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MEADOWOOD RETIREMENT VILLAGE, LLC SCALF	509 PINEVIEW AVENUE GLENCOE, AL 35905

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A 000	Initial Comments On June 24, 2021, an unannounced licensure survey and complaint investigation was conducted for this 51 bed Specialty Care Assisted Living Facility (SCALF) with a census of 24. On August 16 and 17, 2021, an investigation of care survey was conducted at the facility and the census was 25. There were three (3) complaints investigated during the initial onsite survey. Complaint #20210519005 and Complaint #20210324012 were investigated and substantiated with multiple deficiencies cited. Complaint #20201116003 was investigated and a portion of the complaint was substantiated with deficiencies cited as a result of the complaint investigation. No complaints were investigated during the onsite investigation in August 2021. Two facility-reported incidents were investigated. Intake ID 20210811015 and Intake ID 20210809014 were investigated with deficiencies cited as a result of the investigations. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practices resulted in actual harm to one resident and the potential for harm to all residents.	A 000		
A 301	420-5-20-.03 (1) (a) (b) (c) (d) Administration. (1) The Specialty Care Assisted Living Facility Governing Authority. (a) A specialty care assisted living facility shall have an identified sole proprietorship,	A 301		

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

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

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

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

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

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

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

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A 301	Continued From page 2 (d) The governing authority is responsible for appointing and supervising the administrator who is responsible for overall management and the day-to-day operation of the facility. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the Governing Authority failed to properly supervise the Administrator to ensure the facility operated in compliance with the SBOH rules for SCALFs. The Governing Authority's lack of adequate oversight and the Administrators' neglect to perform their duties resulted in failure to implement policies and procedures necessary to ensure the day to day operations of the facility were managed responsibly and compliance with SBOH rules for SCALFs was achieved and maintained. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON JULY 14, 2016 AND ON SEPTEMBER 22, 2016. Findings: The current Administrator, Employee Identifier (EI#1) had only been employed at the facility about 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 previous Administrators due to failure to perform duties of the Administrator. Review of ADPH records confirmed EI#1 was the fifth administrator since May 2017 when the current Governing	A 301		

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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 plans to be 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 for oversight. The forms were dated March 18 and 19, 2021, May 4, 2021 and June 3, 2021. The March 19, 2021 form documented eight SCALF residents who did not have comprehensive assessments/monthly assessments/admission assessments completed as required. Completion of these assessments was required by a Registered Nurse (RN). Even though this deficiency in RN duties was identified in March, three months prior to the survey, there was no dedicated RN working at the facility at the time of the survey. In fact, after interviews with EI#2, EI#8 and EI#23, surveyors were unable to confirm a RN had worked at the facility at all in the past two months. The May 4, 2021 form documented a need for cardiopulmonary resuscitation (CPR) and diabetes training. According to the RNC Visit form, training on CPR, hospice and diabetes was being scheduled by the Unit Coordinators for assisted living and SCALF. This training had not been completed at the time of the survey. The June 3, 2021 form documented dull and stained floors in need of striping, waxing and edging in both the ALF and

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A 301	Continued From page 4 the SCALF. This remained a deficiency at the time of the survey. The June 2021 form also documented spider webs in corners of doors. The surveyors noted spider webs in corners at the time of the survey. Although these 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 Alabama Department of Public Health received multiple complaints since the last onsite survey which was conducted on February 13, 2020. The complaints included lack of adequate staffing, ineligible residents, inadequate housekeeping and laundry services, dirty toilets, no dedicated RN and toilet not working. These complaints were substantiated during the current survey and were all repeat deficiencies from previous surveys. Inadequate laundry service was cited in February 2018 and remained a deficiency, cited as a result of multiple complaints. Failure to provide privacy for residents was cited during a September 2016 survey and remained a deficient practice during the current survey, even though EI#5 reported equipment had been purchased to provide privacy in semi-private rooms. Failure to properly perform fire drills was cited during a February 2020 survey and during a July 2016 survey but continued to be a deficient practice currently. Dirty resident rooms and toilets were cited during the July 2016 survey and were again found at the facility during the current survey. Failure to perform building/equipment repairs was cited in July 2016 and February 2020 and again during the current survey. Staffing was inadequate at the facility in July 2016. Current survey findings were	A 301		

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the facility did not provide the minimum staffing ratio. In July 2016 and February 2020, the facility was cited for failure to provide required staff training including cardiopulmonary resuscitation (CPR). This was again cited during the current survey. In July 2016 and September 2016, deficiencies were cited for RN assessments and care plans not completed as required. During the current survey, there was no dedicated RN at the facility, resulting in multiple assessments and care plans not completed. Also, in July 2016, Licensed Practical Nurses (LPNs) were completing assessments which were required to be completed by a RN. This also was repeated during the current survey. In July 2016, a resident was admitted in need of hospice services and residents were retained at the facility with Physical Self Maintenance Scores (PSMS) above the level allowed in a SCALF. The same deficient practices were found during the current survey. Failure to provide a safe and decent environment was cited in September 2016, in February 2020 and during 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 all residents of the facility at risk of harm.

During investigation of the allegation that there was no RN at the facility, five current and discharged resident files were reviewed which contained identical signatures of EI#2 on completed Comprehensive Assessment forms. These Comprehensive Assessments were as follows: Resident Identifier (RI)#2 on May 12, 2021; RI#4 on February 11, 2021; RI#9 on May 27, 2021; RI#12 on May 22, 2021 and RI#15 on May 12, 2021. The signatures on these forms resembled a copy as they were lighter in color

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A 301	Continued From page 6 than the handwriting on other areas of the form and were clearly a different handwriting. Some of the signatures appeared to have been traced over to make them darker. In addition, a form containing this identical signature and RI#8's name and brief information was found in RI#8's facility record, undated. Also, an otherwise blank form containing only this identical signature was found in RI#8's facility record. The handwriting which documented resident information on each of these forms appeared to be from the same person and EI#8 identified this handwriting as hers (EI#8's). However, during an interview on June 24, 2021, EI#8 denied any knowledge of or use of a copied RN signature. During an interview on June 24, 2021, EI#2 also denied any knowledge of a copied signature and stated she (EI#2) had never provided a copy of her (EI#2's) signature on a blank form to the facility. EI#2 also stated she (EI#2) only visited the facility for oversight and did not perform resident assessments except on rare occasions. EI#2 stated EI#23 had been available since November 2020 to perform resident assessments. EI#2 provided her (EI#2's) signature to surveyors and it was very similar to the signatures on each form. The surveyors were unable to determine how these signatures were placed on forms which were completed by EI#8. EI#3 reiterated to surveyors his (EI#3's) confidence that EI#1 had the ability to regain and maintain compliance with SBOH rules for SCALF 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. Surveyors were not contacted by the owner of the facility during the survey. The surveyor contacted EI#24, Owner, by phone on the morning of July 7,	A 301		

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2021. EI#24 stated he (EI#24) purchased the facility approximately four years ago and did not realize the facility was in trouble at that time. EI#24 stated he (EI#24) 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#24 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#24 stated he (EI#24) was sending a maintenance crew to the facility within the next two weeks and plans to have building issues addressed within 60 days. EI#24 verbalized a concern that issues at the facility had not been passed on to him (EI#24) and, therefore, may not have been addressed. However, EI#24 added EI#1 now contacts him (EI#24) directly with concerns or needs instead of going through the Regional Vice President. Although he (EI#24) had made regular visits to the facility prior to the survey, EI#24 stated he (EI#24) now plans to visit more frequently.

The initial onsite visit for this survey was conducted by surveyors 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), owned by the same governing authority, which resulted in the transfer of multiple residents from the SNF to the assisted living facility (ALF) and to the SCALF on August 9, 2021. Five of these residents were admitted to the SCALF on August 11, 2021, bringing the total census of the facility to 25. However, the admission process was inadequate and did not include completion of proper forms including financial agreements, resident bill of rights and inventory of personal effects. The

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residents had not been properly screened for admission at the time of the second onsite survey, five days after they were transferred on an emergency basis. No care plans had been developed for the residents. In fact, the five residents did not have all physician-ordered medications available six days after the transfer. Inadequate staffing had been identified at the facility prior to admission of these five 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 continued inadequate available staff.

During the second onsite visit to the facility, surveyors also investigated a facility-reported incident involving a resident who had a fractured femur following a fall during a transfer from the bed to the chair. This resident had been identified by surveyors, during the first onsite visit, as needing two-person assistance with transfers. However, the resident's care plan did not direct the care staff to use two-person assistance for transfers. The fall occurred while the resident was being transferred by only one staff member. The resident's care plan had not been updated to include two-person assistance with transfers and was still not updated after the resident sustained a fall with injury. Although a portable x-ray was ordered following the fall due to pain in the leg, the incident was not reported to the Alabama Department of Public Health until two weeks later when the resident was sent to the hospital. The incident was not adequately investigated by the administrator and no interventions were put in place to prevent a recurrence.

Deficient practices continued at the facility following the initial visit by surveyors. The facility's failure to update a resident's care plan with

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	appropriate interventions to meet the care and safety needs of the resident resulted in actual harm to the resident.			
A 302	420-5-20-.03 (e) Administration.	A 302		
	(e) Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). All residents shall be informed of new policies or changes in existing policies that may have bearing on the resident. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies shall cover the following:			
	(i) Facility responsibility to protect all residents from abuse, neglect, and exploitation.			
	(ii) How allegations of abuse, neglect, and exploitation will be handled by the facility.			
	(iii) Resident confidentiality.			
	(iv) Admission and continued stay criteria.			
	(v) Discharge criteria and notification procedures for residents and sponsors.			
	(vi) Facility responsibility when a resident's personal belongings are lost.			

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A 302	Continued From page 10 (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. (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.	A 302		

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(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, 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 JULY 14, 2016 AND ON SEPTEMBER 22, 2016.

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Findings:

RN Duties and Assessments

According to the facility's Registered Nurse-SCALF Policy and Procedure, "...The Registered Nurse (RN) is responsible for:...The RN shall perform a monthly assessment on each resident of the facility...The RN shall perform a comprehensive assessment of each resident upon admission, when a significant change in health or behavior occurs, and when the monthly assessment identifies a problem as listed in the ADPH's rules and regulations for Specialty Care Assisted Living Facilities. The PSMS and Behavior Screening will also be completed when there is a significant change in the resident...The RN shall evaluate both the facility's implementation and the resident's response to the Plan of Care and shall modify the Plan of Care when necessary to meet the needs of the resident...The RN shall identify and coordinate staff training needs...The RN shall consult with the administrator on all issues of resident safety, health and well-being,...The RN shall carefully evaluate each resident to ensure appropriate admission and continued stay eligibility...The RN shall identify resident care problems areas and formulate written interventions to address those problems...The RN shall communicate with the resident's attending physician and family member when a resident experiences a significant change...". There was not a dedicated RN at the facility to fulfill these duties. Some RN duties were being completed by a LPN at the facility. Refer to deficiencies 405, 604, 611, 620 and 621 for additional information.

Care Coordinator

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According to the facility's Unit Coordinator-SCALF Policy and Procedure, "...The Unit Coordinator shall carefully evaluate each resident for admission and continued stay eligibility...". The Care Coordinator failed to properly evaluate residents prior to admission and for continued stay. Refer to deficiencies 620 and 621 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 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.

Staffing

According to the facility's Staffing Policy and Procedure, "...Adequate, competent staff is scheduled to meet all facility services and needs...The facility shall have at least two staff members on duty twenty-four hours a day, seven days a week. The facility shall not have fewer staff on duty than the specified table below:...Staff Number 3...7 AM-3 PM 17-24 Residents...3 PM-11 PM 17-36 Residents...11 PM-7 AM 17-48 Residents...". The facility did not provide the

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minimum staffing ratio at times and did not provide sufficient staff to meet the care needs of the residents. Refer to deficiency 401 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:...the resident's baseline weight and vital signs...a statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases...At least annually, a physician shall assess each resident and document his or her finding on the Medical Exam and Plan of Care...". At least one resident (RI#2) did not have an annual Medical Exam and residents' Medical Exams were incomplete. Refer to deficiency 602 for additional information.

Care Plans

According to the facility's Resident Records-Plan of Care Policy and Procedure, "...The Administrator of the facility shall be responsible for insuring that a written Plan of Care is developed for each resident prior to or at the time of admission...It shall document the personal care and service required from the facility by the resident. This Plan shall be kept current, reviewed and updated when there are any significant changes in the resident's condition, after each hospitalization, and at other appropriate times. The plan of care shall be modified when necessary to meet the needs of the resident...". Residents' care plans were not current, did not address the current care and safety needs of the residents and were

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A 302	Continued From page 15 non-existent for at least one resident. Refer to deficiency 611 for additional information. Privacy for Residents According to the facility's Personal Care-Activities of Daily Living Policy and Procedure, "...Always provide privacy...". Privacy was not provided during personal care of a resident. Refer to deficiencies 504 and 803 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 803, 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.	A 302		
A 303	420-5-20-.03 (2) (a) Administration. (2) The Administrator.	A 303		

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(a) Responsibility.

1. The administrator shall be a direct representative of the governing authority in the management of the specialty care assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties.

