residents from the first

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and second floors in the event of a fire.

The surveyor learned on June 22, 2021, from EI#14, MT, that the call light display board mounted in the dining room, on the second floor, only lit up for rooms on the second floor. Therefore, if a staff member hears the sound of the call system being activated, the staff member has to go down to the first floor to determine the location of the room where assistance is needed. EI#14 told the surveyor she (EI#14) uses her personal cell phone to call another staff member when she needs assistance, but the facility discourages use of personal cell phones in the facility.

The surveyor discussed the findings with EI#1, EI#2, and EI#9, on June 23, 2021 at 11:03 AM. They stated they would immediately devise a plan for the staff to call for help in the event of an emergency situation.

During a return visit to the facility on August 16-17, 2021, surveyors found staffing remained inadequate. On August 16, 2021, EI#1 reported to surveyors he (EI#1) had remained at the facility 24 days straight due to staffing concerns. EI#1 further stated he (EI#1) would sleep in his (EI#1) office but was available to staff if needed.

Surveyors investigated a death which occurred on August 11, 2021. During an interview with EI#17 concerning this incident, the surveyor expressed concern regarding one (1) staff member being able to conduct wellness checks every two (2) hours for 33 residents located on two (2) floors. EI#17 said she (EI#17) can normally perform those checks on her (EI#17) shift (7 PM to 7 AM). The facility did not make attempts to observe all residents throughout the day and night for

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A 401	Continued From page 24 changes in condition. EI#8 told the surveyor she (EI#8) had been working second shift and EI#9 had been working third shift due to short staffing. EI#8 also said, "We can't do our office work because we are working the floor." There was one (1) nurse scheduled to work the night shift on the SCALF from 7:00 PM until 7:00 AM. This nurse was also responsible for assisting on the ALF as needed. Inadequate staffing on the 7:00 PM to 7:00 AM shift remained a concern at the facility even after the deficient practice was identified by surveyors during the June 24, 2021 survey. The facility continued to admit residents in spite of this staffing problem.	A 401		
A 402	420-5-4-.04 (3) Personnel. (3) Employee Screening. (a) Prior to any resident contact, such as but not limited to assistance with activities of daily living, newly employed personnel shall have a physical examination certifying that the employee is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to residents through normal staff to resident contact. Employees who develop signs or symptoms of infectious skin lesions or diseases that would be capable of transmission to residents through normal staff to resident contact shall not be permitted to have resident contact until free from such signs and symptoms. (b) Not more than 30 days prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis.	A 402		

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(c) Vaccines. Assisted living facilities shall immunize employees in accordance with current recommended Centers for Disease Control and Prevention (CDC) guidelines (www.cdc.gov/vaccines). Any particular vaccination requirement may be waived or delayed by the State Health Officer in the event of a vaccine shortage.

(d) An assisted living facility shall not hire an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry.

This Rule is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure employees were properly screened for hire prior to working at the facility.

Findings:

Review of employee files on June 23, 2021 revealed the following deficient practices.

EI#1 was hired at the facility on March 15, 2021. Documentation in the employee file showed a skin test was administered to EI#1 for tuberculosis screening on March 16, 2021. However, there was no documentation the skin test was read and results obtained to confirm EI#1 was negative for tuberculosis.

EI#6 was hired at the facility on June 7, 2021 and ceased employment at the facility on June 21, 2021. Documentation in the employee file showed a skin test was administered to EI#6 for tuberculosis screening on June 7, 2021. Although

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A 402	Continued From page 26 a "read" date of June 9, 2021 was documented on the "T.B. Verification" form, there was no documentation of the test results to confirm EI#6 was negative for tuberculosis. In addition, there was no documentation that EI#6 was screened through the Alabama Department of Public Health Nurse Aide Abuse Registry prior to hire. EI#1 agreed documentation on employee files was incomplete.	A 402		
A 405	420-5-4-.04 (6) Personnel. (6) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained in the facility. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on assisted living facilities. 2. Facility policies and procedures. 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.	A 405		

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A 405	Continued From page 27 5. Identifying and reporting abuse, neglect, and exploitation. 6. Basic first aid. 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environment safety. 10. Special needs of the elderly, mentally ill, and mentally retarded. 11. Safety and nutritional needs of the elderly. 12. Identifying signs and symptoms of dementia. (b) Cardiopulmonary Resuscitation. An assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of an assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within 90 days of hire. An assisted living facility equipped with an automated external defibrillator (AED) shall be 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	A 405		

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of those courses or certifications offered by the American Heart Association or American Red Cross in CPR or AED utilization.

(c) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training.

(d) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to provide written documentation the staff received training for residents with special needs.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 13, 2020.

Findings:

The morning of June 22, 2021, EI#9, ALF Coordinator, informed the surveyor the facility admitted and retained residents with special needs. EI#9 explained RI#12 and RI#13 were receiving hospice services and RI#12 was also being administered thickened liquids for silent aspiration. The surveyor asked EI#9 if she (EI#9) had been trained to thicken liquids. EI#9 said she (EI#9) received training while working at the nursing home. EI#9 also said she (EI#9) trained EI#14, RCA, how to thicken liquids, but there was no documentation the training had been done for

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A 405	Continued From page 29 either of them (EI#9 and EI#14) . On June 23, 2021, training records were reviewed by the surveyor. There was no documentation in the employee files the staff had been trained on the needs of hospice residents or the correct way to thicken liquids. EI#8, LPN, and EI#9, LPN, were unable to provide documentation of the special needs training during the survey.	A 405		
A 503	420-5-4-.05 (3) (a) (b) (c) Records and Reports. (3) Resident Records. (a) Records shall be current from the time of admission to the time of discharge or death and shall be retained in the facility for at least three years after a resident's death or discharge. (b) When an individual is admitted to an assisted living facility, records and information regarding the resident shall be protected from unauthorized disclosure. Employees and authorized agents of the Department shall be permitted to review all medical records and all other records to determine compliance with these rules. With the written consent of the resident, or with the written consent of the legal guardian of an incompetent resident, the local ombudsman shall be permitted access to all records regarding the resident. Records necessary to assess a resident's medical condition or to otherwise render good medical care shall be provided to the resident's treating physician or physicians or to the resident or to his or her legally authorized representative. A resident or his or her legal guardian may grant permission to any other individual to review the resident's confidential	A 503		

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records by signing a standard release.

(c) In addition to all records required for the provision of resident care, for each resident, the assisted living facility shall maintain on its premises the required documents listed below and any other documents required by the facility's policies and procedures:

1. Statement of resident rights signed by the resident.

2. Financial agreement.

3. Inventory of personal effects.

4. Admission record.

5. Incident investigations and reports involving the resident.

In addition to the above documents, the facility shall also maintain on its premises any Advance Directive or Portable Physician Do Not Attempt Resuscitation (DNAR) Order that has been executed by the resident. NOTE: Under no circumstances shall the facility require or refuse to allow a resident to execute an Advance Directive or Portable Physician DNAR Order. Advance Directives shall be typewritten or legibly written in ink and may include the appointment of a health care proxy consistent with the specific language in the Natural Death Act (Code of Alabama 22-8A-1 et. seq). A Portable Physician DNAR Order shall follow the rule and form found in the Alabama Administrative Code 420-5-19 Appendix II. These records shall be protected from unauthorized disclosure.

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to establish resident records with the required documents upon admission.

Findings:

On August 9, 2021, the ADPH was notified a skilled nursing facility (SNF) on the same campus had damage due to a fire. EI#1, Administrator, reported they would be moving three (3) of the SNF residents over to the ALF. Upon arrival to the facility on August 16, 2021, EI#1 provided the surveyors with a packet of documents. EI#1 explained it was the pre-admission assessments completed by EI#22, Registered Nurse (RN) for Resident Identifier (RI)#18 and RI#19. The surveyor observed and interviewed RI#18 and RI#19. EI#1 told the surveyor the third SNF resident was discharged to home and was not at the ALF. The Pre-Admission Approval Checklists were dated August 11, 2021, for RI#18 and RI#19. EI#1 and EI#22 signed the checklist giving their approval for admission. EI#1 confirmed the date of admission for RI#18 and RI#19 was August 11, 2021, however, the required documents still had not been obtained six (6) days after admission to the ALF.

The facility had not obtained the following required documents at the time of admission; statement of resident rights signed by the resident, financial agreement and inventory of personal effects.

Refer to deficiency 505 for additional information.

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A 504 420-5-4-.05 (3) (d) Records and Reports. A 504

(d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate.

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

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

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

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

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participate in and benefit from social, religious, and community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.

6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the premises, an individual account record for each resident shall be maintained by the administrator and an up-to-date record shall be maintained for all transactions.

