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MORNINGSIDE OF VESTAVIA HILLS	2435 COLUMBIANA ROAD BIRMINGHAM, AL 35216

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A 000	Initial Comments On December 1, 2022, an unannounced licensure survey and complaint investigation was conducted for this 66 bed Assisted Living Facility with a census of 39. There were two complaints investigated during this survey. LC#20220811013 and LC#20210225003 were substantiated and deficiencies were cited as a result of the complaint investigations. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities (ALF). The deficiencies cited placed all residents of the facility at significant risk of harm and require a plan of correction.	A 000		
A 203	420-5-4-.02 (3) The License. License. If an applicant submits a timely and complete application accompanied by the appropriate license fee and any supporting documentation that may be required by the Department, and if the Department is satisfied that the applicant is likely willing and capable of compliance with these rules, and if granting such a license would not violate any other state or federal law or regulation, then the Department, as agent for the Board, may grant a license to the applicant. All licenses granted shall expire at midnight on December 31 of the year in which the license is granted. The Department, as agent for the Board, may deny a license. A license shall only be valid	A 203		

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A 203	Continued From page 1	A 203		

at the licensed premises and for the individual or business entity licensed. It is a condition of licensure that the licensee must continuously occupy the licensed premises and remain open as an assisted living facility, fully staffed and otherwise capable of admitting and providing assisted living services. If a facility fails to remain open and staffed as required for a period of 30 days, its license shall become void unless the Department has been notified that services are temporarily suspended for remodeling or minor alterations. If a licensee abandons the licensed premises, the license shall immediately become void.

(a) Issuance of License Certificate. The license certificate issued by the State Board of Health shall set forth the name and location of the assisted living facility, the classification of the assisted living facility, and the facility's bed capacity.

(b) Separate Licenses. Each assisted living facility shall be separately licensed, regardless of whether it is owned or managed by the same entity as another assisted living facility.

(c) Posting of License Certificate. The license certificate shall be posted in a conspicuous place on the licensed premises.

(d) License Renewal. Licenses may be renewed by the applicant as a matter of course upon submission of a completed renewal application and payment of the required fee. When the Department has served written notice on the facility of its intent to revoke or downgrade the license, a renewal application shall be filed but does not affect the proposed adverse

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A 203	Continued From page 2 licensure action. (e) Failure to Renew a License. Any licensee who fails to renew a license on or before the close of business on the last business day in December shall be assessed a late fee equal to the amount of the original license fee. A license may only be renewed with the payment of a late fee before the close of business on the last business day in January of the succeeding calendar year. A license which has not been renewed by the end of January has expired and shall be void. (f) Change of Ownership. An assisted living facility license is not transferrable. In the event that the legal ownership of the right to occupy a facility's premises is withdrawn or transferred to an individual or entity other than the licensee, the facility license shall become void and continued operation of the facility shall be unlawful pursuant to §22-21-22, Code of Ala. 1975, and subject to penalties as provided in §22-21-33, Code of Ala. 1975, unless an application for a change of ownership has been submitted to and approved by the Department prior to the transfer of legal ownership. At least 30 days prior to any proposed change in ownership, the new prospective licensee of an assisted living facility shall file a change of ownership application with the State Board of Health. An application for change of ownership shall be submitted on the form prescribed by the Department, shall be accompanied by the requisite application fee set forth in §22-21-24, Code of Ala. 1975, and shall be subject to the same requirements and considerations as are set forth above for initial license applications. An application for a change of ownership shall be submitted and signed by	A 203		

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the prospective new licensee, or its agent, and also either signed by the current licensee or its agent, or accompanied by a court order demonstrating that the current licensee has been dispossessed of the legal right to occupy the premises and that the prospective new licensee has been awarded the legal right to occupy the premises. Upon approval of a change of ownership, the Department shall notify the current licensee and the new license applicant, and shall issue a license certificate to the new licensee.

Indicia of ownership of a facility include the right to hire, terminate, and to determine the compensation and benefits paid to the facility's administrator and other staff; the right to receive payment from residents and third parties for services provided by the facility; the right to establish and to change the policies, procedures, and protocols under which the facility operates; and the right to overrule operational decisions made by the facility administrator and other staff.

(g) Change in Bed Capacity. A facility may apply for a change in licensed bed capacity by submitting a completed application on a form prescribed by the Department and accompanied by the fee prescribed in §22-21-24, Code of Ala. 1975, together with such other documentation as the Department may require. Upon approval of a change of bed capacity, the Department shall notify the licensee and shall issue a revised license certificate to the licensee, which may be predicated on the return of the old license certificate.

(h) Change of Name. A facility may apply for a change of name by submitting a completed application on a form prescribed by the

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Department. There is no application fee for a change of name application. The Department may in its discretion deny an application for a change of name if the Department determines that the proposed name is misleading to the public or that the name is overly similar to the name of an already licensed facility. Separately licensed facilities owned by the same governing authority may have names that are similar to one another and distinguished from one another in some other manner, such as a geographic description. Upon approval of a change of name, the Department shall notify the licensee and shall issue a revised license certificate to the licensee, which may be predicated on the return of the old license certificate.