2. Any individual employed as an administrator shall be properly licensed.

3. Any individual employed as an administrator shall meet all applicable statutory requirements.

4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days.

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

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

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

8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe

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

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

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

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

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

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

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, EI#1, Administrator, failed to adequately perform his (EI#1) duties to ensure the proper

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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 SCALFs and failed to ensure previously cited deficiencies were corrected and compliance with SBOH rules for SCALFs was maintained. These failures placed all 25 residents of the facility at significant risk of harm and resulted in actual harm to one resident.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON JULY 14, 2016 AND ON SEPTEMBER 22, 2016.

Findings:

On June 22-24, 2021, surveyors with the ADPH conducted an onsite survey and complaint investigation at the facility. Three complaints were investigated. The complaints contained numerous allegations including inadequate staffing, ineligible residents, inadequate housekeeping and laundry services, dirty resident toilets and a toilet that was not functional, no RN at the facility and resident rooms not cleaned properly. Surveyors substantiated all these complaints while onsite and identified other deficient practices as well.

On August 16 and 17, 2021, surveyors returned to the facility for investigation of care related to facility-reported incidents. Additional deficiencies were cited as a result of these investigations.

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

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which were in place when he (EI#1) began as Administrator.

Multiple staffing issues were identified by surveyors. There was inadequate staff to meet the care and safety needs of the current residents. Staff were not properly screened prior to hire and prior to resident contact. Staff members were not certified in CPR and were not trained in special needs of residents. The Care Coordinator was not properly trained in the SBOH rules for SCALFs. The Care Coordinator was a LPN but was performing RN duties without knowledge this was an incorrect practice. The one facility RN was not dedicated and had not worked at the facility in at least two months at the time of the survey.

Numerous resident care issues resulted from the inadequate training of the Care Coordinator and lack of a facility RN. Residents were not assessed and screened for facility admission as required and were not assessed when significant change in status occurred. As a result of inadequate screening, one resident was admitted in need of hospice services and at least two residents were retained at the facility with PSMS results above the level allowed in a SCALF. Resident assessments, including pre-admission, change of condition and monthly assessments were documented incorrectly by the Care Coordinator (LPN) with no signature or were not documented at all. Residents' medical examinations were incomplete. Resident care plans were not current to meet the care and safety needs of the residents.

EI#1 initially informed the surveyors there was no plan to hire a fulltime RN at the facility. On June 24, 2021, a dedicated RN was hired for the

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facility, after surveyors made EI#1, EI#2 and EI#3 aware of the above deficiencies and the absence of a RN at the facility. EI#1 stated he (EI#1) was not aware the RN had not been working. EI#2 stated there were two RNs at the sister skilled nursing facility who had been trained to do RN assessments. EI#8 stated she (EI#8) had not been instructed to contact these RNs and did not know how to contact them. In fact, the last time EI#8 had contacted a RN to complete assessments at the facility was on April 29, 2021.

Although a RN was hired by EI#1 on June 24, 2021, resident care plans still were not current when surveyors returned to the facility in August 2021. In fact, five new residents had no care plans at all. One resident's care plan was not updated even after the resident sustained a fracture following a fall. The incident involving the fall was not reported to ADPH by EI#1 and was not adequately investigated. The administrator failed to ensure residents' care plans were current with interventions to meet the residents' care and safety needs and failed to ensure an incident was properly reported and adequately investigated, even after a resident sustained harm at the facility.

Multiple repeated deficiencies were cited during this survey. Refer to deficiency 301 for additional information. Some 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. EI#1 informed the surveyors multiple times he (EI#1) was committed to bringing the facility to full compliance with SBOH rules for SCALFs, as long as he (EI#1) had the support and assistance of the Governing Authority.

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A 303	Continued From page 21 The following deficiencies were cited as a result of the Administrator's failure to apply the SBOH rules to the day to day operations of the facility, as well as the lack of oversight of the Administrator by the Governing Authority. 302 - The facility failed to follow its own policies and procedures. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON JULY 14, 2016 AND ON SEPTEMBER 22, 2016. 401 - There was inadequate staffing at the facility. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 14, 2016. 402 - Employees were not properly screened prior to hire and prior to resident contact. 405 - Registered Nurse duties were not performed or were performed by a LPN. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 14, 2016. 406 - Staff were not properly trained in CPR and special needs of residents. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON JULY 14, 2016 AND 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 and failed to provide privacy	A 303		

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A 303	Continued From page 22 for residents. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON SEPTEMBER 22, 2016 AND ON FEBRUARY 13, 2020. 505 - Financial agreements were not signed or were incomplete for new admissions. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 28, 2018. 508 - A reportable incident was not reported to ADPH as required and was not adequately investigated. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON FEBRUARY 28, 2018 AND ON SEPTEMBER 22,2016. 601 - Physicians' orders were not followed for administration of medication to residents. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON SEPTEMBER 22, 2016. 602 - Residents' medical examinations were incomplete or non-existent. 604 - Health supervision of residents was inadequate. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON JULY 14, 2016 AND ON SEPTEMBER 22, 2016. 605 - General observation of residents was inadequate. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 14, 2016. 611 - Residents' care plans were not current to address the care and safety needs of the residents or were non-existent. Care plans were not developed for new residents upon admission.	A 303		

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THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON JULY 14, 2016 AND ON SEPTEMBER 22, 2016.

613 - The facility allowed unlicensed staff to administer medications to SCALF residents.

615 - Nurses did not document all required information on residents' Medication Administration Records (MARs). THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 28, 2018.

618 - Resident oxygen use was not documented appropriately. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 13, 2020.

620 - A resident was admitted to the facility in need of hospice services with a PSMS result above the level allowed in a SCALF. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 14, 2016.

621 - Residents were retained at the facility with PSMS results above the level allowed in a SCALF. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 14, 2016.

803 - Maintenance repairs were not completed and equipment was not provided to a resident to allow privacy. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON JULY 14, 2016, ON SEPTEMBER 22, 2016 AND ON FEBRUARY 13, 2020.

901 - Laundry services were inadequate. THIS

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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 FEBRUARY 13, 2020.

A 401 — 420-5-20-.04 (1) (2) Personnel. — A 401

(1) A specialty care assisted living facility shall ensure adequate personnel are employed and on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. No specialty care assisted living facility shall have fewer staff on duty than specified in Table A below. Even if this minimum staffing ratio is met, the governing authority of a specialty care assisted living facility shall have additional staff on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. Facilities with resident bedroom wings separated from the remainder of the facility by a lockable door shall maintain dedicated staff to these areas adequate to meet all care and safety needs of the residents in these areas at all times.

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Table A

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

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

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A 401	Continued From page 26 (b) A specialty care assisted living facility must be sufficiently staffed to ensure the safe evacuation of all residents in the event of a fire or emergency. (2) Employee Schedule. A specialty care assisted living facility shall post a schedule of employees indicating names and days and hours scheduled to work. This schedule shall be retained in the facility for 6 months after use. In the event of an unplanned staff shortage which would make it otherwise impossible to meet the staffing requirements imposed by these rules, a facility may employ a certified nurse aide who has not received the training specified in these rules. For the purposes of this subsection, a certified nurse aide is defined as an individual who has been deemed or determined to be competent by the Alabama Nurse Aide Registry maintained by the Alabama Department of Public Health. This individual may not work unless accompanied at all times by an individual who is appropriately trained in accordance with these rules. Such employment shall last only until the facility has employed staff trained in accordance with the above. In no event may the period during which such staff is employed in a facility exceed 120 consecutive hours. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility was not staffed with even the minimum staffing requirement and was not staffed adequately to meet the care needs of the residents at all times.	A 401		

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

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

Findings:

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

The census at the facility on June 24, 2021 was 24 residents, with one of those residents currently in the hospital. Review of a Daily Census Report, provided by EI#1, revealed the facility's daily census for the past two months fluctuated between 23 and 26 residents. Review of the Second Shift Schedule for June 2021, also provided by EI#1 on June 22, 2021, revealed only one nurse (EI#12) and one resident care assistant (RCA) (EI#21) worked at the facility between the hours of 11:00 PM until 7:00 AM on June 1, 2021, June 4, 2021 and on June 18, 2021. This was verified by review of employee time sheets. The minimum required staff for the facility with a census of 17-48 residents on the 11:00 PM-7:00 AM shift was three (3).

There were multiple shifts on the Second Shift Schedule for June 2021 when one nurse and two RCAs were scheduled to work. These shifts were on June 2, 3, 5, 6, 7, 8, 9, 10, 11, 14, 17, 19, 20, 22, 23 and 24, 2021. Through interviews with EI#1, EI#8, EI#10 and EI#12 the surveyor learned the nurse on duty between 11:00 PM and 7:00 AM was required to leave the SCALF and go to

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the assisted living facility in the same building to administer eye drops and perform fingerstick blood sugar checks for residents as well as administer insulin injections each night. During the nurses' absence from the SCALF on these dates, only two RCAs were left in the facility. When only one RCA was scheduled, the RCA was left alone on the SCALF while the nurse provided care for assisted living residents.

Interviews were conducted with multiple RCAs and nurses during the onsite survey. During these interviews, EI#10, EI#12, EI#14, EI#19 and EI#22 all stated they had worked at the facility when only two staff members were scheduled to work. In addition, multiple staff members reported they had recently been required to assist with laundry and housekeeping duties due to lack of adequate staff in those departments. Refer to deficiencies 901 and 1002 for additional information on laundry and housekeeping.

The following resident care concerns were noted by the surveyor through observations and interviews. One resident (RI#9) was bedridden and terminally ill, requiring assistance to turn and reposition, incontinent care and pain management. RI#1, RI#3, RI#4, RI#8, RI#11 and RI#13 all required one or two person assistance with transfers and personal care. Multiple residents required assistance with toileting and three residents (RI#8, RI#11 and RI#13) required assistance with eating. RI#7 would become agitated at times and had recently been admitted to the hospital due to aggressive behaviors.

During a return visit to the facility on August 16 and 17, 2021, surveyors found staffing remained inadequate. The census at the facility on August 17, 2021 was 25 with one resident currently in the

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A 401	Continued From page 29 hospital. 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's) office but was available to staff if needed. Surveyors investigated a death which occurred on the ALF on August 11, 2021. During an interview with EI#8, SCALF Care Coordinator and LPN, concerning this incident, EI#8 reported three staff members (EI#8, EI#16 and EI#27) were scheduled to work the SCALF the evening of August 11, 2021 around 9:00 PM. This was confirmed by review of time sheets for this date and time. EI#8 stated she (EI#8) and EI#27 went to the ALF to provide assistance for approximately one-two hours, leaving only EI#16 on the SCALF for one-two hours. EI#8 further stated "That's probably happened before when I get called to the ALF". EI#8 told the surveyors she (EI#8) had been working third shift due to staffing shortage. EI#8 also said, "We can't do our office work because we are working the floor". One nurse was 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. No staff was available on the ALF to relieve the nurse to leave the SCALF and go to the ALF. The facility was not staffed with the minimum requirements for a SCALF based on the daily census and was not staffed to meet the care and safety needs of all residents at all times. The facility continued to admit residents in spite of this staffing deficit.	A 401		
A 402	420-5-20-.04 (3) Personnel.	A 402		

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(3) Employee Screening.

(a) Prior to any resident contact, such as but not limited to assistance with activities of daily living, newly employed personnel shall have a physical examination certifying that the employee is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to residents through normal staff to resident contact. Employees who develop signs or symptoms of infectious skin lesions or diseases that would be capable of transmission to residents through normal staff to resident contact shall not be permitted to have resident contact until free from such signs and symptoms.

(b) Not more than 30 days prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis.

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

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

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

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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 began working 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 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 EI#6 was screened through the Alabama Department of Public Health Nurse Aide Abuse Registry prior to hire.

EI#14 began working at the facility on February 1, 2021. An "Employee Health Examination Record" was documented for EI#14 on January 30, 2021. However, the question on the form, "Is this individual free from communicable diseases?" was not answered by the physician.

EI#16 began working at the facility on March 27, 2020. Documentation in the employee file showed a skin test was administered to EI#16 for tuberculosis screening on March 25, 2020. Although a "read" date of March 27, 2020 was

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A 402	Continued From page 32 documented on the "T.B. Verification" form, there was no documentation of the test results to confirm EI#16 was negative for tuberculosis. EI#1 agreed documentation on employee files was incomplete.	A 402		
A 405	420-5-20-.04 (6) (7) (8) Personnel. (6) Medical Director. Each specialty care assisted living facility shall have a medical director who is a physician currently licensed to practice medicine in Alabama. The medical director is responsible for implementation of resident care policies, and the coordination of medical care in the facility. The medical director shall participate in quality assurance activities in the facility. A nurse practitioner or physician's assistant shall not serve as the medical director of a specialty care assisted living facility. (7) Registered Professional Nurse. Each facility shall have at least one RN. An RN may also serve as the administrator or as the care coordinator, but not as both. In all instances where the facility's RN is assigned other duties as an administrator or care coordinator the facility must assure that the RN devotes sufficient time and effort to all clinical duties. (a) Responsibility. The RN shall be responsible for oversite and coordination of resident care. 1. The RN shall assess the residents in the specialty care assisted living facility. 2. The RN shall develop, document, and evaluate resident plans of care.	A 405		

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

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

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

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

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

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility did not have an RN to devote sufficient time and effort to clinical duties as required. In addition, the Care Coordinator was not correctly and adequately trained in the duties of the Care Coordinator required to manage the daily delivery of resident care. Also, staff training needs were not identified and met.