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

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

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

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.

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11. Every resident shall have the right to at least 30 days prior written notice of involuntary relocation or termination of residence from the facility unless the resident is a patient in a facility providing a higher level of care and no longer meets the eligibility and continued stay requirements in these rules, or for medical reasons the resident is considered by a physician to require an emergency relocation to a facility providing a more skilled level of care, or unless the resident engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record.

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

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

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:

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A 504	Continued From page 35 (i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care. (ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation; and (iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time without recourse. 15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges. 16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities. 17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll-free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll-free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area.	A 504		

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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, to keep and use his or her own personal possessions including toilet articles except for personal possessions too large to be stored in the resident's room.

22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings.

23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours and to freely come and go from the home.

24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences

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for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to provide a safe and decent environment for residents. In addition, the facility failed to ensure medication assistance and wellness checks were provided in accordance with established and recognized community health care standards.

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

THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 13, 2020 AND JULY 14, 2016.

Findings:

Safe and Decent Environment:

The Alabama Department of Public Health received complaints which alleged the facility was short staffed on second shift, medications were late, oxygen was not being monitored, housekeeping and laundry services were inadequate, toilets were dirty, rooms were not clean, soiled linens and clothing were piled in residents' rooms. During the three day onsite survey, the following issues were identified which substantiated these complaints and deprived residents of their right to a safe and decent environment.

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The evening shift (7 PM to 7 AM) was staffed with only one (1) person who was responsible for monitoring residents (31) on the lower and upper floors. Also, there was not a system in place for the evening staff person to respond safely and quickly to an emergency situation. New residents and employees were not properly screened. Staff were not trained in the special needs of the residents as required. Refer to deficiencies 401, 402, 405, and 602 for additional information.

The evening SCALF nurse was responsible for performing blood glucose checks, administering insulin injections, and instilling eye drops on the ALF unit, as well as the SCALF unit. As a result, a nurse was not available the evening of June 21, 2021, to check blood glucose levels to determine if insulin injections were needed. Also, scheduled insulin injections and eye drops were not given when the nurse was working. EI#10, LPN, told the surveyor sometimes it is difficult to get the blood sugar checks and eye drops done on time on the ALF unit. In addition, the MT were giving medications to a visually impaired resident who could not safely use the unit dose packaging system. Refer to deficiencies 601 and 613 for additional information.

A resident was diagnosed with dysphagia and silent aspiration of thin liquids. This condition required thickened liquids which is a service beyond the capabilities of the facility. Refer to deficiency 606 for additional information.

Multiple resident rooms were dirty, including toilets and showers, with laundry piled up in baskets and overflowing onto the floor. Hallway floors were dirty. Offensive odors of urine and cigarette smoke were present. Refer to deficiencies 901 and 1002 for additional

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information.

Residents were not being assisted with nail care resulting in long, dirty, and stained fingernails. Refer to deficiency 611 for additional information.

Medication Assistance Community Standard:

On June 23, 2021 at 8:00 AM, the surveyor observed EI#15, Med Tech (MT), with the medication cart on the second floor. EI#15 assisted RI#14 with medications shortly thereafter. At 8:36 AM, EI#15 assisted RI#11 with medications. EI#15 arrived at RI#9's room with her/his medications at 8:49 AM. RI#9 told the surveyor it was not uncommon for morning medications to be late. The last of the 7:00 AM medications were administered at 9:00 AM to RI#8. EI#15, acknowledged to the surveyor the accepted guideline for medication assistance was plus or minus one hour of the scheduled time. EI#15 told the surveyor it was hectic on Wednesday mornings because it was clinic day and the nurse was tied up with the doctor. EI#15 explained RI# 8 and was constantly calling for assistance in her/his room, RI#13 was having trouble breathing, and she (EI#15) had to get another resident ready to go out for a procedure. The surveyor asked EI#15 if she (EI#15) could get the 7:00 AM medications to all 31 residents by 8:00 AM without any interruptions. EI#15 said it would be difficult because she (EI#15) doesn't start her shift until 7:00 AM. EI#15 also said she had to count narcotics with the off-going MT before she can start medication assistance. The surveyor informed EI#1, EI#2, and EI#9, the morning medications were an hour late. EI#2 told the surveyor she (EI#2) was unaware the MT was having difficulty getting the medications done on time because she (EI#2) had not been informed.

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Wellness Checks Every Two (2) Hours
Community Standard:

On August 12, 2021 at 9:12 AM, the Administrator, Employee Identifier (EI)#1, submitted an incident report to the Alabama Department of Public Health (ADPH) Online Incident Reporting System. EI#1 reported a death (RI#6) had occurred the previous evening at 9:10 PM on August 11, 2021.

The ADPH received a complaint on August 13, 2021, from a family member reporting their loved one had been found dead at the facility and the family thought he/she had been harmed. On the morning of August 16, 2021, two (2) surveyors with the ALF unit were dispatched to the facility to conduct an on-site investigation.

Resident Identifier (RI)#6 was admitted to the facility on April 15, 2021. According to the facility medical examination, dated April 15, 2021, RI#6 had a diagnosis of chronic schizophrenia. RI#1's medications included Depakote, hydrochlorothiazide, Remeron, Invega, and trazodone. RI#6 was on a regular diet and was independent with activities of daily living (ADL). RI#6's condition changed on May 27, 2021, and EI#9, Licensed Practical Nurse (LPN), notified the physician RI#6 had increased talking to self, homicidal ideations, and hallucinations. The physician ordered for RI#6 to be sent to the local emergency department (ED) for evaluation. RI#6 was hospitalized for 18 days in the psychiatric unit with a diagnosis of chronic schizoaffective disorder with acute exacerbation. RI#6's medications were adjusted and RI#6 returned to the facility on June 14, 2021. The medical examination, dated June 10, 2021, included

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A 504	Continued From page 41 additional diagnoses of weakness, decreased balance, fall risk, and muscle weakness. The physician also documented RI#6 needed assistance with bathing, dressing, hygiene, ambulation, and activities affecting personal safety. However, the facility Resident Service Plan documented RI#6 was "Independent" with ADLs. On June 16, 2021, RI#6 saw the nurse practitioner and complained of right knee pain when ambulating. The nurse practitioner ordered x-rays and RI#6 was found to have severe degenerative joint disease (DJD). In addition, home health and physical therapy were ordered to evaluate and treat. According to written and verbal statements from EI#17, she (EI#17) entered RI#6's room (first floor) to assist with his/her evening medications on August 11, 2021, at 9:10 PM. EI#17 said RI#6 did not answer her knock on his/her door so she used her (EI#17) key to let herself into his/her room. EI#17 said the bathroom door was closed and when she looked inside she (EI#17) saw RI#6 face down between the toilet and bathtub. EI#17 said she (EI#17) immediately telephoned EI#8, LPN, for help. EI#8 and EI#18, RA, responded to the call per their written witness statements. EI#8 said she (EI#8) called the local emergency medical services personnel (EMSP) while en route to RI#6's room from the second floor memory care unit. EI#8 said RI#6 was unresponsive and did not have a pulse. EI#8 said EI#17 and EI#18 attempted to "unwedge" RI#6 from between the toilet and bathtub but were unable to move him/her. The surveyor reviewed the "Patient Care Report" that was generated by EMSP, dated August 11, 2021. The following times were documented by the EMSP; Received Time 2111, Dispatch Time 2111, En Route Time 2111, and On Scene Time 2119. The EMT noted	A 504		

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RI#6 was cold, pale, and stiff. Per the EMSP assessment there were no respirations, no heart rate, and pupils were fixed. The EMSP called the local emergency department (ED) and were instructed by the ED physician do not attempt cardiopulmonary resuscitation (CPR). EI#17 told the surveyor she (EI#17) called RI#6's brother at approximately 10:00 PM, and left a voice message to call the facility as soon as possible.

Based on interviews and witness statements during the investigation the surveyors learned RI#6 had not been visually observed by the staff in 14 hours. The timeline of events for August 11, 2021, are as follows.

6:00 AM to 6:15 AM medications were given to RI#6 by EI#17 without difficulty.

6:30 AM to 7:00 AM breakfast tray was delivered by EI#20, dietary staff. RI#6 instructed EI#20 to set the tray on his/her bed and began to eat as usual. EI#20 said RI#6 ate 100% of his/her breakfast.

Wednesday Morning Bible Study. Activity Coordinator, EI#21, said RI#6 would occasionally come to this activity but she (EI#21) was off on August 11, 2021, and was not aware of anyone conducting the activity in her (EI#21) absence.