(i) Denial of a License. The Board may deny a license to any applicant on grounds of insufficient evidence of the willingness or ability to comply with §§22-21-20 through 22-21-34, Code of Ala. 1975, or these rules, including the following reasons:

1. The applicant or any principal associated with the applicant has violated any provision of §§22-21-20 through 22-21-34, Code of Ala. 1975.

2. The applicant or any principal associated with the applicant has been convicted of engaging in, permitting, aiding, or abetting the commission of an illegal act in any licensed health care facility.

3. The applicant or any principal associated with the applicant has engaged in conduct or practices deemed by the Board to be detrimental to the welfare of the residents of the

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A 203	Continued From page 5 health care facility. 4. Conduct and practices deemed detrimental to the welfare of residents of a facility or provide grounds pursuant to this subsection for denial of a license include: (i) The applicant or an agent authorized by the applicant has deliberately falsified any material information or record submitted as part of the application for licensure. (ii) The applicant has changed its corporate name, charter, entity, or its partnership name or composition to avoid the imposition of liens or court action. (iii) The applicant or any principal associated with the applicant has been convicted of engaging in the physical, mental, or sexual abuse or in the financial exploitation of a patient or patients. (iv) The applicant or any principal associated with the applicant has operated a health care facility in Alabama or in any other jurisdiction in a manner that resulted in one or more violations of applicable laws or other requirements and as a result caused death, injury, disability, or serious risk of death, injury, or disability to any resident or patient of the facility and such past conduct causes the Department to reasonably believe that granting a license to the applicant would likely be detrimental to the life, health, or safety of prospective residents of the facility for which licensure is sought. (v) The applicant or any principal associated with the applicant has been convicted	A 203		

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A 203	Continued From page 6 of fraud in this or any other jurisdiction. (vi) The applicant or any principal associated with the applicant has in the past deliberately falsified records or has otherwise made a deliberate and material misrepresentation of facts to an employee of the Department in an attempt to influence the outcome of a survey or some other regulatory compliance determination by the Department. (vii) The applicant or any principal associated with the applicant has in the past induced or attempted to induce a subordinate employee to falsify records or to otherwise make a deliberate and material misrepresentation of facts to an employee of the Department in an attempt to influence the outcome of a survey or some other regulatory compliance determination by the Department. (viii) The applicant or any principal associated with the applicant is operating, or has in the past operated, an unlicensed health care facility. (ix) The applicant or any principal associated with the applicant has at any time been debarred from participation in the Medicare or Medicaid programs. (x) Other serious misconduct which, in the judgment of the Board, poses a serious risk to patient health or safety. 5. An applicant may appeal the denial of a license pursuant to the provisions of the Alabama Administrative Procedure Act, §41-22-1, et seq., Code of Ala. 1975, and the Board's Rules	A 203		

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A 203	Continued From page 7 for Hearing of Contested Cases, Chapter 420-1-3, Ala. Admin. Code. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to post the license certificate in a conspicuous place on the premises. Findings: During a tour of the facility on the morning of November 29, 2022, no license certificate was posted on the licensed premises. Both Employee Identifier (EI)#2 and EI#4 agreed the license was not posted in a conspicuous place. A copy of the license was later provided to the surveyor.	A 203		
A 401	420-5-4-.04 (1) (2) Personnel. Personnel. (1) An assisted living facility shall ensure personnel are employed and on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. (a) An assisted living facility shall be staffed at all times by at least one individual who has a current certification in cardiopulmonary resuscitation (CPR). (b) An assisted living facility must be staffed to ensure the safe evacuation of all residents in the event of a fire or emergency. (2) Employee Schedule. An assisted living facility shall post a schedule of employees	A 401		

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A 401	Continued From page 8 indicating names and days and hours scheduled to work. This schedule shall be retained in the facility for 6 months after use. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide adequate staffing to meet the care and safety needs of all residents 24 hours a day, 7 days a week. Findings: The census at the facility during the onsite survey was 39 residents. On the morning of November 29, 2022, EI#4 provided the surveyor with a copy of the current staffing schedule. EI#4 explained the facility was staffed with two Resident Assistants (RAs) and one Licensed Practical Nurse (LPN) minimum on each shift and at times an additional RA or LPN would be assigned. In addition, a housekeeper worked during the day shift Monday through Friday and the facility Registered Nurse (RN) was available at varying times but was obligated to multiple duties including Director of Nursing for the ALF and Specialty Care Assisted Living Facility (SCALF), scheduling and at times working as a medication nurse on the ALF and/or SCALF unit. The facility provided a nurse to assist with medications. Usually one LPN was assigned to assist all residents with medications, except the two residents who self-administered their medications. EI#10, LPN and EI#22, LPN, both stated two nurses were needed for day and evening shift on the ALF unit due to the number of residents and the level of care required by the current residents. EI#10 explained she (EI#10)	A 401		

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constantly had to stop her (EI#10's) duties and assist residents who were confused or could not find their rooms, which distracted EI#10 from medication assistance and other responsibilities such as assisting physicians, contacting physicians, ordering medications and ensuring physicians' orders were noted and followed. EI#10 added that medications frequently were not provided to residents within the allowed window of one hour before or one hour after the scheduled time due to these other resident care issues that would arise.