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 JULY 14, 2016.

Findings:

The Alabama Department of Public Health received a complaint which alleged there was not an RN at the facility. The complaint also alleged there was no posting of the supervisor on call at the facility. The surveyor was able to substantiate these deficiencies during the onsite survey. Multiple deficient practices were cited as a result of failure to maintain a dedicated RN at the facility.

Failure to Provide Dedicated RN and Care Coordinator Inadequate/Improper Training

When surveyors entered the facility on June 22, 2021, they (surveyors) were informed by EI#1 that both EI#2, Regional Registered Nurse Consultant, and EI#23, RN, worked part time at the facility to fulfill RN duties. EI#1 stated in a later interview he (EI#1) was not aware of any plans to hire a fulltime RN.

During an interview on the morning of June 24, 2021, EI#2 informed surveyors she (EI#2) was not the dedicated RN for the facility but was the RN consultant. EI#2 further stated she (EI#2) visited the facility about every other month to provide oversight of the facility nurses. EI#2 added that, as of November 2020, EI#23 was available to complete comprehensive and other assessments of residents and she (EI#2) thought EI#23 was scheduled to work 10 hours every week and as needed. In addition, EI#2 stated two RNs from a nursing home (owned by the same company) had been trained and were available to assess residents as needed. EI#2 provided surveyors with documents from a "RNC

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(Registered Nurse Consultant) Visit" to the facility, dated March 19, 2021. These documents recorded multiple deficient practices observed on the SCALF unit, including monthly assessments, comprehensive assessments and pre-admission assessments not completed for eight residents. EI#2 informed the surveyors this report had been given to the Administrator and to the Regional Vice President following the visit.

During a telephone interview on the afternoon of June 24, 2021, EI#23 stated she (EI#23) had not worked at the facility for several months due to accepting an RN position which required travel. EI#23 stated when previously working at the facility, EI#5 or EI#8 would call her (EI#23) and let her (EI#23) know what resident assessments were needed. EI#23 reiterated that she (EI#23) had not been contacted by the facility recently.

During review of resident records on June 23 and 24, 2021, the surveyor noted numerous monthly assessments and comprehensive assessments which had been written but were not signed. In addition, numerous monthly assessments had not been completed at all. Refer to deficiency 604 for additional information. Pre-admission assessments had not been completed to evaluate residents for admission, resulting in at least one inappropriate admission. Refer to deficiency 620 for additional information. Residents were retained at the facility with PSMS results above the level allowed in a SCALF without current assessments being completed. Refer to deficiency 621 for additional information. Comprehensive assessments were not completed when significant changes occurred in residents. Refer to deficiency 604 for additional information. Residents' care plans were not current. The care plan entries were not signed but

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EI#8, LPN, informed the surveyor she (EI#8) updated the care plans and was unaware this was an incorrect practice. Refer to deficiency 611 for additional information.

On the morning of June 22, 2021, EI#8, LPN/Care Coordinator, informed the surveyor the paperwork on the SCALF was not currently up to date due to staffing issues which caused EI#8 to work the unit on various shifts. During an interview on the afternoon of June 24, 2021, EI#8 stated EI#23 had signed some type of agreement with the facility to work a certain number of hours but she (EI#8) was unsure the date EI#23 last worked at the facility. After reviewing her (EI#8's) cell phone, EI#8 stated she (EI#8) last contacted EI#23 on April 29, 2021. EI#8 informed the surveyor she (EI#8) had been completing most resident assessment forms, then either EI#2 or EI#23 would come by the facility to review the forms, sometimes see the residents and sign the forms. EI#8 added this method had been taught to her (EI#8) by a previous RN at the facility and she (EI#8) was unaware this was an incorrect practice.

Staff Training Needs

Review of employee files on June 23, 2021 revealed staff had not been trained in CPR and in the special needs of residents to include hospice and diabetes. In addition, facility nurses were unaware which manager was on call for questions or problems that arose at the facility. Although EI#1 provided surveyors with a calendar listing which manager was on call at the facility each week, this schedule had not been provided to staff. EI#11, LPN and 7 AM-3 PM nurse, and the surveyor were unable to locate a copy of this calendar on the unit on June 22, 2021. EI#10,

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LPN and 3 PM-11 PM nurse, and EI#12, LPN and 11 PM-7 AM nurse, also stated they (EI#10 and EI#12) were unaware of a manager on call schedule at the facility. These staff training needs had not been identified and addressed by a facility RN. Refer to deficiency 406 for additional information.

The facility had not provided an RN to perform the necessary assessments and oversight of the unit for several months resulting in a chaotic environment and placing all residents at extreme risk of harm. The need for a RN and failure to perform RN duties had been identified by EI#2 in March 2021 but was not addressed timely. The Care Coordinator was not properly and adequately trained in the duties of the Care Coordinator, resulting in the Care Coordinator devoting a great deal of time to RN duties instead of performing the duties required to manage the daily functions of the unit. Facility nurses had not been trained on the proper notification of management for problems or questions at the facility.

When interviewed on June 24, 2021, EI#1 stated he (EI#1) was not aware EI#23 was not working and not available to work. EI#1 immediately hired a dedicated RN for the facility prior to the end of the onsite survey.

A 406 420-5-20-.04 (9) Personnel.

(9) Training.

(a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. An

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RN shall identify staff training needs and shall provide or arrange for needed training. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that, prior to resident contact, all staff members receive training on the subject matter listed below:

1. State law and rules on specialty care assisted living facilities.

2. Facility policies and procedures.

3. Resident rights.

4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire.

5. Identifying and reporting abuse, neglect, and exploitation.

6. Basic first aid.

7. Advance directives.

8. Protecting resident confidentiality.

9. Resident fire and environmental safety.

(b) Prior to providing any resident care, all staff shall complete The Dementia Education and Training Act (DETA) Care Series Training developed by the Alabama Department of Mental Health or equivalent training approved by the State Health Officer. All licensed staff shall

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complete DETA Brain Series Training, The Pharmacological Management of Dementia, and the Dementia Assessment Series provided by the DETA Program or equivalent training approved by the State Health Officer prior to resident contact. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained.

(c) All staff who have resident contact shall be able to demonstrate diversional methods and redirection. All staff shall be able to demonstrate an understanding of the implications of caring for residents with agnosia, amnesia, aphasia, and apraxia. All staff shall be able to demonstrate an understanding of the facility's fire and evacuation plan and all other policies regarding safety, including policies for preventing elopements, responding to elopements, and fall prevention.

(d) Cardiopulmonary Resuscitation. A specialty care assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of a specialty care assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within 90 days of hire. A specialty care assisted living facility equipped with an automated external 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

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(EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or the American Red Cross in CPR or AED utilization.

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

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

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure all staff obtained certification in CPR within 90 days of hire. In addition, training in special needs of residents was not provided to all staff.

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

Findings:

CPR

Interviews with staff as well as review of employee files on June 23, 2021 revealed EI#14 and EI#16 did not have current certification in CPR. EI#14 had worked at the facility since February 1, 2021 and EI#16 had worked at the facility since March 27, 2020. Although EI#8 was previously certified in CPR, the certification had

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A 406 Continued From page 41 A 406

expired in April 2021 and had not been renewed at the time of the survey. All three of these employees worked at the facility at the time of the survey. On June 23, 2021, EI#1 stated a CPR certification class had been scheduled at the facility on Monday, June 28, 2021 and all employees who did not have current certification would be certified at that time. EI#1 further ensured the facility was covered with at least one employee who was certified in CPR until the time of the class.

Special Needs Training

Review of resident records and interviews with staff revealed the following information. RI#9 and RI#11 were currently receiving hospice services at the facility. RI#7 and RI#14 had a diagnosis of diabetes mellitus. There was no documentation staff had been trained in the special needs of these residents. EI#8, Care Coordinator, was unable to provided documentation of this special needs training.

A 503 420-5-20-.05 (3) (a) (b) (c) Records and Reports. A 503

(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 3 years after a resident's death or discharge.

(b) When an individual is admitted to a specialty care assisted living facility, records and information regarding the resident shall be protected from unauthorized disclosure. Employees and authorized agents of the

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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 records by signing a standard release.

(c) In addition to all records required for the provision of resident care, for each resident the specialty care 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

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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. Advanced 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.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to establish resident records for new admissions which contained required information.

Findings:

On August 9, 2021, the Alabama Department of Public Health received an incident report documenting the emergency housing of multiple residents at the SCALF following a fire at a SNF, owned by the same governing authority, on that same date. According to the report, these residents were to be housed at the SCALF on a short term basis until they could be appropriately placed.

On August 11, 2021, five residents from the SNF (RI#17, RI#18, RI#19, RI#20 and RI#21) were admitted to the SCALF. On August 16, 2021, the surveyors requested facility records/charts for these five residents from EI#1. The charts

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A 503	Continued From page 44 provided to surveyors were the residents' SNF charts. No SCALF charts had been created for the residents although they had been admitted to the SCALF five days prior. When questioned about admission forms and signatures by sponsors, EI#28, Business Office Manager, provided the following information. A blank admission paperwork packet was provided to surveyors by EI#28. It contained the following forms: Assisted Living and Specialty Care Facility Admission Record; Pre-Arranged Discharge Plan; Advanced Directives/Living Will/Power of Attorney/Guardianship; New Admission Resident Personal Needs; Deposit Record, Room Assignment and Laundry Request; Financial Agreement-SCALF/ALF; Resident Bill of Rights; Inventory of Personal Effects; Alternative Dispute Resolution Agreement; Door Locking Arrangement; Disaster Evacuation Waiver and Permission Agreement; Omnicare Pharmacy Services Resident Move-In Record and Agreement; Letter to Sponsors and Family Members from Executive Director; Etowah Foot Specialists Health Insurance Claim Form and Policy and Acknowledgement of Receipt of Notice of Privacy Practices; In Room Appliance Policy; Dietary Department Diet Orders and Diet Changes; Family and Facility Understanding of the Potential for Falling While Walking; RX Advantage Agreement for Pharmaceutical Services; Medical Exam and Plan of Care ALF/SCALF; Integrated Behavioral Health Informed Consent for Services/Release of Information Within Facilities. EI#28 stated she (EI#28) had spoken with all five resident's sponsors and emailed packets containing these forms to the sponsors. EI#28 further stated the sponsors were supposed to return the completed forms by email as soon as possible. According to	A 503		

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A 503	Continued From page 45 EI#28, the packets were emailed to sponsors on August 12, 2021 (the day after the residents were admitted to the SCALF). However, only two sponsors had returned the paperwork packets to the facility at the time of the survey. RI#19's forms had been returned but were incomplete; most were not dated and were not witnessed by designated facility staff. A "Date of Admission" on the Admission Record form read "8/8/2021". RI#20's forms were also incomplete but did contain a date of August 12, 2021. However, the forms were not witnessed by designated facility staff. RI#17's, RI#18's and RI#21's paperwork packets had not been returned by sponsors at the time of the survey. The following forms were incomplete or non-existent for these five residents almost one week after admission to the facility: statement of resident rights signed by the resident/sponsor; financial agreement; inventory of personal effects. No current and complete facility records had been created for these five residents.	A 503		
A 504	420-5-20-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission, of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate.	A 504		

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A 504	Continued From page 46 1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility. 2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints. 3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy. 4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time. 5. Every resident shall have freedom to participate in and benefit from social, religious, and community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. 6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to 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.	A 504		

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A 504	Continued From page 47 7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so. 8. Every resident shall have the right to a reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals. 9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident. 10. Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to receive or reject medical care, dental care, or other health care services except those required to control communicable diseases. 11. Every resident shall have the right to at least 30 days prior written notice of involuntary relocation or termination of residence from the facility unless the resident is a patient in a facility providing a higher level of care and no longer meets the eligibility and continued stay requirements in these rules, or for medical reasons the resident is considered by a physician to require an emergency relocation to a facility 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.	A 504		

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A 504	Continued From page 48 12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person without restraint, interference, coercion, discrimination, or reprisal. 13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file. 14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the facility, provided that: (i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care. (ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation. (iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time	A 504		

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without recourse.

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

16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities.

17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll-free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll-free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area.

18. All state inspection reports and any resulting corrective action plan from the past 24 months shall be posted in a prominent location. If there has been no inspection in the past 24 months, then the results of the most recent inspection and any resulting corrective action plan shall be posted.

19. Every resident shall have the right to 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

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change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents.

21. Every resident shall have the right to wear his or her own clothes, and to keep and use his or her own personal possessions, including toilet articles, except for personal possessions too large to be stored in the resident's room.

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

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

24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to provide a safe and decent environment for residents and failed to provide privacy for at least one resident.

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

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THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON FEBRUARY 13, 2020 AND ON SEPTEMBER 22, 2016.