11:30 AM to 12:00 NOON lunch tray was delivered by EI#20. RI#6 was not seen. EI#20 said the bathroom door was closed but could hear RI#6 in the bathroom making noises (toilet seat being let down). EI#20 said RI#6 said something when she told him/her through the door she (EI#20) had his/her lunch. EI#20 thought his/her response may have been "okay" but he/she did not sound in distress. EI#20 left

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the lunch tray on the bed as was his/her preference.

1:40 PM (approximately) EI#19, from dietary, went to pick up the lunch trays. RI#6 was not seen. RI#6's tray was not left in the hallway for pick-up as usual. EI#19 went into RI#6's room and retrieved the lunch tray from the bed. The food had not been eaten. EI#19 thought RI#6 was out of his/her room. EI#19 did not inform the nurse on duty RI#6 did not eat lunch.

2:00 PM RI#21 conducts a Bible study on Wednesday afternoons. RI#21 said RI#6 participated regularly in this activity but did not show on this day. RI#20 also a regular attendee of the Bible study and friend of RI#6 told the surveyor when he/she did not come to the activity he (RI#20) went to his/her room and knocked on the door. RI#6 did not respond and RI#20 said he (RI#20) did not inform anyone.

5:00 PM Medication (Artane) was scheduled to be given. EI#14, Med Tech on duty told the surveyor the medication was not given. EI#14 told the surveyor RI#6 normally stayed in his/her room and she (EI#14) rarely saw him/her. EI#14 said it had been a crazy day and she forgot to give the medication. EI#8 explained to the surveyor the facility was in a state of emergency and the med tech was called off the cart to help transfer nursing home residents.

5:00 PM (approximately) EI#19 delivered the dinner tray to RI#6's room. EI# 19 said RI#6 was usually in the bed when she (EI#19) brought the dinner tray but he/she was not seen and the bathroom door was closed. EI#19 said she (EI#19) thought he/she may have been in the activity room so she (EI#19) left the dinner tray on

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the bed and left.

9:10 PM RI#6 was discovered by EI#17 as described above.

During an interview with EI#1 on the afternoon of August 16, 2021, the surveyor inquired what the facility's policy was regarding how often residents are checked on throughout the day. EI#1 stated there was not a facility policy that addressed the frequency residents are to be checked. EI#1 went onto say it was not unusual for RI#6 to stay to himself/herself nor was it uncommon for RI#6 not to be seen out of his/her room. It should be noted at the time of admission a document was presented to the family that stated the facility would make regular rounds to check on the safety and conditions of the residents.

During an interview on the morning of August 17, 2021, with EI#9, ALF Coordinator, the surveyor asked her (EI#9) how often did she (EI#9) expect her (EI#9) staff to check on residents. EI#9 replied every two (2) hours was her (EI#9) expectation and that was how she (EI#9) trained the staff. The surveyor asked her to explain why RI#6 was not checked on at least every two (2) hours. EI#9 said she did not have an explanation because she was not working on August 11, 2021, and was not the nurse on duty.

During a telephone interview with EI#17, RA, Med Tech, on August 19, 2019 at 6:44 PM, the surveyor asked EI#17 how often was she (EI#17) trained to check on the residents. EI#17 said, "We are supposed to peek in every so often." EI#17 was an experienced RA and agreed every two (2) hours was the standard she (EI#17) was familiar with in an ALF. EI#17 also said the staff makes rounds at the end of their shift and reports

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to the on-coming staff any problems encountered during their shift. The surveyor asked if she (EI#17) was informed by the off going Med Tech, EI#14, that RI#6 did not receive his/her scheduled medication at 5 PM. EI#17 said she did not think so.

These deficiencies contributed to a disorderly, unsafe and unsanitary environment for all residents and placed all residents at risk of harm.

A 505 — 420-5-4-.05 (3) (e) Records and Reports. — A 505

(e) Financial Agreement.

1. Prior to, or at the time of admission, the administrator and the resident or the resident's sponsor shall execute a written financial agreement. This agreement shall be prepared and signed in two or more copies with at least one copy given to the resident, or sponsor, if the resident did not sign the agreement, and one copy retained in the assisted living facility. This document shall be made readily accessible to personnel from the State Board of Health during inspections.

2. In addition to any information otherwise required by the facility's policies and procedures this agreement shall contain the following:

(i) A complete list of the facility's basic charges (room, board, laundry and personal care and services).

(ii) The period covered by the financial agreement.

(iii) A list of services not covered under

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A 505	Continued From page 46 basic charges and for which additional charges will be billed. (iv) The policy and procedures for refunds of any payments made in advance. (v) The provisions governing termination of the agreement by either party. (vi) The facility's bed-hold policy, procedures, and charges. (vii) Documentation that the resident and sponsor understand that the facility is not staffed and not authorized to perform skilled nursing services nor to care for residents with severe cognitive impairment and that the resident and sponsor agree that if the resident should need skilled nursing services or care for a severe cognitive impairment as a result of a condition that is expected to last for more than 90 days, that the resident will be discharged by the facility after prior written notice. (viii) A reminder to the resident or sponsor that the local ombudsman may be able to provide assistance if the facility and the resident or family member are unable to resolve a dispute about payment of fees or monies owed. (ix) Signatures of both parties or authorized representatives. 3. Prior to execution of the financial agreement the facility shall ensure that the resident or sponsor fully understands its provisions. In the event that a resident is unable to read the agreement due to illiteracy or infirmity, the administrator shall take special steps to	A 505		

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ensure communication of its contents to the resident (for example, by having the administrator or sponsor read the agreement to a vision-impaired or illiterate applicant).

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to execute appropriate financial agreements with residents or sponsors prior to or at the time of admission.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 28, 2018.

Findings:

On August 11, 2021, RI#18 and RI# 19 were admitted to the ALF, however, the residents did not have financial agreements on file. EI#1 told the surveyors the Financial Agreements had been sent to the sponsors via email but signatures had not been obtained by the sponsors. According to EI#1, the admission packets were emailed to sponsors on August 12, 2021 (the day after the residents were admitted to the ALF).

The surveyors requested a copy of the Financial Agreement that was emailed to the sponsors for signature. The surveyors were presented a blank document. The basic information, monthly lease rate, and commencement date were left blank. The surveyor questioned EI#1 regarding the missing lease rate and EI#1 said the residents were not going to be charged for the services

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A 505	Continued From page 48 provided by the ALF. The afternoon of August 17, 2021, the surveyor contacted the Guardian/ Attorney for RI#18. The guardian stated it was his understanding the ALF stay was temporary and RI#18 would be returning to the SNF. The guardian thought it was someone from the nursing home that contacted him but did not recall a name. The guardian said no one from the ALF had discussed payment with him or anything else RI#18 might need. The guardian said the financial agreement may have been received by someone in his office, but he had not seen it yet. The surveyor attempted to contact the sponsor (daughter) for RI#19, but could not be reached on August 17, 2021.	A 505		
A 601	420-5-4-.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	A 601		

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system (911 or another emergency call).

(b) Back-up Physician Support. Each 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 an assisted living facility.

(c) All physician orders shall be written in accordance with community standards. If verbal orders are used, they are to be used infrequently. A physician verbal order shall only be accepted by an RN or LPN employed by the facility and authorized to do so by facility policy and procedures and state law. All verbal orders shall be reduced to writing on the physicians' order sheet by a licensed facility nurse and shall be dated and signed by the nurse receiving the order. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, or another practitioner who is responsible for the care of the resident and authorized to write orders by facility policy. All verbal orders must be authenticated within such time period as provided by facility policy, but in no case shall exceed 30 days following entry of the order.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure all residents received medications (insulin, eye drops and oral)

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and oxygen (liters per minute) as prescribed by the physician.

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

THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 13, 2020 and FEBRUARY 28, 2018.

Findings:

On May 19, 2021, the Alabama Department of Public Health received an anonymous complaint which alleged blood sugars and eye drops were sometimes late on second shift. The complainant also alleged RI#13 was having problems with the administration of oxygen.

Medication Omissions:

On the afternoon of June 22, 2021, the surveyor reviewed medication assistance records (MAR) filed in a binder located in the second floor medication room. The binder was labeled MAR Book for Nurses. The surveyor immediately noted that none of the evening medications (3 PM through 8 PM) had been initialed as given on June 21, 2021. The surveyor brought this to the attention of EI#1 and EI#9, LPN, ALF Coordinator. EI#9 explained it is the facility's policy that only licensed staff (LPN) perform Accuchecks, insulin injections, and eye drop instillation. EI#9 said she (EI#9) would check with the other nurses and get back to the surveyor. The next morning on June 23, 2021, the surveyor was informed by EI#9 the insulin and eye medications were not given the evening of June 21, 2021. EI#1 explained to the surveyor he (EI#1) thought the day shift nurse (EI#11, LPN)

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was staying over to give the insulin and eye drops on June 21, 2021. However, he (EI#1) was notified at 7:00 PM there was not a nurse available to give the medications. EI#1 said he (EI#1) contacted EI#10, LPN, and she (EI#10) agreed to come in and do the medications for the evening. In an interview on June 22, 2021, EI#10 informed the surveyor when she (EI#10) arrived at 8:00 PM she (EI#10) was told the evening medications had already been done. EI#10, LPN, could not recall who told her (EI#10) the medications had already been given prior to her (EI#10) arrival. EI#10 acknowledged she (EI#10) did not check the medication administration record (MAR) for confirmation.

The medication omissions that were found by the surveyor for June 21, 2021 are as follows:

Insulin
RI#2 did not have an Accucheck done at 4 PM to determine if insulin was required per sliding scale.
RI#3 did not receive 26 units of Novolin 70/30 with evening meal.
RI#11 did not have an Accucheck done at 4 PM to determine if insulin was required per sliding scale.
RI#12 did not have an Accucheck done at 4 PM to determine if insulin was required per sliding scale.
RI#15 did not have an Accucheck done at 5 PM.
RI#16 did not receive Lantus 20 units at 3 PM or Humalog 10 units with meal at 4 PM

Eye Drops
RI#7 did not receive Ciprofloxacin, Prednisolone, and Diclofenac eye drops in the left eye at 6 PM.
RI#9 did not receive ophthalmic Ketrolac 0.04% in each eye at 4 PM and 8 PM

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EI#9 informed the surveyor she had notified the physicians of the above omissions and no new orders were received.

The surveyor also found numerous instances for June 2021 where the nurse did not initial the MAR to indicate they had administered medications at the time scheduled. Refer to deficiency 615 for additional information.

Oxygen Administration:

On June 22, 2021 at 11:20 AM, the surveyor visited with RI#13 in her/his room. RI#13 was receiving oxygen via nasal cannula and told the surveyor she/he had chronic obstructive pulmonary disease (COPD) and had to "use oxygen 24/7." The surveyor checked the oxygen concentrator for the rate and noted it was set at 2 liters per minute (LPM). RI#13 told the surveyor the oxygen rate had changed but she/he wasn't sure what it was supposed to be. The surveyor questioned EI#9, LPN, regarding the correct LPM and she (EI#9) said she would have to check the doctor's order. At 12:15 PM, EI#9 confirmed the oxygen concentrator should be set at 3 LPM. EI#9 said the durable medical equipment (DME) employee changed the LPM yesterday (June 21, 2021) without checking the doctor's order. EI#9 acknowledged this was not an acceptable excuse and that the facility was responsible for ensuring the oxygen rate was correct. A review of the initial Medical Exam dated September 28, 2020, revealed a physician's order for oxygen at 3 LPM. Refer to deficiency 618 for additional information on oxygen for RI#13.

The medication omissions that were found by the surveyor for August 17, 2021 are as follows:

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Medication Omission:

RI#6

During the course of the death investigation (RI#6) on August 17, 2021, the surveyor learned medications were not given as ordered.. RI#6 had a order for Artane 2 mg twice a day by mouth. The Artane was scheduled for 6 AM and 5 PM. EI#14, Med Tech, said she forgot to give RI#6 the 5 PM dose on August 11, 2021, because it was a crazy day. RI#6 was hospitalized from May 27, 2021 to June 14, 2021 for chronic schizoaffective disorder with acute exacerbation. At the time of discharge, RI#6 was prescribed haloperidol (Haldol) 2 mg daily (6 AM) and 5 mg at bedtime (9 PM). The surveyor was told by EI#14, if a med tech did not give a medication they would circle their initials on the MAR and document the reason on the back page. A review of the August 1-11, 2021 MAR revealed RI#6 only received one (1) daily dose on August 11, 2021 at 6 AM and only three (3) doses at bedtime (9 PM) on August 1, 7, and 10, 2021. During a telephone interview the evening of August 19, 2021, EI#17 told the surveyor RI#6 had thrown the pill (Haldol) in the garbage can or threw the pill across the room. However, there were no reasons for refusal documented on the back page of the MAR. The surveyor also spoke with EI#9, LPN, on the telephone about RI#6 failing to receive his/her medications as ordered. EI#9 said none of the med techs had reported to her (EI#9) RI#6 was refusing his/her medications.

RI#18 was a new admission to the facility from the SNF on August 11, 2021. The docusate sodium 100 mg twice a day (9 AM and 5 PM) was ordered for constipation but it had not been given for seven (7) days. The famotidine 10 mg was

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ordered at bedtime (9 PM). The famotidine blister card was empty. EI#14 said there would not be a bedtime dose available for August 17, 2021.

RI#19 was a new admission to the facility from the SNF on August 11, 2021. The aspirin 81 mg daily, ferrous sulfate 325 mg daily, Vitamin D3 daily, simethicone 80 mg three times a day, had not been given for six (6) days. The medication Lopid 600 mg was ordered twice a day (8 AM and 8 PM). The 8 AM dose of Lopid had been given but there was not any more available for the 8 PM dose. The melatonin 3 mg was ordered at bedtime (9 PM). The melatonin blister card was empty. EI#14 said there would not be a bedtime dose available for August 17, 2021.

EI#1 told the surveyor the medications were sent from the SNF to the ALF, and were in the unit dose packages, as required.

On August 17, 2021 at 3;00 PM, the surveyor reviewed the medications for RI#18 and RI#19, which were located in Med Cart #2, with EI#14, med tech. The surveyor also compared the medications (blister cards) to the MARs for RI#18 and RI#19. EI#14 told the surveyor when the med tech makes a circle on the MAR it means the medication was not available or "we don't have it." EI#14 also said the med techs are supposed to write the reason the medication is not given on the back page. EI#14 acknowledged the back page was blank and reasons for medications not being administered were not documented. EI#14 said she (EI#14) didn't know if anyone had ordered refills for the medications. EI#14 said EI#9, LPN, would usually request refills from the pharmacy but wasn't sure if it had been done.

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A 602	Continued From page 55	A 602		
A 602	420-5-4-.06 (2) (a) (b) (c) Care of Residents. (2) Medical Examination Record. (a) Initial Physical Examination. Not more than 30 days prior to admission of any resident to an assisted living facility, the resident or prospective resident shall be examined by a physician. For purposes of the initial physical examination only, a currently licensed physician in good standing with the Medical Licensure Commission of any state may complete this physical assessment. The physician shall report his or her findings in writing to the facility. In addition to any information otherwise required by the facility's policies and procedures, and in addition to any other information the physician recommends or believes is pertinent, the initial physical examination record shall contain the following: 1. All of the physician's diagnoses, and the resident's baseline weight and vital signs. 2. Medication presently prescribed (name, dosage, and strength of drug, frequency, and route of administration). 3. A statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact. 4. Documentation of evaluation for tuberculosis within the previous 12 months. (b) Annual Physical Examination. In addition to the admission physical examination,	A 602		

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

1. The resident's weight and vital signs.

2. Changes in diagnoses.

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

4. Changes in treatment.

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

1. New diagnoses.

2. Changes in condition.

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

4. Changes in treatment.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to obtain certification from the physician stating a resident was free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents prior to admission. The facility also failed to provide documentation of tuberculosis (TB) within the previous 12 months of admission. In addition, the move-in Medical Exam was not dated by the physician completing the physical assessment.

Findings:

RI#13 was admitted to the facility on October 5, 2020, and the initial Medical Exam was dated September 28, 2020. However, the physician did not provide a written statement that RI#13 was free from contagious diseases prior to admission. On June 24, 2021, the surveyor discussed the importance of obtaining certification from the physician prior to admission with EI#9, LPN. EI#9 verbalized agreement and understanding.

RI#18 was a new admission to the facility on August 11, 2021. On August 16, 2021, the surveyor asked EI#1 to provide documentation an evaluation of TB had been completed prior to admission. The next day, EI#1 presented the surveyor with a chest x-ray report dated August

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A 602	Continued From page 58 17, 2021. There were no evidence of communicable disease or active tuberculosis. The medical exam contained the physician signature but it was not dated by the physician to indicate the date the exam was completed. RI#19 was also a new admission on August 11, 2021. RI#19 did not have evidence of TB evaluation for six (6) days. The chest x-ray was dated August 17, 2021, and the report read there was no evidence of communicable disease or active TB. The medical exam contained the physician signature but it was not dated by the physician to indicate the date the exam was completed. EI#1 acknowledged the TB evaluation had not been obtained as required prior to move-in. The morning of August 17, 2021, EI#9, LPN, told the surveyors the nurse practitioner worked last night and ordered mobile chest x-rays for the new residents due to the emergent transfers to the Alf from the nursing home.	A 602		
A 604	420-5-4-.06 (3) (a) (b) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility shall assess prospective residents for facility eligibility. This assessment shall document identified care needs and serve as a baseline for future assessments. (b) Monthly Assessments. The facility shall assess each resident monthly and more often when necessary to identify changes in resident's status. In addition to other items that may be required by the facility's own policies and	A 604		

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procedures, the monthly assessment shall:

1. Assess the resident's ability to safely self-manage medications or safely self-administer medications with assistance.