Findings:

The Alabama Department of Public Health received multiple complaints which alleged the facility was short staffed, housekeeping and laundry services were inadequate, toilets were dirty, rooms were not clean, soiled linens and clothing were piled in residents' rooms and no RN was at the facility. These complaints were investigated June 22-24, 2021. In addition, two facility-reported incidents were investigated during a second visit to the facility on August 16 and 17, 2021. During the two onsite visits to the facility, surveyors identified the following issues which substantiated the complaints and deprived residents of their right to a safe and decent environment and to privacy.

Staffing at the facility did not meet the minimum staffing requirements for a SCALF and was, at times, limited to only one person on the unit. This deficient practice existed when surveyors initially entered the facility on June 22, 2021 and continued when surveyors returned to the facility on August 16, 2021. Employees were not properly screened. Staff did not have current certification in CPR and were not trained in the special needs of the residents as required. However, the facility continued to admit residents in spite of staffing shortages and had admitted five new residents when surveyors returned to the facility in August 2021. Refer to deficiencies 401, 402 and 406 for additional information.

There was no dedicated RN at the facility to assess residents and provide adequate health

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supervision. In fact, a RN rarely visited the facility, resulting in resident assessments and care plans not completed or completed by a LPN. Even after a RN was hired at the facility, care plans were not current and were non-existent for five new residents. Prospective residents were not adequately assessed for admission resulting in at least one resident being admitted in need of care beyond the level of care allowed in a SCALF. Residents were retained at the facility whose level of care exceeded the level of care allowed in a SCALF. Refer to deficiencies 405, 604, 605, 611, 620 and 621 for additional information.

When surveyors returned to the facility on August 16, 2021, five new residents (RI#17, RI#18, RI#19, RI#20 and RI#21) did not have complete medical examinations, tuberculosis screenings, required admission paperwork and some medications. This was five days after the residents had been admitted to the facility. Refer to deficiencies 503, 505, 601 and 602 for additional information.

One resident (RI#3) required 2-person assistance with transfers for safety. The care plan for this resident was not updated to address this care and safety need. While being transferred by only one staff member, RI#3 fell, resulting in harm to the resident (fractured femur). The fall was not reported to ADPH and was not adequately investigated to prevent a recurrence. Refer to deficiencies 508 and 611 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. Spiderwebs were noted. Refer to deficiencies 803, 901 and 1002 for additional

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A 504	Continued From page 53 information. Personal care was provided for a resident in a semi-private room with the roommate present and no means of privacy even though this deficiency had been previously cited and, according to EI#5, a privacy screen purchased for use in semi-private rooms. Refer to deficiency 803 for additional information. These deficiencies all contributed to a disorderly, unsafe and unsanitary environment for all residents, placing all residents at significant risk of harm and resulting in actual harm to one resident.	A 504		
A 505	420-5-20-.05 (3) (e) Records and Reports. (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 specialty care 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	A 505		

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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 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 and that the resident and sponsor agree that if the resident should need skilled nursing services for 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

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agreement, the facility shall ensure that the resident or sponsor fully understands its provisions. In the event that a resident is unable to understand the agreement due to illiteracy or infirmity, the administrator shall take special steps to 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:

Five residents (RI#17, RI#18, RI#19, RI#20 and RI#21) were admitted to the facility from a SNF on August 11, 2021. Refer to deficiency 503 for additional information on these five residents' admission paperwork. Three of the five residents (RI#17, RI#18 and RI#21) had no signed Financial Agreement on August 17, 2021. EI#28 explained the forms had been sent to the residents' sponsors on August 12, 2021 and she (EI#28) was waiting for the sponsors to return the forms. RI#20 had a Financial Agreement which was documented a Commencement Date of August 11, 2021 and was signed by RI#20's sponsor on August 12, 2021. However, the agreement was blank beside Monthly Lease Rate

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and did not contain a list of the facility's basic charges. The form also was not witnessed by the facility administrator/designee. RI#19's Financial Agreement was signed by RI#19's sponsor but did not contain a Monthly Lease Rate, the facility's basic charges, a Commencement Date, the administrator/designee's signature or a signature date.

Surveyors requested (from EI#1) a copy of the Financial Agreement that was sent to the sponsors for signature and were presented with a blank document. The basic information, monthly lease rate and commencement date were left blank. On August 16, 2021, when questioned about incomplete Financial Agreements, EI#1 stated the facility was not completing the section which required a rate for basic charges because the facility was not charging these five residents for SCALF services. EI#1 further stated it was his (EI#1's) understanding all five residents would return to the SNF where they previously resided when the SNF was repaired.

A 508 420-5-20-.05 (3) (h) Records and Reports. A 508

(h) Incident Investigation. When an incident, as defined below, occurs in a specialty care assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review.

1. Incidents which require investigation

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are:

(i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as extensive bruising, pain, or injury that is not consistent with actions necessary in providing day-to-day care to a resident or for which medical treatment was sought.

(ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid including but not limited to a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office.

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

(iv) Elopement by a resident.

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

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

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

(viii) An outbreak (for purposes of these rules, an outbreak is considered to be two

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

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

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

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

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

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

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

2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following:

(i) Names of all residents involved.

(ii) Names of all staff involved including person in charge at the time of the incident.

(iii) When the administrator was notified

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(date and time).

(iv) Circumstances under which the incident occurred.

(v) When the incident occurred (date and time).

(vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn).

(vii) Immediate actions taken.

(viii) The extent and description of injury, if any, to the affected resident or residents.

(ix) Immediate treatment rendered.

(x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified.

(xi) Names, telephone numbers, and addresses of witnesses.

(xii) Date and time relatives or sponsor were notified.

(xiii) Out-of-facility treatment.

(xiv) Follow-up care.

(xv) Outcome resolution.

(xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future.

(xvii) The investigative file includes the

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incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation.

(xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request.

(xix) The entire investigative file and documentation of all corrective action taken shall be retained for a period of not less than 3 years after the resident is discharged or dies.

(xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff.

3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident:

(i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention.

(ii) Elopement by a resident.

(iii) Suspected, alleged, confessed, witnessed, or actual abuse, neglect, or exploitation of a resident or residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human

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

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4. The report to the Department's Online Incident Reporting System shall include the following:

(i) Facility name and direct phone number.

(ii) Time and date of the report.

(iii) Reporter's name.

(iv) Name of resident(s), staff, or visitor(s) involved in the incident.

(v) Names of staff on duty at the time of the incident.

(vi) Date and time of the incident.

(vii) A brief description of the incident.

(viii) Any injury or injuries to resident(s).

(ix) Action taken by the facility in response to the incident.

(i) Vital Statistics Reports. A record shall be kept of all births, deaths, and stillbirths that occur within the specialty care assisted living facility. By the fifth day of each month, the administrator shall make a report of such births, deaths, and stillbirths for the preceding month on such forms as the State Board of Health shall provide to the county health officer, or in counties without a county health officer, to the State Registrar. This report shall be in addition to the official birth, death, and stillbirth certificates. If

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there are no births, deaths, or stillbirths in any month, a report shall be made stating that fact to the county health officer.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to report an incident to the ADPH as required and failed to adequately investigate the incident.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON FEBRUARY 28, 2018 AND ON SEPTEMBER 22, 2016.

Findings:

The Alabama Department of Public Health received an incident report on August 11, 2021, documenting RI#3 had been sent to the hospital for evaluation on August 10, 2021 at 11:20 PM due to pain. At the request of the Department, an investigation of the incident was also submitted which included report of a fall involving RI#3 on July 28, 2021.

RI#3 was transferred to the SCALF from the ALF on July 9, 2020 and had diagnoses which included dementia, hypertension, chronic kidney disease, hyperlipidemia and anxiety. During the first onsite visit at the facility from June 22-24, 2021, four RCAs (EI#13, EI#14, EI#15 and EI#22) informed the surveyors two people were needed to transfer RI#3 due to RI#3's inability to assist and risk of falling. The surveyor observed RI#3 being transferred by two staff members on the morning of June 23, 2021 and substantiated

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two person assistance was required to ensure RI#3's safety.

Following the first visit to the facility, on July 28, 2021 around 5:42 PM, RI#3 sustained a fall at the facility while being transferred from the bed to the wheelchair by one staff member (EI#20). An internal incident report was provided to surveyors by EI#1 and was written by EI#8, LPN. The report read, "concerned with resident's left leg, resident refused to go to the hospital, portable x-rays ordered". EI#9, LPN, reported she (EI#9) worked the night shift on July 28, 2021 after RI#3's fall. According to time sheets, EI#9 clocked in to work at 9:41 PM on July 28, 2021. EI#9 stated RI#3 complained of pain in the leg during the night and EI#9 called to get an x-ray ordered. The x-ray of RI#3's left hip and pelvis was completed on July 29, 2021 and the report read "There is no acute fracture or dislocation...".

EI#14 was working at the time the incident occurred. During an interview on the morning of August 17, 2021, EI#14 stated EI#20 was screaming for help and she (EI#14) went to the room. EI#14 further reported RI#3 complained of pain in the hip and leg. EI#14 stated a male staff member from the laundry was called to assist with lifting RI#3 from the floor and the nurse (EI#8) was notified, then she (EI#14) went back to the dining room to pass dinner trays. None of this information was included on EI#14's witness statement, only "did not witness". Both EI#14 and EI#8 reported to the surveyors a male staff member was called from the laundry room to assist with lifting RI#3. There was no witness statement from this laundry staff member.

During an interview on the evening of August 17, 2021, EI#20 gave the following report of the

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incident. EI#20 went to RI#3's room alone to get RI#3 up for supper. The wheelchair was placed by the bed and the wheels were locked. RI#3's feet were placed on the floor. RI#3's leg got bent under RI#3 so that, when RI#3 was placed in the wheelchair, RI#3 slid to the floor. EI#20 reported she (EI#20) then left RI#3 on the floor and went to the dining room because she (EI#20) had residents in the dining room. EI#20 notified EI#8 of the fall once in the dining room and the next thing she (EI#20) knew was RI#3 was in the dining room in the wheelchair. EI#20 then apologized to RI#3. EI#20 informed the surveyors she (EI#20) again transferred RI#3 by herself a few days after the fall occurred and RI#3 "hollered". EI#20 also reported RI#3 complained of pain in the hip during the days after the fall and EI#20 noted swelling in RI#3's leg after the fall. EI#20's Witness Statement read "...I left thinking someone was going to help me. I had residents in the dining room".

During an interview on the evening of July 28, 2021, EI#8 gave the following account of RI#3's fall. EI#8 heard EI#20 talking loudly in RI#3's room and went to the room to find RI#3 on the floor. RI#3 was assisted from the floor by a male staff member from the laundry room and another "tech". RI#3 was then taken to the dining room because RI#3 wanted to eat. EI#8 attempted to send RI#3 to the emergency room to be checked but RI#3 refused to go.

During interviews on August 16 and 17, 2021, seven staff members (EI#8, EI#9, EI#13, EI#14, EI#19, EI#20 and EI#29) reported RI#3 continued to complain of pain in the left hip/leg/foot and reported the leg was swollen and bruised after the fall. RI#3 was eventually sent to the hospital on August 10, 2021 due to excruciating pain in

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the leg and was diagnosed with a fractured femur. RI#3 remained in the hospital at the time of the surveyors' second visit to the facility.

The initial incident (fall), which occurred on July 28, 2021, was not reported to ADPH even though RI#3 complained of pain and an order was obtained for a mobile x-ray. EI#1 stated he (EI#1) did not think the incident should have been reported because the resident did not complain of pain initially and was not sent out for evaluation and treatment. The investigation of RI#3's fall was inadequate. There were not statements from all witnesses and witness statements provided were not complete. There were no immediate interventions put in place to prevent a recurrence. In fact, EI#20 admitted she (EI#20) again transferred RI#3 without the assistance of another person after the fall occurred. RI#3 was not assessed by the facility RN following the fall in spite of continued complaints of pain and reported swelling and bruising for two weeks. RI#3's facility care plan was not updated to include interventions to prevent a recurrence including two person assistance with transfers.

On August 17, 2021, EI#1 was questioned about EI#20's written statement that she (EI#20) left RI#3 on the floor after the fall. EI#1 agreed it sounded like EI#20 abandoned RI#3 and stated someone needed to talk to her (EI#20). EI#1 then gave EI#20's phone number to the surveyors to contact EI#20. All staff members interviewed about this incident gave conflicting accounts of the events to surveyors. This incident, which resulted in actual harm to a resident, had not been investigated adequately by EI#1 to determine if appropriate actions had been taken following the fall and to ensure there was not a recurrence of the same deficient practice at the

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A 508	Continued From page 67 facility.	A 508		
A 601	420-5-20-.06 (1) Care of Residents. (1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician. (a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her choice. If the resident is unable to designate an attending physician, or does not wish to designate an attending physician, the facility shall assist the resident in identifying an attending physician who will serve the resident. A resident shall be permitted to change the designation of his or her attending physician at any time. Whenever a resident requires medical attention, an attempt shall first be made to contact the resident's attending physician, except in medical emergencies requiring activation of the local EMS system (911 or other emergency call). (b) Back-up Physician Support. Each specialty care assisted living facility shall have an agreement with one or more duly licensed physicians to serve in those instances when a resident's own attending physician cannot be reached, and to provide temporary medical attention to any resident whose attending physician is temporarily not available. A nurse practitioner or physician's assistant shall not serve as the back-up physician in a specialty care assisted living facility. (c) All physician orders shall be written in accordance with community standards. If verbal orders are used, they are to be used infrequently.	A 601		

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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 record reviews and interviews, the facility failed to follow physicians' orders for residents' medications.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON SEPTEMBER 22, 2016.