2. Accurately weigh and record the weight of each resident. 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 or greater weight loss in a period of three months or less, or a ten percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician.

3. Document identified changes in resident status.

4. Assess the appropriateness of each resident's plan of care. Any decline in resident status requires immediate implementation and documentation of interventions or reassessment of existing interventions.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to complete monthly assessments for all residents.

Findings:

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A 604	Continued From page 60 During record reviews on June 23, 2021, the surveyor discovered the monthly assessments had not been completed for 23 residents during the months of February and March of 2021. The surveyor discussed the deficiency with EI#1, EI#2, and EI#9. EI#9 informed the surveyor she (EI#9) was not the ALF coordinator during this time. EI#2 said she was out on leave during February and most of March 2021. However, on March 18, 2021, EI#2, RNC completed an audit of the monthly assessments and documented non-compliance. EI#1 told the surveyor shortly after his arrival to the facility he (EI#1) knew the previous ALF coordinator was not doing her job. EI#1 provided the surveyor with a copy of the Employee Termination Form for the previous ALF coordinator who quit without notice on March, 23, 2021. The previous ALF coordinator was marked not eligible for rehire due to repeated no show and poor performance.	A 604		
A 605	420-5-4-.06 (3) (c) Care of Residents. (c) Observation. Each 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.	A 605		

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to provide general observation for all residents to identify changes in the resident's health and awareness of the need for medical attention.

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

Findings:

The facility had notified the ADPH of a resident's death (RI#6) that occurred on August 11, 2021. The facility reported RI#6 was found deceased in his/her bathroom at 9:10 PM by staff (EI#17). The family also contacted the ADPH regarding the death of RI#6. The morning of August 17, 2021, the surveyor spoke with RI#6's sister and sister in law. They both told the surveyor they felt the facility had neglected their brother and they were obtaining toxicology and autopsy reports.

Interviews were conducted on August 17, 2021, with staff and residents. The surveyor learned the last time anyone observed RI#6 was at 7 AM (14 hours) when his/her breakfast was delivered to his/her room by EI#20. EI#20 reported talking with RI#6 while he/she was in the bathroom at lunch time (9 hours), but did not observe RI#6.

On the morning of August 17, 2021, the surveyor interviewed EI#9, LPN, regarding the extended length of time in which a staff member made attempts to observe RI#6 for any health status changes. EI#9 said she (EI#9) could not answer

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A 605	Continued From page 62 why RI#6 was not checked on because she (EI#9) was not working that day but, told the surveyor that was not acceptable. Refer to deficiency 504 for additional information.	A 605		
A 606	420-5-4-.06 (3) (d) Care of Residents. (d) Services Beyond Capability of Assisted Living Facility. Whenever a resident requires hospitalization, medical, nursing, or other care beyond the capabilities and facilities of the 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 observations, interviews, and record reviews, the facility was providing care (thickened liquids) for a resident which was beyond the capabilities of an assisted living facility. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 28, 2018. Findings: RI#12 had been residing at the facility since November 2, 2018. RI#12 had a significant past medical history of diabetes mellitus, atrial fibrillation, hyperlipidemia, ischemic cardiomyopathy, and pacemaker. In addition,	A 606		

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RI#12 was admitted to hospice on May 6, 2021, with a primary diagnosis of hypertensive heart disease with heart failure. On June 22, 2021, during review of the resident's conditions with EI#9, LPN, the surveyor learned RI#12 was receiving thickened liquids. EI#9 explained she (EI#9) had experience in thickening liquids and had trained EI#14, RCA. During a wellness visit on April 7, 2021, the nurse practitioner (NP) documented RI#12 had been coughing with eating and drinking. A barium swallow study was performed on April 9, 2021, which revealed "silent aspiration" and "dysphagia deficits." Based on the assessment the speech language pathologists (SLP) recommended a soft diet with mildly thick (nectar thick) liquids. At the next wellness visit on April 14, 2021, the NP wrote RI#12 failed the swallowing study and requires a special diet and has received a 30 day notice. On June 22, 2021 at 11:52 AM, RI#12 was observed eating a taco salad and drinking water and tea. The surveyor inquired if the tea and water had been thickened before being served to RI#12. EI#9 replied the liquids had not been thickened and removed the beverages from the table. EI#9 took the beverages into the medication room and thickened per the instructions on the "Active" container. EI#9 said the Active thickener was supplied by the hospice nurse. The surveyor expressed concern to EI#9 regarding the dangers of aspiration and inquired why a 30 day notice had not been issued as noted in the NP note. EI#9 explained the 30 day notice was rescinded after the family signed a "Hold Harmless Agreement" that RI#12's liquids did not have to be thickened. The surveyor requested to see the signed agreement but it was not produced during the survey.

Although RI#12's dysphagia had been identified

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A 606	Continued From page 64 by the NP approximately three (3) months prior to the June 24, 2021 survey, the facility had made no arrangements to transfer or discharge RI#12 to a health care facility able to provide the appropriate level of care.	A 606		
A 611	420-5-4-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall be based on the initial medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be reviewed and updated based on the annual examination, and all other physician examinations, diagnoses, and recommendations of the resident's treating physician, and the resident's monthly assessments. The plan of care shall be developed and updated in cooperation with the resident and, if appropriate, the sponsor. All entries on the plan of care shall be accurately dated. 1. The plan shall at all times reflect the current condition of the resident and document the personal care and services required from the facility by the resident. In addition to other items that may be required by the facility's own policies	A 611		

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and procedures, the plan of care shall contain the following:

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

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

4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider.

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

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

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

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

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

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(v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed.

(vi) Personal Safety. Residents shall be provided assistance with personal safety.

6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility's Resident Service Plans (RSP) were not updated and did not reflect the current condition of the resident. In addition, the facility did not ensure all residents had a clean and well-kept appearance.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON FEBRUARY 13, 2020

Findings:

Resident Service Plans:

RI#1

RI#1 was admitted to the facility on April 24, 2020. RI#1 was dependent on a wheelchair for ambulation and required assistance with activities of daily living. RI#1 told the surveyor he/she had complications from hip surgery and could not

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A 611	Continued From page 67 bear weight on his/her left leg. The staff described RI#1 as a two person assist for bathing and transferring, but the staff was doing transfers with just one person. On June 23, 2021, the surveyor observed EI#15, MT, transfer RI#1 from the wheelchair to the bedside. RI#1 was unsteady while pivoting on one (1) foot and EI#15 had to support most his/her weight (164 pounds). EI#15 told the surveyor it would be easier with two (2) people. The monthly assessments dated for April 2021 and May 2021 noted RI#1 needed maximum assistance for transfers. However, the RSP indicated RI#1 only needed the assistance of one (1) person for bathing and transfers. EI#9, LPN, informed the surveyor she (EI#9) had arranged for home health to in-service the staff on transferring RI#1 in/out of the wheelchair using proper body mechanics. RI#1 used a urinal but this was not mentioned on the RSP. The RSP was not updated after two (2) hospital admissions. On November 27, 2020, RI#1 was treated for approximately ten (10) days at a local hospital for sepsis and hypotension. RI#1 was readmitted to the facility from the hospital on March 24, 2021, after being diagnosed with a cerebral infarction, chronic renal insufficiency, coronary artery disease (CAD) ,and diabetes mellitus. The RSP did not include any of these new diagnoses with appropriate interventions. According to the clinic visit note dated March 24, 2021, RI#1 had a small open wound on the right anterior foot which occurred in the hospital. The physician ordered home health to evaluate, however, this was not included in the RSP. The RSP was not signed nor were any of the entries dated. RI#6 RI#6 was admitted to the facility on April 15,	A 611		

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2021. RI#6 was on a regular diet and independent with activities of daily living (ADL). However, RI#6's condition changed on May 27, 2021, and was admitted to the hospital and treated for chronic schizoaffective disorder with acute exacerbation. RI#6 returned to the facility on June 14, 2021. The medical examination completed by the physician on June 10, 2021, indicated RI#6 needed assistance with bathing, dressing, hygiene, ambulation/transfer, and activities affecting personal safety. The facility RSP, documented RI#6 was "Independent" with ADL. The RSP was not updated with the increased need for assistance with ADL. On June 16, 2021, RI#6 saw the nurse practitioner and complained of right knee pain when ambulating. The nurse practitioner ordered x-rays and RI#6 was found to have severe degenerative joint disease (DJD). In addition, physical therapy (PT) was ordered. The PT documented on June 18, 2021, RI#6 was currently using a walker and was non-compliant. The RSP again was not updated with these new problems and the appropriate interventions to help prevent a fall.

RI#8

RI#8's RSP was not signed nor were any of the entries dated. There was an attachment titled, "Service plan revised or updated." The attachment did have "Dates" and "Reasons" documented for the revisions or updates but there were not any written interventions to coincide with the "Reason". The service plan attachment for RI#8 had 12 reasons documented since November 27, 2020, but none of them had been signed by a staff member.

RI#12

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RI#12 had been residing at the facility since November 2, 2018. RI#12 had the following diagnoses; insulin dependent diabetes mellitus, atrial fibrillation, hyperlipidemia, ischemic cardiomyopathy, hypertension, and a pacemaker. During a clinic visit dated April 7, 2021, the nurse practitioner (NP) documented RI#12 had coughing with eating and drinking. A swallowing study confirmed on April 9, 2021, RI#12 had "silent aspiration" while swallowing thin liquids. The speech therapist made numerous recommendations for safe feeding and swallowing precautions. The new diagnoses of aspiration and the swallowing precautions were not included on the RSP. Refer to deficiency 604 for additional information. On April 7, 2021, and again on April 14, 2021, the NP assessed RI#12 for weight loss. RI#12 reported to the NP he/she had no appetite and did not like the food. The NP ordered a dietary supplement (Glucerna) three times a day and weekly weights. On April 14, 2021, the NP diagnosed RI#12 with dysphagia, protein malnutrition (low pre albumin 10.5 mg/dl), vitamin D, and folate deficiency. The RSP was not updated with any of these nutritional deficiencies or interventions to prevent a further decline. RI#12 was admitted to hospice on June 6, 2021, with a terminal diagnosis of hypertensive heart disease with heart failure. This was not reflected on the RSP with applicable interventions.

RI#13

RI#13 was admitted to the facility on October, 5, 2020, with diagnoses to include chronic obstructive pulmonary disease (COPD), chronic bronchitis, congestive heat failure (CHF), and hypertension. During a clinic visit on January 6, 2021, RI#13 reported to the NP an episode of

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vaginal bleeding. The NP ordered a clinical work-up but this was not mentioned on the RSP. On June 9, 2021, the NP diagnosed RI#13 with a urinary tract infection (UTI) and treated with an antibiotic (Cipro). The causative bacteria was Escherichia coli (E-Coli). The RSP did not address this new diagnosis with known interventions to help prevent another UTI. RI#13 was admitted to hospice services on June 15, 2021, with a diagnosis of COPD. The do not resuscitate order (DNR) was rescinded by RI#13, however, the RSP was not updated with this new information.

RI#15

RI#15 had been a resident at the facility since July 18, 2018. RI#15 had a medical history of bipolar disorder with psychotic features, hypertension and Type 2 diabetes mellitus According to the monthly assessment dated January 31, 2021, RI#15 had some health status changes. RI#15 had two (2) falls with a laceration to left arm and 2 plus (+) edema in the lower extremities, however, these needs were not mentioned on the RSP with appropriate interventions.

On June 24, 2021 at 1:50 PM, the surveyor reviewed some of the RSP deficiencies with EI#9. EI#9 stated she (EI#9) had been in her (EI#9) role as ALF coordinator since March 30, 2021, and was trained by EI#8. EI#9 went onto say some of the RSP had been completed by the previous ALF coordinator. EI#9 agreed the care plans were inadequate to meet the care needs of the residents. The surveyor reminded EI#9 the RSP should accurately reflect the current condition of the residents, should be signed and every entry dated. EI#9 verbalized understanding.

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RI#18 was admitted to the ALF from the SNF on August 11, 2021; however, the RSP was not developed until five (5) days later on August 16, 2021, by EI#9, LPN. The Medical Exam dated August 10, 2021, included the following diagnoses; acute respiratory failure with hypoxia, acute systolic heart failure, pruritus, pneumonia, paroxysmal atrial fibrillation, vascular dementia with behavioral disturbance, osteoporosis, and constipation. Although EI#9 did include the medications to treat most of these conditions she (EI#9) did not mention the diagnoses on the RSP.

RI#19 was admitted to the ALF from the SNF on August 11, 2021; however, the RSP was not developed until five (5) days later on August 16, 2021, by EI#9, LPN. EI#9 was interviewed the morning of August 17, 2021, after she (EI#9) had worked 9 PM to 9 AM. EI#9 explained she (EI#9) was doing the best she (EI#9) could to keep up with the paper work.

Personal Appearance:

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

Findings:

The Alabama Department of Public Health received a complaint which alleged the resident's were not assisted with daily grooming in the Memory Care Unit. During a tour of the facility the surveyor found this to be a deficient practice in the ALF unit. The surveyor observed the following residents had dirty and untrimmed fingernails; RI#3, RI#6, RI#12, and RI#15. All four (4) residents told the surveyor they would like to have their nails trimmed.

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A 611	Continued From page 72 On June 23, 2021, at 11:00 AM, the surveyor informed EI#9 of the findings. EI#9 told the surveyor the resident's fingernails are to be checked by all staff for cleanliness. EI#9 said only a nurse can trim fingernails for a resident diagnosed with diabetes. RI#3, RI#12, and RI#15 are diabetics. On June 24, 2021, during the exit conference, EI#9 told the surveyor the residents fingernails had been cleaned and trimmed.	A 611		
A 613	420-5-4-.06 (5) (a) (b) (c) (d) (e) Care of Residents. (5) Medications. (a) Medications as defined in these rules, may be administered to a resident of an assisted living facility only after the drugs have been prescribed specifically for the resident by an individual currently licensed to prescribe medications in Alabama. A currently licensed physician in good standing with the Medical Licensure Commission of any state may prescribe medications to a resident of an assisted 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.	A 613		

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(d) Nothing in these rules shall preclude a facility from using a licensed nurse employed by the facility or nursing agency to administer medication to any resident. An RN or LPN shall administer medications to residents in the assisted living facility only in accordance with physician orders and the Nurse Practice Act.

(e) A resident who is incapable of recognizing his or her name, or understanding the facility unit dose medication system, or does not have the ability to protect himself or herself from a medication error shall require medication administration. Medication administration shall be provided only by a physician or by an RN or LPN. If the resident cannot understand or be trained to understand the unit dose medication system used by the facility or cannot protect himself or herself from medication errors by facility staff, the resident will be appropriately discharged.

This Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide a nurse to administer medications to a resident who was not able to utilize the unit dose medication system and protect himself or herself from medication errors.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 13, 2020.

Findings:

On June 23, 2021 at 8:49 AM, the surveyor was observing EI#15, RCA/Med Tech, during the morning medication assistance. The surveyor

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A 613	Continued From page 74 observed RI#9 sitting in a wheelchair at her/his doorway. RI#9 told the surveyor she/he had macular degeneration eye disease and was legally blind. The surveyor questioned RI#9 if she/he could see her/his name on the medication packets and RI#9 replied no she/he could not. RI#9 told the surveyor, "I have to trust them to give me the right medicine." At 8:54 AM, EI#15 presented RI#9 with medications (med packs and blister card) and asked RI#9 if she/he could identify her/his name on the medicines. RI#9 responded she/he could not. EI#15 placed the tablets in a medication cup and RI#9 swallowed them. EI#15 told the surveyor she (EI#15) was aware RI#9 had a visual impairment and had been unable to recognize her/his name in previous medication assistance. The surveyor discussed these findings with EI#1, EI#2, and EI#9. All three (3) employees stated RI#9's vision was not as limited as she/he reported to the surveyor. EI#2 said they had offered RI#9 some form of tactile identifiers but RI#9 refused to use them. EI#2 informed the surveyor she (EI#2) had completed a mini mental state examination (MMSE) on RI#9 and she/he had failed (score 18). EI#2 documented RI#9 was not appropriate for ALF care related to medication observation. However, a MMSE was completed on March 19, 2021 with a documented score of 19 (10-20 points: moderate dementia). According to the last three (3) monthly assessments, RI#9 passed the medication awareness testing by EI#2 on March 19, 2021 and passed testing by EI#9 on April 12, 2021 and May 13, 2021.	A 613		
A 614	420-5-4-.06 (5)(f)(g)(6)(7)(a)-(i) Care of Residents. (f) A resident may self-manage his or	A 614		

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her medications. For the purposes of these rules, self-manage shall mean the resident is capable of maintaining possession and control of his or her medications, who does maintain possession and control of his or her medications, and self-administers his or her medications without creating an unreasonable risk to health and safety.