Findings:

Five residents were admitted to the facility on August 11, 2021 from a SNF. These five residents were housed at the facility from August 9, 2021, following a fire at the SNF, until admission to the SCALF. According to information provided by EI#1 during the onsite survey August 16 and 17, 2021, SNF staff provided all care for the five residents until their admission to the SCALF. This care included administration of medications.

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On the afternoon of August 17, 2021, the surveyor reviewed each of the five residents' medications (as ordered by the physicians) with EI#11, LPN, and compared these medications to the residents' MARs. EI#11 stated medications were provided to the SCALF from the SNF upon admission of the residents. EI#11 also reported the medications provided did not contain all medications ordered by the residents' physicians. The review of medications revealed the following medications were not available in the medication cart.

RI#17 - Famotidine 20 milligrams twice daily, Calcium 600 milligrams twice daily, Vitamin D3 1000 units twice daily

RI#18 - Omeprazole 20 milligrams once daily, Fexofenadine 180 milligrams daily

RI#19 - Famotidine 20 milligrams daily, Thiamine 100 milligrams daily, Aspirin 25 milligrams/Dipyridamole 200 milligrams extended release every twelve hours

RI#20 - Docusate Sodium 100 milligrams twice daily, Multivitamin one daily, Thiamine 100 milligrams daily

RI#21 - Multivitamin one daily, Atorvastatin 40 milligrams daily at bedtime, Sodium Bicarbonate 325 milligrams two tablets daily

EI#11 stated these medications needed to be ordered. EI#11 prepared a list of what medications were needed and stated EI#8 usually ordered medications. Multiple doses of the medications were circled on the residents' MARs August 14, 15, 16 and 17, 2021 and noted to be

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A 601	Continued From page 70 unavailable. On the evening of August 17, 2021, EI#8, LPN and SCALF Care Coordinator, stated she (EI#8) planned to order these medications that night while she (EI#8) worked the 7:00 PM until 7:00 AM shift and would have them delivered to the facility as soon as possible. EI#8 also stated she (EI#8) had not had time to perform her (EI#8's) office work because she (EI#8) had been working night shift due to staff shortage.	A 601		
A 602	420-5-20-.06 (2) (a) (b) (c) Care of Residents. (2) Medical Examination Record. (a) Initial Physical Examination. Not more than 30 days prior to admission of any resident to a specialty care assisted living facility, the resident or prospective resident shall be examined by a physician. For purposes of the initial physical examination, a physician currently licensed and in good standing with the Medical Licensure Commission of any state may complete this physical assessment. The physician shall report his or her findings in writing to the facility. This examination is not required for a resident of a facility dually licensed as an assisted living facility and as a specialty care assisted living facility in those cases when the resident is transferred from the assisted living unit to the specialty care assisted living unit in the same facility. In addition to any information otherwise required by the facility's policies and procedures and in addition to any other information the physician recommends or believes is pertinent, the initial physical examination record shall contain the following:	A 602		

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1. All of the physician's diagnoses and the resident's baseline weight and vital signs.

2. Medication presently prescribed (name, dosage, and strength of drug, frequency, and route of administration).

3. A statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident-to-resident contact.

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

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

1. The resident's weight and vital signs.

2. Changes in diagnoses.

3. Changes in condition.

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

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5. Changes in treatment.

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

1. Changes in diagnoses.

2. Changes in condition.

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

4. Changes in treatment.

This Rule is not met as evidenced by:
Based on record review and interview, residents' Physical Examination records did not contain required information. In addition, one resident did not have an annual Physical Examination as required.

Findings:

RI#2

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RI#2 was admitted to the facility on December 13, 2018 and had diagnoses which included paranoid schizophrenia. Review of RI#2's facility record on June 24, 2021 revealed annual Physical Examinations were documented on December 11, 2019 and on May 6, 2021. No annual Physical Examination was provided for the year 2020.

RI#3

RI#3 was transferred to the SCALF on July 9, 2020 and had diagnoses which included dementia, hypertension, chronic kidney disease, hyperlipidemia and anxiety. RI#3 had previously resided in the assisted living facility (ALF) located in the same building and had an Initial Physical Examination documented in March 2020 upon admission to the ALF. The Medical Exam and Plan of Care, dated March 19, 2020, was also used as the Initial Physical Examination for the SCALF and did not contain any baseline vital signs or a baseline weight for RI#3.

RI#7

RI#7 was admitted to the facility on March 5, 2021 and had diagnoses which included chronic schizophrenia, dementia, hypertension, coronary artery disease, vitamin D deficiency, pulmonary mass, diabetes mellitus and thoracic aortic aneurysm. RI#7's Initial Physical Examination, dated February 9, 2021, did not contain RI#7's baseline weight.

RI#9

RI#9 was admitted to the facility on May 25, 2021 and had diagnoses which included malignant neoplasm of the small intestine, essential hypertension, atrial fibrillation and hypothyroidism.

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A 602	Continued From page 74 RI#9's Initial Physical Examination, dated May 21, 2021, did not contain RI#9's baseline weight. In addition, the statement by the physician that RI#9 was free of signs and symptoms of infectious skin lesions and diseases was not marked "Yes" or "No" by the physician. There was no documentation of a tuberculosis skin test or other screening for tuberculosis. EI#8 stated to the surveyor on June 22, 2021 that the documentation at the facility was not current and not complete. On August 16 and 17, surveyors returned to the facility and reviewed records for five residents (RI#17, RI#18, RI#19, RI#20 and RI#21) who were admitted on August 11, 2021 from a SNF. The charts provided to surveyors were the residents' records from the SNF and included Physical Examinations. However, only one resident (RI#20) had documentation of tuberculosis screening within the previous 12 months. None of the residents' records contained a statement by the physician that the resident was free of signs and symptoms of infectious skin lesions and diseases that were capable of transmission to other residents through normal resident-to-resident contact. These five residents had not been properly screened and cleared for admission to the facility. This medical screening and clearance was completed on August 16, 2021 during the onsite survey.	A 602		
A 604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30	A 604		

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days prior to admission, the facility RN or care coordinator shall screen prospective residents for eligibility for admission into the specialty care assisted living facility. The screening shall include a clinical history, a mental status examination to include aphasia screening, a geriatric depression screen, a physical self-maintenance screen, and a behavior screen.

Appendix A herein, contains the Physical Self Maintenance Scale (PSMS) form and the Behavior Screening form. These forms shall be completed to screen physical functioning and behaviors. The PSMS and Behavior Screen assessments shall be completed by the RN or care coordinator upon admission, annually, and when there is a change in the resident's status.

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

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

(c) Comprehensive Assessment. The facility RN shall perform a comprehensive assessment and communicate with the resident's attending physician and with the resident's sponsor or responsible family member when a

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decline in health status or behavior occurs, or if the resident develops any of the following problems:

1. Weight loss:

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

(ii) A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half percent or greater weight loss in a period of 3 months or less, or a 10 percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician.

2. Falls (two or more falls within a 30 day period).

3. Elopement.

4. Any sign and symptom of adverse drug reaction, interaction or over sedation, or circumstances which contraindicate medications that have been prescribed for the resident.

5. Unmanageable, combative, or potentially harmful behavior(s).

6. Any accident with injury.

(d) Focused Assessments. The RN or

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LPN shall conduct focused assessments when necessary to identify changes in resident status.

(e) Any change in resident status requires immediate documentation and implementation of interventions or reassessment of existing interventions.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, health supervision of residents was not completed as required to ensure residents were appropriate for the SCALF and received appropriate care and to ensure residents' plans of care were based on the residents' current functional status.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON SEPTEMBER 22, 2016 AND ON JULY 14, 2016.

Findings:

RI#3

RI#3 was admitted to the facility on July 9, 2020. Refer to deficiency 602 for additional information on RI#3. No clinical history, depression screening and aphasia screening were completed for RI#3 to assess for eligibility to the SCALF. On May 25, 2021, RI#3 was sent to the emergency department due to aggressive behavior. No comprehensive assessment, PSMS and behavior screening were documented following this significant change in condition. On July 28, 2021, RI#3 sustained a fall at the facility while being transferred from the bed to the wheelchair. EI#9

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reported RI#3 complained of pain the night of July 28, 2021, following the fall, and an order was obtained for a portable x-ray. No comprehensive assessment, PSMS and behavior screening were documented following this decline/significant change in RI#3's condition. Staff members (EI#9, EI#13, EI#14, EI#19 and EI#20) reported RI#3 continued to complain of pain in the left hip/leg/foot after the fall and had bruising and swelling in the left leg. Three of these staff members (EI#13, EI#14 and EI#19) also reported facility nurses (EI#8, EI#9 and EI#11) were made aware of RI#3's pain. RI#3 was still not assessed by the facility RN in spite of this continued pain and swelling and was eventually sent to the hospital by EI#8, LPN, on August 10, 2021 due to excruciating pain and diagnosed with a femur fracture. A Consultation Note from the hospital, dated August 11, 2021, documented RI#3 "...Complains of left knee pain. Unable to get out of bed for the last few days due to knee pain...". The diagnosis documented on the hospital Consultation Note was left femur fracture and fracture of left superior pubic ramus.

RI#4

RI#4 was admitted to the facility on July 12, 2019 and had diagnoses which included Alzheimer's dementia with behavioral disturbance, hypertension, seizure disorder and gastroesophageal reflux disease. No monthly assessment was documented for RI#4 in May 2021. RI#4 sustained a significant weight loss of 10.8% for one month in April 2021 (185 pounds in March 2021 and 165 pounds in April 2021). No comprehensive assessment, PSMS and behavior screening were documented when the weight loss occurred. RI#4 was sent to the hospital shortly after surveyors arrived at the facility on

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June 22, 2021 due to a decline in condition.

RI#5

RI#5 was admitted to the facility on December 5, 2018 and had diagnoses which included spinal stenosis, falls, dementia and hypertension. No monthly assessment was documented for RI#5 in May 2021. In addition, RI#5 was sent to the hospital with stroke-like symptoms in May 2021 and returned to the facility on June 2, 2021. No comprehensive assessment, PSMS and behavior screening were documented for this significant change in condition.

RI#7

RI#7 was admitted to the facility on March 5, 2021. Refer to deficiency 602 for additional information on RI#7. No monthly assessments and no pre-admission assessments were found in RI#7's facility record. RI#7 was sent to the hospital on May 21, 2021 due to aggressive and hostile behaviors. No comprehensive assessment, PSMS and behavior screening were documented for this significant change in condition.

RI#8

RI#8 was admitted to the facility on June 22, 2018 and had diagnoses which included coronary artery disease, dementia, hypertension, atrial fibrillation and hyperlipidemia. No monthly assessments were documented for RI#8 since March 2021. No comprehensive assessments, PSMS and behavior screenings were found in RI#8's current facility record. At the request of the surveyor, EI#8 completed a PSMS for RI#8 on June 24, 2021. The result was a total score of 27

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with a score of 5 in dressing (completely unable to dress self and resists efforts of others to help), a score of 5 in grooming (actively negates all efforts of others to maintain grooming), a score of 4 in physical ambulation (sits unsupported in chair or wheelchair, but cannot propel self without help) and a score of 5 in bathing (does not try to wash self and resists efforts to keep him/her clean). Although the surveyor requested the most recent PSMS prior to June 24, 2021 from EI#8, it was not provided. Therefore, it was unknown how much time had passed since RI#8 had been properly evaluated and how long RI#8 had been retained at the facility with these high PSMS scores.

RI#9

RI#9 was admitted to the facility on May 25, 2021. Refer to deficiency 602 for additional information on RI#9. No depression screening, aphasia screening and clinical history were documented prior to admission to assess RI#9 for eligibility in the SCALF. A comprehensive assessment, PSMS and behavior screening were documented for RI#9 on May 27, 2021, two days after admission. RI#9 was not properly assessed prior to admission and was, in fact, admitted to the facility in need of hospice services with a PSMS result above the level allowed in a SCALF. Refer to deficiency 620 for additional information on RI#9. On June 21, 2021, RI#9 was sent to the hospital due to chest pain. No comprehensive assessment, PSMS and behavior screening were documented for this significant change in condition.

RI#10

RI#10 was admitted to the facility on November

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15, 2019 and had diagnoses which included dementia with behavioral disturbance. No monthly assessments were documented for RI#10 in February 2021, March 2021 and April 2021.

RI#11

RI#11 was admitted to the facility on January 3, 2018 and had diagnoses which included altered mental status, dementia, anemia, hypothyroidism, hyperlipidemia, heart failure and Alzheimer's disease. Comprehensive assessments were documented for RI#11 on May 8, 2021 and on February 17, 2021 but were not signed. EI#8, LPN, identified the handwriting on the comprehensive assessment forms as hers (EI#8). A PSMS, attached to the comprehensive assessment form on May 8, 2021, contained no resident name or date, but documented a total score of 28. A PSMS for RI#11, dated February 17, 2021 and signed by EI#8, documented a total score of 28 also with a score of 5 in dressing (completely unable to dress self and resists efforts of others to help), a score of 5 in physical ambulation (bedridden more than half the time) and a score of 5 in bathing (does not try to wash self and resists efforts to keep him/her clean). Although RI#11 had a documented PSMS score of 28 for more than 4 months, no comprehensive assessment had been completed by an RN to properly evaluate RI#11 for eligibility and care needs.

RI#12

RI#12 was admitted to the facility on May 23, 2019 and had diagnoses which included hypertension, breast cancer, vascular dementia, hyperlipidemia, sarcoma of the hip, vitamin D deficiency, vitamin B12 deficiency and chronic

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A 604	Continued From page 82	A 604		

kidney disease stage 2. No monthly assessment was documented for May 2021 on RI#12.

During an initial interview on June 22, 2021, EI#8 informed surveyors assessments and care plans at the facility had not been completed due to her (EI#8) having to work shifts at the facility due to staffing shortage. Most monthly assessments reviewed for the year 2021 did not contain signatures but appeared to be written by EI#8. During an interview on June 24, 2021, EI#8, Care Coordinator and LPN, stated she (EI#8) had been taught by a previous RN at the facility to complete the comprehensive assessments and monthly assessments, then have the RN come by the facility to review and sign the assessments. EI#8 also stated the last time she (EI#8) had contacted the current facility RN (EI#23) was on April 29, 2021. EI#8 further stated the RN would sometimes just review the note and sign it and would sometimes see the resident before signing the assessments.

It was also noted monthly weights were not recorded on the monthly assessment forms during the month of May 2021. During the exit conference on June 24, 2021, EI#8 provided the surveyors with a chart which contained residents' weights for the year 2021. The weight recorded for RI#4 did not match the weight noted above. For the month of April 2021, the weight documented on the weight chart for RI#4 was 163.6 pounds, not 165 pounds as documented on RI#4's monthly assessment form. If accurate, this increased RI#4's significant weight loss for April 2021 to 11.5 percent. In addition, the weight chart documented a significant weight loss of 10.7 percent for RI#5 in May 2021 (293.6 pounds in April 2021 and 262 pounds in May 2021). This significant change was not addressed in a

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A 604	Continued From page 83 monthly assessment for RI#5 as no monthly assessment was documented for the month of May 2021. Residents were not properly evaluated for admission to the SCALF, following significant changes in condition and monthly to ensure the residents were appropriate for the SCALF and the residents' care needs were being identified and met. EI#1 hired a dedicated RN for the facility on June 24, 2021 after these deficient practices were identified by surveyors. However, when surveyors returned to the facility on August 16 and 17, 2021, the deficient practices continued as documented above for RI#3.	A 604		
A 605	420-5-20-.06 (3) (f) Care of Residents. (f) Observation. Each specialty care assisted living facility shall provide general observation and health supervision of the residents to identify changes in all residents' health conditions and physical abilities, and awareness of the need for medical attention or nursing services as the changes develop. Whenever a resident requires medical attention, nursing services, or changes in personal care and assistance with activities of daily living provided by the facility, the facility shall arrange for or assist the residents in obtaining necessary services.	A 605		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to provide adequate general observation and health supervision of residents to identify changes in residents' health conditions and physical abilities and arrange for or assist the residents in obtaining necessary services.

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

Findings:

RI#8

RI#8 had resided at the facility since June 22, 2018. Refer to deficiencies 604, 611 and 621 for additional information on RI#8. RI#8 weighed about 96 pounds (May 2021) and required total care, including transfers, incontinent care, dressing, bathing and eating assistance. RI#8 sometimes resisted care, making transfers difficult due to RI#8 holding to wheelchair. No monthly assessments had been documented for RI#8 since March 2021. The most recent Medical Examination documented for RI#8 was June 4, 2020 (one year prior to the survey). No comprehensive assessments, behavior screenings or PSMS results were found in RI#8's current facility record. On June 24, 2021, the surveyor requested results of the most recent assessment for RI#8 from EI#8. No assessments were provided. The surveyor requested a current PSMS for RI#8 which was completed by EI#8, LPN, on June 24, 2021. The total score on RI#8's current PSMS was 27 with a score of 5 in Dressing, Grooming and Bathing and a score of 4 in Physical Ambulation. Each of these scores was above the level allowed in a SCALF. It was

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unknown exactly how long RI#8's functional status and physical abilities had been at this level but no arrangements had been made to transfer RI#8 to a higher level of care at the time of the survey. No 30-day discharge notice had been issued.

RI#11

RI#11 had resided at the facility since January 3, 2018. Refer to deficiencies 604 and 621 for additional information on RI#11. RI#11 weighed about 107 pounds (May 2021), was frail and required total care, including transfers, assistance with turning, incontinent care, dressing, bathing and eating assistance. RI#11 was currently receiving hospice services at the facility. RI#11 had a history of falls and weight loss and an "overall decline" in condition documented on the Resident Service Plan as early as October 2018 (three years prior to the survey). The most recent comprehensive assessments documented on RI#11 were on May 8, 2021 (new plan of care) and February 17, 2021 (cough and congestion). The PSMS results attached to each of these comprehensive assessments were completed by EI#8, LPN, and were the same on each date. RI#11 had a total PSMS of 28 since at least February 2021 with a score of 5 in Dressing, Physical Ambulation and Bathing. Each of these scores was above the level allowed in a SCALF. Although RI#11's decline in functional status and physical abilities had been identified, the problem had not been addressed. No arrangements had been made to transfer RI#11 to a higher level of care at the time of the survey and no 30-day discharge notice had been issued.

Both of these residents (RI#8 and RI#11) remained at the facility in need of a higher level of

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A 605	Continued From page 86 care, without adequate staff to meet the ongoing care needs of the residents, and without assistance from the facility to obtain necessary services for the residents. EI#1 stated he (EI#1) would have the new RN properly assess each resident.	A 605		
A 611	420-5-20-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. The RN shall develop written plans of care for each resident prior to or at the time of admission. The plans of care shall be based on resident's assessments, diagnoses, and recommendations of the resident's physician. The plan of care shall be developed in cooperation with the resident, if appropriate, and the sponsor. The RN shall identify resident care problem areas and formulate written interventions to address those problems. The RN shall evaluate the implementation of the interventions and the resident's response to the interventions and modify the plan of care as necessary. 1. The plan shall at all times reflect the current condition of the resident. All entries on the plan of care shall be accurately dated. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following:	A 611		

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

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

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

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

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

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

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

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

(v) Shaving. Men shall be assisted with

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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, facility care plans were not completed, were not current and were not developed by a RN.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON SEPTEMBER 22, 2016 AND ON JULY 14, 2016.

Findings:

RI#3

RI#3 had resided at the facility since July 9, 2020, after transferring to the SCALF from the ALF in the same building. Refer to deficiencies 602 and 604 for additional information on RI#3. The surveyor observed EI#13 and EI#17 provide personal care to RI#3 on June 23, 2021. Two staff members were required to transfer RI#3 from the wheelchair to the bed due to RI#3's left-sided weakness and left footdrop. RI#3 also required assistance to reposition in the bed and was incontinent of bowel and bladder. RI#3 used a wheelchair for mobility and did not ambulate but

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could propel his/her wheelchair with his/her arms/hands. RI#3's Resident Service Plan contained the following entries: "...Transfers...RCA to assist rsd in and out of bed. Rsd to call when needing to go to the restroom...Ambulation...Rsd uses walker to ambulate. Needs assisted x 1...". The entries were not signed or dated and did not meet the current care needs of RI#3.

On August 11, 2021, the Alabama Department of Public Health received an incident report from the facility which stated RI#3 had been sent to the hospital on August 10, 2021 due to severe pain. Included in this report was documentation of a fall involving RI#3 which occurred on July 28, 2021 when RI#3 was being transferred from the bed to the wheelchair by only one staff member (EI#20). Review of RI#3's facility care plan on August 16, 2021 revealed the care plan had been updated by the facility RN on July 16, 2021. However, RI#3's care plan did not contain instructions for a 2-person assistance with transfers. RI#3's fall on July 28, 2021 likely was a result of only one staff member transferring RI#3. RI#3's facility care plan had not been updated to address the need for 2-person assistance to protect RI#3 from falls and injury.

During interviews with staff (EI#8, EI#9, EI#13, EI#14, EI#19, EI#20 and EI#29) on August 16 and 17, 2021, surveyors were informed RI#3 continued to complain of pain in the left leg with movement following the fall on July 28, 2021 and required even more assistance with transfers due to the pain. After this fall occurred and RI#3's condition declined further, RI#3's facility care plan was not updated with interventions to prevent a recurrence. EI#25 stated she (EI#25) had not evaluated RI#3 and updated the care plan

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following the fall.

RI#4

RI#4 had resided at the facility since July 12, 2019 and sustained significant weight loss at the facility in April 2021. Refer to deficiency 604 for additional information on RI#4. A Physician's Note, dated June 16, 2021, documented the following about RI#4, "...not eating well...wt. loss...Dietician to eval. Weekly weights. Staff to assist with all meals...". RI#4's facility care plan did not include any of these interventions; in fact, the care plan did not include a care problem of weight loss at all. RI#4's current Resident Service Plan read, "...Weight stable/wt. monthly...". This entry on the care plan was unsigned and undated.

RI#7

RI#7 had resided at the facility since March 5, 2021. Refer to deficiencies 602 and 604 for additional information on RI#7. RI#7's facility care plan did not contain any dates or signatures on the entries. RI#7 was sent to the hospital in May 2021 due to aggressive and hostile behaviors. The behaviors were not addressed on the facility care plan with interventions to monitor RI#7 for behaviors and appropriately intervene.

RI#8

RI#8 had resided at the facility since June 22, 2018. Refer to deficiencies 604 and 605 for additional information on RI#8. The surveyor observed EI#20 transfer and provide incontinent care for RI#8 on June 22, 2021. The transfer was difficult with one person as RI#8 did not assist at all and held tightly to the wheelchair, resisting the

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transfer. A second staff member's assistance would have made the transfer safer and easier. RI#8 did not ambulate and was physically lifted from the chair to the bed. RI#8 was incontinent of bowel and bladder. RI#8's Resident Service Plan contained the following entries: "...Bathing...res. able to bath face and hands staff to wash rest of body...Dressing...res able to dress/undress self w/minor assist...Grooming...res able to groom self w/moderate assist...Toileting...freq accidents wears pullups for accidents...Transfers...Rollater for short distances. Wheelchair for long distances...Ambulation...Rollator-short distances. Wheelchair-long distances. Independent...". At the request of the surveyor, a PSMS was completed for RI#8 on June 24, 2021. The following results were documented by EI#8 which did not correlate with the current facility care plan: Toileting score of 5 (no control of bowels or bladder); Dressing score of 5 (completely unable to dress self and resists efforts of others to help); Grooming score of 5 (actively negates all efforts of others to maintain grooming); Physical Ambulation score of 4 (sits unsupported in chair or wheelchair but cannot propel self without help); Bathing score of 5 (does not try to wash self and resists efforts to keep him/her clean).

RI#9

RI#9 had resided at the facility since May 25, 2021 and was mainly bedbound, was terminally ill and receiving hospice services. RI#9 had been sent to the hospital on June 21, 2021 due to chest pain and had multiple recent medication changes due to pain. Refer to deficiencies 602 and 604 for additional information on RI#9. No care plan had been developed for RI#9 at the time of the survey, four weeks after RI#9 had been admitted. EI#8, LPN, stated she (EI#8) had

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not had time to write a care plan for RI#9.

RI#11

RI#11 had resided at the facility since January 3, 2018. Refer to deficiencies 604 and 605 for additional information on RI#11. RI#11 was thin and frail, requiring assistance with feeding and dependent on a wheelchair for mobility. RI#11 was unable to propel the wheelchair and required staff to push the wheelchair. RI#11 was receiving hospice services at the facility. On June 23, 2021, the surveyor observed EI#13 and EI#17 transfer RI#11 from wheelchair to bed and perform incontinent care. The transfer required two people due to RI#11's inability to provide any assistance with the transfer or with turning once in the bed. RI#11 was incontinent of bowel and bladder. RI#11's Resident Service Plan contained the following entry: "...Update 10/29/18 Ambulation/Transfer-another person x 2...needs assist in/out W/C (propel self in W/C)...". A PSMS completed by EI#8 for RI#11 on February 17, 2021 documented a score of 5 in Physical Ambulation (bedridden more than half the time). This score did not correlate with documentation of RI#11's functional status on the facility care plan.