(g) A resident that cannot self-manage his or her own medication without creating an unreasonable risk to health and safety may be assisted with self-administration of medication by any assisted living facility staff, including staff members who hold no professional licensure provided:

1. The resident can and does identify his or her name on the medication package and has a reasonable understanding of the unit dose packaging system in use by the facility such that the resident could protect himself or herself from medication errors when unit dose packages are brought to the resident by facility staff. The resident shall have the opportunity to demonstrate his or her ability to correctly utilize the unit dose package system at every opportunity for medication use.

(6) Assistance with self-administration of medication includes the following practices:

(a) Reminding a resident that it is time to take a medication or medications, where such medications have been prescribed for a specific time of day, a specific number of times per day, specific intervals of time, or for a specific time in relation to mealtimes or other activities such as arising from bed or retiring to bed.

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A 614	Continued From page 76 (b) Physically assisting a resident by opening or helping to open a container holding medications. (c) Offering liquids to a resident to assist that resident in ingesting oral medications. (d) Physically bringing a container of medication to a resident. (7) Assistance with self-administration of medications shall under no circumstances include any of the following practices: (a) Medication administration as defined in these rules. (b) Determining the amount of medication to be given. If a medication is not available in unit dose packaging, unlicensed facility staff may measure the prescribed amount of medication only under the direction and control of the resident, provided that the resident is capable of determining the amount of medication to be given. (c) Giving a resident injections of any kind. (d) Telling or reminding a resident that it is time to take a PRN, or as needed medication. (e) Placing medications in a feeding tube. (f) Giving enemas or suppositories. (g) Crushing or splitting medications,	A 614		

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A 614	Continued From page 77 provided that a physician has ordered a specific medication to be crushed or split and the resident is capable of self-managing his or her own medication or the resident is capable of medication self-administration with assistance and would be capable of crushing or splitting his or her own medications but for limitations of mobility or dexterity, may be assisted with crushing or splitting medications by unlicensed staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. (h) Mixing medications with food or liquids, provided that a physician has ordered a medication to be mixed with food or liquid and the resident is capable of self-managing his or her own medications or the resident is capable of medication self-administration with assistance and would be capable of mixing his or her own medications with food or liquid but for limitations of mobility or dexterity, may be assisted with mixing medications with food or liquid by unlicensed staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. (i) Assisting with self-administration of eye drops, eardrops, nose drops, inhalers, nebulizers, or topical medications, provided that a resident who is capable of self-managing his or her own medication or a resident who is capable	A 614		

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A 614	Continued From page 78 of medication self-administration with assistance and who would be capable of self-administration of his or her own medications but for limitations of mobility or dexterity, may be assisted with eye drops, ear drops, nose drops, inhalers, nebulizers, or topical medications by unlicensed facility staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a resident with a visual impairment a method to protect herself/himself from a medication error. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 13, 2020. Findings: Refer to deficiency 613 for additional information where unlicensed staff, EI#15, administered medications to RI#9 who was unable to protect him/herself from medication errors due to visual impairment.	A 614		
A 615	420-5-4-.06 (7) (j) Care of Residents. (j) All medications administered to residents and all medications self-administered with assistance of facility staff in an assisted living	A 615		

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facility shall be contemporaneously recorded on a standard medication administration or medication assistance record. "Contemporaneously recorded" means recorded at the same time or immediately after medications are administered. The medication administration or medication assistance record shall include at least the following:

1. The name of the resident to whom the medication was administered or assisted.

2. The name of the medication administered or assisted.

3. The dosage of the medication administered or assisted.

4. The method of administration or assistance.

5. The site of injection or application, if the medication was injected or applied.

6. The date and time of the medication administration or assistance.

7. Any adverse reaction to the medication.

8. The printed name, initials, and written signature of the individual administering the medication or assisting the resident with self-administration of the medication.

This Rule is not met as evidenced by:
Based on observation, interview and record review, the facility did not ensure all medications

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were contemporaneously recorded on the medication assistance record (MAR). In addition, the nurses failed to provide their printed name, initials, and written signature on the MAR for all residents

THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 13, 2020 and FEBRUARY 28, 2018.

Findings:

Contemporaneously Recorded:

On the afternoon of June 22, 2021, the surveyor reviewed medication assistance records (MAR) filed in a binder located in the second floor medication room. The binder was labeled MAR Book for Nurses. The surveyor found numerous instances where the nurses did not initial the MAR from June 1-20, 2021, to indicate they had administered medications at the time scheduled. EI#9 explained she (EI#9) discussed this with the other nurses (full-time, PRN and weekends) and they reported the medications had been given as ordered but they failed to sign the MAR contemporaneously. Refer to deficiency 601 for additional information.

The following days were not signed contemporaneously by the nurses on the MAR:

RI#2 - June 1, 7, 11, 16, and 17
RI#7 - June 11, 13, 14, 15, 16, 17, 18, and 20
RI#9 - June 7, 8, 9, 10, 11, 16, 17, and 20
RI#11 - June 1, 7, 15, 16, 17, and 20
RI#12 - June 1, 16, and 20
RI#15 - June 1, 11, 16, 17, 18, and 20
RI#16 - June 11, 16, 17, and 20

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A 615	Continued From page 81 Information on MAR: The nurses did not consistently write their name, initials, and signature on the back page of the MAR for all residents during medication administration. On June 22, 2021 at 4:45 PM, EI#9 acknowledge the nurses information was missing on the MAR and she (EI#9) would follow-up on this.	A 615		
A 618	420-5-4-.06 (9) Care of Residents. (9) Oxygen Therapy. (a) A resident of an assisted living facility that requires oxygen therapy shall self-manage his or her own oxygen therapy or self-administer his or her own oxygen therapy with assistance of facility staff. A resident that cannot safely self-manage or self-administer his or her own oxygen therapy with assistance shall have oxygen administered only by a physician, RN, or LPN. A resident that cannot direct his or her administration of oxygen and cannot be taught to direct his or her administration of oxygen shall be appropriately discharged. (b) Oxygen use including date, time, rate, and proper function of the equipment shall be documented on the medication administration or medication assistance record at least once per shift unless oxygen therapy is self-managed by the resident. (c) If a resident receives oxygen therapy in a facility: 1. All oxygen equipment, such as tubing, masks, and nasal cannula shall be	A 618		

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A 618	Continued From page 82 maintained in a safe and sanitary condition. 2. All oxygen tanks shall be safely maintained and stored. 3. The facility shall require safe use of oxygen therapy. No smoking and appropriate precautionary signs shall be posted. 4. The facility shall ensure that each resident using oxygen therapy maintains an adequate supply of oxygen. Refer to National Fire Protection Association (NFPA) 99 for oxygen storage requirements. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all residents could safely self-manage their own oxygen therapy. In addition, the facility staff did not document the date, time, rate, and proper function of the equipment on the Medication Administration Record (MAR) at least once per shift. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 13, 2020. Findings: RI#13 was admitted to the facility on October 5, 2020, with diagnoses of COPD, chronic bronchitis, congestive heart failure (CHF), and hypertension. In addition, RI#13 was admitted to hospice on June 7, 2021, with a terminal diagnosis of COPD. According to the initial Medical Exam dated September 28, 2020, RI#13	A 618		

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A 618 | A 618

Continued From page 83

would require redirection, supervision, and monitoring of medications. The physician also indicated RI#13 would require medication assistance. On June 22, 2021, the surveyor confirmed RI#13 was receiving an incorrect amount of oxygen. Refer to deficiency 601.

On June 24, 2021, the surveyor reviewed the June MAR with EI#9. The oxygen was listed on the MAR (O2 at 3 liters via NC) with a start date of October, 7, 2020. However, there was no documentation the staff checked the oxygen each shift. EI#9 informed the surveyor RI#13 could self-manage her/his oxygen administration but there was not a physician order for RI#13 to self-administer medications. Also on June 22, 2021, during an interview with the surveyor, RI#13 was unable to verbalized what the oxygen rate was supposed to be.

A 901 | A 901

420-5-4-.09 (1) (2) Laundry.

(1) General.

(a) Direction and Supervision. Responsibility for laundry services shall be assigned to an employee.

(b) Linen. Linens shall be handled, stored, processed, and transported in a manner consistent with generally accepted infection control practices.

(2) Location and Space Requirements.