Resident care plans did not contain dates and signatures for all entries. A form titled Service Plan Revised or Updated was filed with each of these care plans and contained signatures and dates when the service plans were reviewed or updated. The signatures for the year 2021 were all from EI#8, LPN. No RN reviews or updates had been documented on these resident care plans for at least six months. In fact, RI#7's care plan did not contain any signatures of a RN, including when the care plan was initiated. On

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June 24, 2021, EI#8, LPN admitted to the surveyors she (EI#8) had been updating residents' care plans because that is what she (EI#8) was trained to do by a previous RN at the facility. The residents had not been adequately assessed by a RN to determine their care needs. The residents' care plans were non-existent, incomplete or inaccurate and did not contain appropriate interventions to address the current care needs of the residents.

On August 11, 2021, five residents (RI#17, RI#18, RI#19, RI#20 and RI#21) were admitted to the facility from a SNF. When surveyors entered the facility on August 16, 2021, care plans had not been developed for these five residents. In fact, care plans for the new residents were not provided to the surveyors until August 18, 2021, one week after their admission to the facility, leaving staff with no guidance and safety measures to utilize in providing care to these residents. EI#25, RN, stated she (EI#25) took responsibility for the care plans not being completed timely.

A 613 | 420-5-20-.06 (5) (a) (b) (c) (d) (e) Care of Residents. | A 613

(5) Medications.

(a) Medications, as defined in these rules, shall be prescribed specifically for the resident by an individual currently licensed to prescribe medications in Alabama. A currently licensed physician in good standing with the Medical Licensure Commission of any state may prescribe medications to a resident of an assisted living facility only during the initial physical examination.

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A 613	Continued From page 94 (b) A physician order is required for a resident to manage and have custody of his or her own medications. (c) A resident may have custody of and manage over the counter topical medications with the written approval of a physician. A physician order is not required for over the counter topical medications that are self-administered by residents and approved by the physician for resident possession. (d) Medication administration, as defined in these rules, shall be conducted only by a physician or an RN or LPN. An RN or LPN shall administer medications to residents in the specialty care assisted living facility only in accordance with physician orders and the Nurse Practice Act. (e) A current copy of A Short Practical Guide for Psychotropic Medications in Dementia Patients or the equivalent shall be in each specialty care assisted living facility as a reference guide. This Rule is not met as evidenced by: Based on interviews, the facility allowed unlicensed staff to administer medications to residents in the SCALF. Findings: During an interview on August 17, 2021, EI#14 reported she (EI#14) was working with EI#8 on	A 613		

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the evening of July 28, 2021 when EI#8 was "acting different", "agitated" and "couldn't get the medications straight". EI#14 further stated EI#26, RCA and Medication Technician, came from the ALF to assist with medications.

On the afternoon of August 17, 2021, EI#26 was interviewed regarding the above reported incident involving medications on the SCALF. EI#26 reported the following information which occurred on the evening of July 28, 2021 around dinnertime. EI#26 was in the medication room which connects to the dining room. SCALF residents and EI#8 were in the dining room and could be heard from the medication room. EI#8 did not seem to be herself and was "talking out of her head". EI#26 heard EI#8 mention she (EI#8) was hurting and EI#26 offered to assist. EI#8 replied "you can be my legs". EI#26 stated EI#8 then began putting residents' medications into cups and EI#26 would take the medications to the residents in the dining room while EI#8 was present in the room. EI#8 prepared all medications to be given and documented the medications, but EI#26 would deliver the medications to the residents to be taken. EI#26 reported this was the only time she (EI#26) assisted with medication administration on the SCALF but she (EI#26) frequently provided medication assistance on the ALF and was a Medication Technician. However, EI#26 was not licensed to administer medications as required for a SCALF.

Both EI#14 and EI#26 stated they (EI#14 and EI#26) contacted EI#1 that evening and reported EI#8's unusual behaviors. When interviewed on the afternoon of August 17, 2021, EI#1 stated he (EI#1) was made aware of EI#8's behaviors by EI#14 and EI#26. EI#1 further stated he (EI#1)

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A 613	Continued From page 96 called EI#8 and she (EI#8) talked normally during the conversation so no further interventions were required. EI#1 did agree EI#26 should not have administered medications to SCALF residents.	A 613		
A 615	420-5-20-.06 (5) (h) Care of Residents. (5) Medications. (h) All medications administered to residents in a specialty care assisted living facility, shall be contemporaneously recorded on a standard medication administration record. "Contemporaneously recorded" means recorded at the same time or immediately after medications are administered. The medication administration record shall include at least the following: 1. The name of the resident to whom the medication was administered. 2. The name of the medication administered. 3. The dosage of the medication administered. 4. The method of administration. 5. The site of injection or application, if the medication was injected or applied. 6. The date and time of the medication administration or assisted. 7. Any adverse reaction to the medication.	A 615		

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A 615	Continued From page 97 8. The printed name, initials, and written signature of the individual administering the medication or assisting the resident with self-administration of the medication. This Rule is not met as evidenced by: Based on record reviews, residents' Medication Administration Records (MARs) did not contain all required information. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON FEBRUARY 28, 2018. Findings: Resident MARs were reviewed for RI#17, RI#18, RI#20 and RI#21 on August 17, 2021. Initials entered on the front pages of the MARs on August 13, 14, 15 and 16, 2021 were not accompanied by matching initials, printed name and written signature on the back pages of the MARs. Nurses did not consistently document their printed name, initials and written signature on the back page of the MAR for all residents during medication administration.	A 615		
A 618	420-5-20-.06 (7) Care of Residents. (7) Oxygen Therapy. (a) A resident of a specialty care assisted living facility that requires oxygen therapy shall have oxygen administered only by a physician, RN, or LPN.	A 618		

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(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.

1. If a resident receives oxygen therapy in a facility:

2. All oxygen equipment, such as tubing, masks, and nasal cannula shall be maintained in a safe and sanitary condition.

3. All oxygen tanks shall be safely maintained and stored.

4. The facility shall require safe use of oxygen therapy. No smoking and appropriate precautionary signs shall be posted.

5. 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 document oxygen use on the resident's Medication Administration Record (MAR) as required.

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

Findings:

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A 618	Continued From page 99 RI#9 was admitted to the facility on May 25, 2021 and was currently receiving hospice services for a terminal diagnosis of malignant neoplasm of the small intestine. Refer to deficiencies 602, 604 and 611 for additional information on RI#9. During the survey, RI#9 was observed using oxygen via nasal cannula. RI#9's Medication Administration Record (MAR) contained a physician's order for oxygen at 2-4 liters/minute via nasal cannula. However, RI#9's oxygen use was not documented on the MAR to include date, time, rate and proper function of the equipment. EI#8 agreed the oxygen use was not documented as required.	A 618		
A 620	420-5-20-.06 (9) (a) Care of Residents (9) Admission and Retention of Residents. Residents admitted to and retained in specialty care assisted living facilities must meet all eligibility and continued stay requirements specified in these rules. (a) Admission. 1. A specialty care assisted living facility shall not admit any individual who: (i) Is receiving or requires skilled nursing care. (ii) Has a wound that requires care beyond basic first aid. (iii) Has unmanageable behaviors or behaviors that may be dangerous to themselves or others. (iv) Has a PSMS score greater than 23	A 620		

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or a score of five in feeding, dressing, grooming, bathing, or a score of four or five in physical ambulation.

(v) Is receiving or in need of hospice services.

(vi) Is diagnosed with an active acute infectious pulmonary disease, such as influenza or active tuberculosis, or with other diseases capable of transmission to other individuals through normal person-to-person contact.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility admitted a resident who did not meet the eligibility requirements for a SCALF.

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

Findings:

RI#9 was admitted to the facility on May 25, 2021 and had diagnoses which included malignant neoplasm of the small intestine, essential hypertension, atrial fibrillation, coronary artery disease and hypothyroidism. Refer to deficiencies 602, 604, 611 and 618 for additional information on RI#9. During the three day onsite survey, RI#9 was observed only in a hospital bed with partial bedrails. RI#9 was alert and able to direct his/her care but demonstrated a depressed mood. All staff who were interviewed stated RI#9 did not get out of the bed. RI#9 had generalized weakness and required assistance to turn side to side but

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could provide minimal assistance by pulling on the siderails. All staff who were interviewed reported RI#9 ate very little and was receiving hospice services at the facility. This was confirmed by the hospice nurse during her visit to RI#9 on June 23, 2021. The hospice nurse stated she (hospice nurse) had not known of RI#9 getting out of the bed since RI#9 was at home prior to admission to the SCALF.

Review of RI#9's facility record on June 22, 2021 revealed RI#9 was admitted to hospice services on November 15, 2020 with a terminal diagnosis of malignant neoplasm of the small intestine. Record reviews also revealed RI#9 had an indwelling Foley catheter prior to admission but EI#8 stated the catheter had been removed to allow RI#9 to be admitted to the SCALF. RI#9 was currently incontinent of bowel and bladder.

It was noted by the surveyor (documented in deficiency 604) RI#9 had not been adequately assessed prior to admission to the SCALF to determine eligibility for admission. A Comprehensive Assessment, behavior screening and PSMS were not completed on RI#9 until two days after RI#9's admission to the facility. The total PSMS result for RI#9 on May 27, 2021 was 23 which is the highest score allowed in a SCALF. In addition, RI#9 scored a 4 in Physical Ambulation (sits unsupported in chair or wheelchair but cannot propel self without help) on the PSMS dated May 27, 2021, which is above the level allowed in a SCALF.

A Physician's Note, written by the Nurse Practitioner and co-signed by the physician on May 26, 2021, documented the following information about RI#9: "...New admit to SCALF from home where (RI#9) was followed

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A 620	Continued From page 102 by...hospice. Reports since last hospice recertification has become weaker and family is no longer able to take care of (RI#9) at home. Requires a hospital bed. Reports (RI#9) is nonambulatory but can sit on side of the bed. Foley DC'd for admission...Reports that (RI#9) is not eating or drinking well x 3 days. Is depressed in regards to (his/her) living situation and thoughts of expiring...Plan: Readmit into...hospice...". This note was written the day after RI#9 was admitted to the facility, confirming RI#9 was already in need of hospice services at the time of admission to the facility and RI#9's functional status was above the level allowed in a SCALF. EI#8 stated RI#9 was in a bad family situation at home and was admitted to the facility for care at the request of the medical director.	A 620		
A 621	420-5-20-.06 (9) (b) Care of Residents. (b) Retention. 1. A specialty care assisted living facility shall not allow any resident to return to the specialty care assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the specialty care assisted living facility is licensed to provide or the facility is capable of providing. 2. A specialty care assisted living facility shall not retain a resident that has a PSMS score greater than 23 or a score of five in feeding, dressing, grooming, bathing or a score of four or five in physical ambulation. 3. A specialty care assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of	A 621		

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A 621	Continued From page 103 residents currently in the facility. 4. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in a specialty care assisted living facility. 5. A specialty care assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless: (i) The individual is capable of performing and does perform all tasks related to his or her own care; OR (ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity but the individual has sufficient cognitive ability to direct his or her own care and the individual is able to direct facility staff and does direct facility staff to provide the physical assistance needed to complete such tasks, and the facility staff is capable of providing such assistance and does provide such assistance. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. 6. If a resident of a specialty care assisted living facility is diagnosed with a terminal illness and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90 days. If the facility is unable or becomes unable to meet the needs of a resident receiving hospice care, or if a resident receiving hospice care	A 621		

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requires care beyond what the facility may lawfully provide pursuant to this section, then the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for specialty care assisted living facilities.

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

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility retained residents who had a PSMS greater than the level allowed in a SCALF.

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

Findings:

RI#8

RI#8 was admitted to the facility on June 22, 2018 and had diagnoses which included coronary artery disease, dementia, hypertension, atrial fibrillation, osteoporosis and hyperlipidemia. Refer to deficiencies 604, 605 and 611 for additional information on RI#8. On the afternoon of June 22, 2021, the surveyor observed EI#20 transport RI#8 from the activity room to resident room by pushing the wheelchair. RI#8 did not attempt to propel the wheelchair even when

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asked to do so. EI#20 transferred RI#8 from the wheelchair to the bed. RI#8 was totally lifted from the wheelchair by EI#20 and held tightly to the wheelchair with his/her feet sliding, making the transfer more difficult. RI#8 was incontinent of urine. Even though RI#8 spoke a few words, the words were random and nonsensical. After incontinent care was provided, RI#8 was left in the bed. When asked if RI#8 could self-propel the wheelchair, EI#20 stated she (EI#20) had not seen her (RI#8) self propel. Earlier that day, the surveyor observed staff pushing RI#8 from the dining room in the wheelchair. RI#8 did not assist at that time either. RI#8 was also assisted with eating by staff.

The surveyor was unable to find a current PSMS score for RI#8 in the facility record. At the request of the surveyor, a PSMS was completed for RI#8 by EI#8 on June 24, 2021. The result was a total PSMS score of 27, well above the total level of 23 which is allowed in a SCALF. The PSMS for RI#8 also included the following scores which were above the level allowed in a SCALF: a score of 5 in dressing (completely unable to dress self and resists efforts of others to help); a score of 5 in grooming (actively negates all efforts of others to maintain grooming); a score of 4 in physical ambulation (sits unsupported in chair or wheelchair, but cannot propel self without help); a score of 5 in bathing (does not try to wash self and resists efforts to keep him/her clean).

RI#11

RI#11 was admitted to the facility on January 3, 2018 and had diagnoses which included altered mental status, dementia, anemia, hypothyroidism, hyperlipidemia, heart failure and Alzheimer's disease. Refer to deficiencies 604 and 605 for

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additional information on RI#11. RI#11 was observed throughout the survey in a wheelchair and was transported about the facility in the wheelchair by staff. RI#11 was not observed propelling the wheelchair. On the morning of June 23, 2021, the surveyor observed EI#13 and EI#17 provide incontinent care to RI#11. RI#11 was transported to his/her room in the wheelchair, pushed by EI#13. RI#11 was transferred to the bed, requiring a total lift from the wheelchair. RI#11 did not assist with standing or pivoting to transfer. Once in the bed, RI#11 had to be turned side to side to remove the soiled diaper and provide perineal care. RI#11 did not assist with any care provided and was left in the bed after the care was complete. Both EI#13 and EI#17 stated RI#11 was unable to self-propel the wheelchair.

Review of RI#11's facility record revealed a total PSMS score for RI#11 of 28, documented as early as February 17, 2021. RI#11's PSMS score was well above the level allowed in a SCALF and also included the following scores which were above the level allowed in a SCALF: a score of 5 in dressing (completely unable to dress self and resists efforts of others to help); a score of 5 in physical ambulation (bedridden more than half the time); a score of 5 in bathing (does not try to wash self and resists efforts to keep him/her clean). These same PSMS scores were documented on another form in RI#11's facility record. Although this form did not contain a resident name and a date, it was stapled to a comprehensive assessment which was completed on May 8, 2021 for RI#11.

Both of these residents were retained at the facility with PSMS scores well above the level allowed in a SCALF. RI#8 had not been properly

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	assessed to determine the current functional status. Even though RI#11 had been assessed, RI#11 had not been issued a 30-day discharge notice at the time of the survey. Both residents remained at the facility requiring extensive personal care and activities of daily living assistance, with inadequate staff to provide the care and safety measures needed. On July 24, 2021, EI#1 stated he (EI#1) planned to have the new RN complete current assessments for all residents.			
A 803	420-5-20-.08 (3) Physical Facilities.	A 803		
	(3) Resident's Physical Facilities.			
	(a) All resident bedrooms shall have an outside window and shall not be below grade. Window areas shall not be less than one-eighth of the floor area, unless proper lighting, ventilation, and air-conditioning are provided. All specialty care assisted living facilities submitted for plan review on or after October 5, 2001, shall ensure that each resident bedroom has at least one outside window with a minimum of 20 feet of clear space to any structure, measured perpendicularly. A peripheral view of the exterior shall be provided from newly constructed bedrooms. Operable window openings may be restricted to prevent residents from exiting through the windows.			
	(b) Resident bedrooms shall be located so as to minimize the entrance of odors, noise, and other nuisances.			
	(c) Residents bedrooms shall be directly accessible to a main corridor or through no more than one intervening sitting room within the			

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bedroom suite. In no case shall a resident bedroom be used for access to another resident's room.

(d) Residents bedrooms shall be individually and consistently identified, (numbered, lettered, or named).

(e) Bedroom Size. As a minimum, floor area shall be as follows:

1. Private bedroom without sitting area: 80 square feet. Double bedroom without sitting area: 130 square feet.

2. Private bedroom with sitting area: 160 square feet. Double bedroom with sitting area: 200 square feet.

3. Bedrooms shall accommodate no more than two residents.

(f) Bedroom furnishings. The resident has the right to furnish his or her room as he or she so chooses, within the facility's guidelines. If the facility offers to provide some or all of the furniture, as a minimum, bedrooms shall contain the following for each resident:

1. A suitable built-in clothes closet or wardrobe with shelving space and clothing pole.

2. A bed with good springs and mattress and sufficient clean bedding. In no case shall a cot or rollaway bed be provided for residents.

3. A dresser or chest of drawers.

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4. A bedside table and bed lamp.

5. At least one comfortable chair, preferably an armchair, recliner, or rocker.

6. Window shades, venetian blinds, or other suitable provisions for closing the view from the window.

7. Adequate number of electrical outlets shall be provided. Extension cords, U.L. approved with overload protection capability may be used for light duty appliances and shall not pose a hazard to residents.

8. A mirror in the bedroom or bedroom suite, unless contraindicated by a resident's condition.

(g) Toilet and Bathing Facilities. As a minimum, the following toilet and bathing facilities shall be provided.

1. For all residents' bedrooms, which do not have adjoining toilet and bathing facilities, plumbing fixtures shall be provided within the resident sleeping area according to the following ratios:

(i) Bathtubs or showers one per eight beds.

(ii) Lavatories one per six beds.

(iii) Toilets one per six beds.

2. When a semi-private bedroom is provided, the facility shall provide a means of privacy for dressing, bathing, and personal care.

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When common area bathrooms are provided, they shall be separated by partitions, curtains, or screens to provide for privacy in the baths and toilets.

3. Non-skid mats or equal surface treatment and safety handgrips or grab bars shall be provided in tubs, showers, and at each toilet fixture. Grab bars shall be installed in new Group and Congregate facilities to conform to the currently adopted building code.

(h) All essential mechanical, electrical, and resident care equipment shall be clean and maintained in a safe operating condition.

(i) Bed and bath linens shall be clean and in good condition.

(j) Housekeeping and maintenance shall provide services necessary to maintain a sanitary, orderly, and comfortable interior.

This Rule is not met as evidenced by:
Based on observations and interviews, maintenance services were not provided to maintain a sanitary and comfortable environment. In addition, the facility failed to provide a means of privacy for dressing and personal care in a semi-private room.

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

THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON JULY 14, 2016, ON SEPTEMBER 22, 2016 AND ON FEBRUARY 13,

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2020.

Findings:

Sanitary and Comfortable Environment

The Alabama Department of Public Health received a complaint on May 19, 2021 which alleged the toilet in Resident Room 373 was not functional. The surveyor was able to substantiate this complaint during the onsite survey.

On the afternoon of June 22, 2021, the surveyor with EI#20 attempted to flush the toilet in the bathroom of Resident Room 373. The toilet would not flush. EI#11 was notified by the surveyor and went to check the toilet. EI#11 reported to the surveyor the water was turned off to the toilet. EI#11 had turned the water back on and stated the toilet was functioning again.

On the afternoon of June 23, 2021, EI#5, Maintenance Director, reported to the surveyor he (EI#5) had checked the toilet in Resident Room 373 and it was flushing but was also leaking. EI#5 stated he (EI#5) was aware of problems with the toilet for some time but it could not be repaired and needed to be replaced. The toilet continued to malfunction at the time of the survey and had not been replaced. Staff reported the resident had to be taken to a toilet in another room.

During an interview on the afternoon of June 23, 2021, EI#1 stated he (EI#1) was not aware of the problem with the toilet but the toilet should have been replaced.

Privacy in a Semi-Private Room

On the afternoon of June 22, 2021, the surveyor

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A 803	Continued From page 112 observed EI#15, RCA, provide personal care service to RI#1. The personal care involved changing RI#1's diaper, providing perineal care and assisting RI#1 with dressing. During the personal care, RI#1's roommate was seated in the semi-private room the two residents shared and observed the entire process while talking with the RCA. No divider or screen was provided to ensure privacy and RI#1 was not taken into the bathroom for privacy. This same deficient practice had been cited during the State survey conducted on September 22, 2016. The Plan of Correction was the purchase of a portable privacy screen for use in semi-private rooms. On June 24, 2021, EI#5 stated a portable screen had been purchased by the facility for use in semi-private rooms. However, the privacy screen was not in use at the time of the survey.	A 803		
A 901	420-5-20-.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 specialty care 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 adequate	A 901		

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rooms and spaces for sorting, processing, and storage of soiled material. Laundry rooms 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 specialty care assisted living facility shall have a system in place to keep clean linen and dirty linen separated and to prevent the re-use 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 specialty care assisted living facility. Provisions shall also be made to prevent the re-circulation of air in commercial equipment laundries into 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 and interviews the facility failed to provide laundry services timely to 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 AND ON 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 and laundry was piled up in residents' rooms. The surveyors substantiated this complaint during the onsite survey.

On 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 prior to the survey. 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 prior to do the memory care residents' laundry on first shift (7 AM - 3 PM) Monday through Friday. The surveyor reviewed the "SCALF Laundry List" for June with EI#7. EI#7 explained once she (EI#7) completed the resident's laundry for the day she (EI#7) would write her (EI#7's) initials by the resident's name on the Laundry List.

On the morning of June 22, 2021, the surveyor observed SCALF residents' rooms with EI#11. Clothing and linens were piled in the bathroom floor of Resident Room 402. The assigned laundry days for Room 402 were 6/21/2021 and 6/24/2021. A laundry basket was overflowing onto the floor with clothing and linens in Resident Room 364. The assigned laundry days for Room 364 were 6/21/2021, 6/23/2021 and 6/27/21. The SCALF Laundry List was not initialed for either of these rooms to indicate laundry was completed

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A 901	Continued From page 115 on 6/21/2021. On the morning of June 24, 2021, the surveyor again observed laundry overflowing from the basket in Resident Room 364. During interviews with Resident Care Assistants (RCAs) and Licensed Practical Nurses (LPNs) on June 22 and 23, 2021, six staff members (EI#12, EI#13, EI#18, EI#19, EI#20 and EI#22) reported concerns about laundry piling up in residents' rooms. Four of these staff members (EI#12, EI#13, EI#19 and EI#22) reported they had even assisted with laundry at times. On the morning of June 22, 2021, the surveyor discussed the laundry situation with EI#5, Maintenance Director. EI#5 confirmed a laundry staff member had quit the previous week and the facility had been trying to hire someone else. EI#5 said we (EI#1, EI#4, EI#5 and RCAs) have been trying to keep up with the laundry but it has been tough.	A 901		
A1002	420-5-20-.10 (2) Sanitation and Housekeeping. (2) Housekeeping and Physical Plant Maintenance. The facility must provide a safe, functional, decent, sanitary, and comfortable environment for residents, staff, and the public. (a) Equipment and Supplies. The home shall maintain an adequate quantity of housekeeping and maintenance equipment and supplies. (b) Bathtubs and Lavatories. Bathtubs and lavatories shall be kept clean and in proper working order, and shall not be used for laundering.	A1002		

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(c) Resident Bedrooms. Resident bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance.

(d) General Storage.

1. Broken beds, extra mattresses, mop buckets, and dust rags shall not be kept in hallways, closets, corners, or occupied resident rooms. Such items must be stored neatly and orderly in designated storage rooms.

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

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kept in a secure area.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to provide housekeeping services necessary to maintain a safe, decent, sanitary and comfortable environment for residents and staff.

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

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

Findings:

The Alabama Department of Public Health received a complaint which alleged residents' toilets were dirty and brown. Surveyors were able to substantiate this complaint during the onsite survey and identified other deficient practices related to housekeeping as well.

On the morning of June 22, 2021, the surveyor observed residents' rooms and bathrooms on the 300 and 400 halls with EI#11. Multiple resident rooms and bathrooms had dirty floors, were cluttered and had spiderwebs in corners. The floors in resident rooms and hallways on the 300 hall were old, dull and worn. The toilet in resident room 361 was black and the tub was dirty. The toilet in resident room 372 was filthy and had feces on the seat and sides. The tub in resident room 382 was filthy and brown in color. Only a small piece of the shower curtain was hanging in

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A1002	Continued From page 118 the tub as if it had been ripped off the rod. During interviews with facility RCAs and LPNs on June 22 and 23, 2021, five of the staff interviewed (EI#12, EI#13, EI#14, EI#19 and EI#22) reported concerns about inadequate housekeeping. Staff reported they assisted with housekeeping at times. One staff member even reported cleaning the staff bathroom herself because it had become so dirty and was not cleaned by housekeeping. EI#2 provided the surveyors with a report of her (EI#2's) findings during a visit to the facility on June 3, 2021. The documented findings under "Facility Rounds" read "...SCALF floors dull and stained. In need of striping, waxing and edging. Spiderwebs noted in corners of doors at floor level...". EI#2 stated she (EI#2) provided a copy of this documentation to EI#1 and to the Regional Vice President following the visit. Even though these issues had been identified by EI#2 almost three weeks prior to the survey, the problems still existed. In fact, the facility was cited for housekeeping and maintenance issues during the surveys conducted on July 14, 2016 and on February 13, 2020. Both EI#1 and EI#5 stated stated the facility had just hired new housekeeping personnel.	A1002		
A1101	420-5-20-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All specialty care assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately	A1101		

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posted in a conspicuous place.

(b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years.

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

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

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

1. Minimizes leaks and spills.

2. Adequately protects against inappropriate access.

3. Complies with the requirements of

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A1101	Continued From page 120 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 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	A1101		

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monthly fire drills.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON FEBRUARY 13, 2020 AND ON 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 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. Even though this deficiency has been previously cited during two State surveys, the deficient practice continued at the facility, placing all residents of the facility at significant risk of harm.

CONNIE CHERRY, REGISTERED NURSE
DEBRA FREEMAN, REGISTERED NURSE