(a) Each assisted living facility shall have laundering facilities unless commercial laundries are used. An on-site laundry shall be located in a specifically designated area, and there shall be

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A 901	Continued From page 84 adequate rooms and spaces for sorting, processing, and storage of soiled material. Laundry rooms in Group and Congregate facilities shall not open directly into resident rooms or food service areas. Domestic washers and dryers which are for the exclusive use of residents may be provided in resident areas, provided they are installed in such a manner that they do not cause a sanitation problem or offensive odors. (b) Each assisted living facility shall have a system in place to keep clean linen and dirty linen separated and to prevent the reuse of dirty linen before it is cleaned. Dirty linens and clothing shall not be stored, even temporarily, in the area set aside for clean linen. (c) Ventilation of Laundry. Provisions shall be made for proper mechanical ventilation of the laundry, if located within the assisted living facility. Provisions shall also be made to prevent the re-circulation of air in commercial equipment laundries into the heating and air conditioning systems outside the laundry area. (d) Lint Traps. Adequate, effective, and clean lint traps shall be used in all dryers. This Rule is not met as evidenced by: Based on observations, interviews, and interviews the facility failed to do the resident's laundry in a timely manner. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.	A 901		

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A 901	Continued From page 85	A 901		

THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 13, 2020 and FEBRUARY 28, 2018.

Findings:

On May 19, 2021, the Alabama Department of Public Health received a complaint, which alleged the facility did not have laundry services available. The morning of June 22, 2021, the surveyor inspected the laundry room with EI#1, Administrator. The surveyor was informed by EI#1 the washing machines and dryers were purchased by the facility about four (4) weeks ago. While in the laundry room, the surveyor interviewed EI#7, Laundry Aide at 10:16 AM. EI#7 said she (EI#7) was hired two (2) weeks ago to do the memory care resident's laundry on first shift (7 AM - 3 PM) Monday through Friday. The surveyor reviewed the "SCALF Laundry List" and the "ALF Laundry List" for June with EI#7. EI#7 explained once she (EI#7) completes the resident's laundry for the day she (EI#7) writes her (EI#7) initials by the resident's name. EI#7 informed the surveyor there was another laundry aide (EI#6) that was supposed to do the assisted living residents' laundry, but she (EI#6) only worked for two (2) weeks before she (EI#6) quit. EI#7 said she (EI#7) did not know who was responsible for doing the laundry for the assisted living residents since EI#6 left. Shortly thereafter, the surveyor discussed the laundry situation with EI#5, Maintenance Director. EI#5 confirmed EI#6 quit last week and they had been trying to hire someone else. EI#5 said we (EI#5, EI#1, EI#4 and RCAs) have been trying to keep up with the laundry but it has been tough. Later that afternoon around 2:00 PM, the surveyor visited RI#6 in her/his room. RI#6 told the surveyor,

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A 901	Continued From page 86 "They need to do the laundry." The surveyor observed a tall laundry basket in RI#6's bathroom overflowing with dirty towels and clothes. At approximately 2:40 PM, the surveyor observed dirty sheets and a pair of soiled underwear on the floor next to RI#8's bed. The surveyor brought this to the attention of EI#14, RCA. EI#14 said she (EI#14) would take care of it and removed the dirty items from the room.	A 901		
A1002	420-5-4-.10 (2) Sanitation and Housekeeping. (2) Housekeeping and Physical Plant Maintenance. The facility must provide a safe, functional, sanitary, decent, and comfortable environment for residents, staff, and the public. (a) Equipment and Supplies. The home shall maintain an adequate quantity of housekeeping and maintenance equipment and supplies. (b) Bathtubs and Lavatories. Bathtubs and lavatories shall be kept clean and in proper working order, and shall not be used for laundering. (c) Resident Bedrooms. Resident bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance. (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.	A1002		

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2. The use of attics for storage of combustible materials shall be prohibited unless protected by an automatic sprinkler system and then only in small quantities so as not to create a hazardous condition.

3. Basements used for storage shall meet acceptable standards for storage and shall be designed and constructed in a manner that protects against fire hazards.

4. Flammable materials such as gasoline, motor fuels, lighter fluid, turpentine, acetone, and oil-based paint shall not be stored in the facility. Unless prohibited by a facility's own policies, however, a cognitively intact resident who uses lighter fluid to fill a personal cigarette lighter, or one who uses flammable materials such as paint or glue in connection with a personal hobby, may store small quantities of those materials in a safe and secure manner within his or her own room.

5. Poisonous or External Use Substances. Facility cleaning supplies and poisons shall be attended at all times or shall be kept in a secure area.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to provide a clean and sanitary environment for all residents.

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

THIS IS A REPEAT DEFICIENCY FROM THE

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SURVEY CONDUCTED ON FEBRUARY 13, 2020.

Findings:

The Alabama Department of Public Health received a complaint on May 19, 2021, which alleged there was no housekeeping services at the facility. On June 22, 2021, the surveyor toured the first and second floors of the assisted living unit with EI#9, LPN. The surveyor and EI#9 observed the following housekeeping issues:

First floor (Rooms 101-126):
1. Hallway had numerous black spots and brown stains.
2. Dirty bathrooms for RI#2 and RI#3.
3. Room smelled of urine RI#3.
4. Dirty floors in bedroom and bathroom, RI#4 an RI#5.

Second floor (Rooms 230-255):
1. Hallway smelled of cigarette smoke.
2. Dirty bathrooms for RI#10 and RI#15.
3. Room smelled of urine, RI#15.

The surveyor interviewed EI#9, LPN, regarding the unsanitary conditions of the resident's bedroom and bathrooms. EI#9 told the surveyor the conditions were not acceptable and she (EI#9) would call housekeeping right away. EI#9 said housekeeping had been a problem off and on for the past three (3) weeks. EI#9 informed the surveyor when she (EI#9) found the bathrooms in need of cleaning she (EI#9) would notify EI#5. EI#9 went onto say she (EI#9) would sometimes come in early (6 AM- 7 AM) to help clean the resident's bathrooms prior to starting her (EI#9) shift. Also, on June 3, 2021, EI#2, RNC, documented during her facility rounds that the

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A1002	Continued From page 89 floors were dull and stained and in need of striping, waxing, and edging.	A1002		
A1101	420-5-4-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift of Group and Congregate facilities. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the currently adopted Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty	A1101		

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wheelchairs.

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

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

1. Minimizes leaks and spills.

2. Adequately protects against inappropriate access.

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

(f) Fire Alarm and Sprinkler System.

1. Fire Alarm System. Where fire alarm systems are required, a corridor smoke detection system shall be installed on each floor, including areas open to the exit access corridor, to comply with NFPA 72, connected to the facility's fire alarm system. In lieu of corridor smoke detection, smoke detectors connected to the building fire alarm system may be installed in each resident's room, open areas, and at smoke doors (except that corridor smoke detection shall not be deleted when its use is dictated by other requirements).

2. Fire alarm and sprinkler system outages of more than 4 hours require evacuation of the facility or the establishment of a continuous fire watch. The fire watch procedure must be coordinated with the Department and the local Fire Marshal. Outages and fire watch documentation shall be reported to the Department within 12 hours or no later than the

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next duty day, and shall be corrected expeditiously.

3. The fire alarm system and the sprinkler system shall be inspected by licensed, trained, and qualified personnel at least semiannually for compliance with the respective codes. Inspection and testing reports shall be maintained in the facility for a period of at least 3 years.

This Rule is not met as evidenced by:
Based on record reviews and interview, the facility failed to properly perform and document monthly fire drills.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 13, 2020 AND JULY 14, 2016..

Findings:

Review of the facility's monthly fire drill reports on June 23, 2021 revealed fire drills were performed and documented separately for the assisted living facility (ALF) and the SCALF (located in the same building) through April 2020. Beginning in May 2020, one fire drill was documented jointly for the ALF and the SCALF by EI#5, Maintenance Director. There was no documentation of the observations for each individual facility to include the effectiveness of the fire drill plan. When interviewed on the afternoon of June 23, 2021, EI#5 stated he (EI#5) was confused about the fire drills and the need to perform separate drills for each facility following the last state survey when the facility was cited for failure to properly perform

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A1101	Continued From page 92 fire drills. EI#5 further stated he (EI#5) contacted a life safety surveyor who informed him (EI#5) it was not necessary to pull the alarm at separate stations for each facility. The surveyors directed EI#5 to the requirement of the SBOH rules for ALF/SCALF that each separate facility must have observations of the fire drill plan effectiveness monthly, even when one alarm is pulled for the entire building. CONNIE CHERRY, REGISTERED NURSE DEBRA FREEMAN, REGISTERED NURSE	A1101		