During interviews, RAs also reported that two RAs for day and evening shift were inadequate to meet the care and safety needs of the current residents. One resident [Resident Identifier (RI)#9] wandered and had eloped from the facility at least two times. Two residents (RI#3 and RI#4) had multiple falls. At least one resident (RI#2) was incontinent and refused assistance with care. Another resident (RI#5) was incontinent and required considerable assistance with personal care. At least five residents (RI#1, RI#8, RI#9, RI#10 and RI#11) were unable to direct their care and protect themselves when medication awareness testing was performed.

RI#11 reportedly had a recent decline in condition and was unable to safely ambulate without assistance. RI#11 was found by EI#10 and the surveyor on November 29, 2022 in RI#11's room, seated in the wheelchair but slid down to the edge of the wheelchair. RI#11 would likely have slid out of the wheelchair onto the floor if EI#10 had not entered the room to assist with medications. RI#11 was confused at the time and did not know where he/she was.

On the morning of November 30, 2022, around

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A 401	Continued From page 10 7:50 AM, the surveyor entered RI#3's room and observed RI#3 sitting on the side of the bed with wheelchair near the bed. RI#3 was placing a phone call and stated he/she was attempting to call the RA on their phone because no one was answering the call light and RI#3 needed assistance to the bathroom. RI#3 was severely visually impaired and had multiple falls and had been instructed by staff to call for assistance to get up. The surveyor pushed RI#3's pendant then went to the front desk and was informed by EI#20 that no calls had been received from RI#3 because RI#3 was not pushing the pendant hard enough. EI#20 called the RA to assist RI#3. The RA was serving meals to other residents in the dining room and had to stop her duties in the dining room to attend to RI#3. RI#1 and RI#10 were observed frequently during the onsite survey stopping staff and asking where they (RI#1 and RI#10) were supposed to go. RI#10 frequently requested directions to his/her room. On the morning of November 30, 2022, around 9:40 AM, RI#1 followed the surveyor into the dining room and asked if it was time to eat. RI#1 had already eaten breakfast. When the surveyor explained it was not time for a meal, RI#1 replied, "I thought it was time to eat. If the doors are open, we are supposed to eat. Why are the doors open?" The facility was not staffed to meet the care and safety needs of all current residents, placing all residents at significant risk of harm. EI#4 stated the facility was currently using a staffing agency to supplement. No agency staff were observed during the survey. A plan to meet the staffing needs of the facility was provided to the surveyor by EI#1, EI#2 and EI#3 during the onsite survey.	A 401		

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A 402	Continued From page 11	A 402		
A 402	420-5-4-.04 (3) Personnel. (3) Employee Screening. (a) Prior to any resident contact, such as but not limited to assistance with activities of daily living, newly employed personnel shall have a physical examination certifying that the employee is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to residents through normal staff to resident contact. Employees who develop signs or symptoms of infectious skin lesions or diseases that would be capable of transmission to residents through normal staff to resident contact shall not be permitted to have resident contact until free from such signs and symptoms. (b) Not more than 30 days prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis. (c) Vaccines. Assisted living facilities shall immunize employees in accordance with current recommended Centers for Disease Control and Prevention (CDC) guidelines (www.cdc.gov/vaccines). Any particular vaccination requirement may be waived or delayed by the State Health Officer in the event of a vaccine shortage. (d) An assisted living facility shall not hire an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry. This Rule is not met as evidenced by:	A 402		

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A 402	Continued From page 12 Based on record reviews and interviews, employees were not screened as required prior to resident contact. Findings: Review of facility personnel records on the afternoon of November 29, 2022 revealed at least three employees (EI#4, EI#13 and EI#16) did not have a physical examination certifying that the employee was free of signs and symptoms of infectious skin lesions and diseases that were capable of transmission to residents through normal staff to resident contact. EI#2 and EI#5 were unable to provide this required information.	A 402		
A 403	420-5-4-.04 (4) Personnel. (4) Personnel Records. An assisted living facility shall maintain a personnel record for each employee. This record shall contain: (a) An application for employment which contains information regarding the employee's education, training, and experience. (b) Verification of current certification or licensure, if applicable. (c) Record of required physical examinations and vaccinations. (d) Verification the facility has not hired an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry. (e) Date of hire.	A 403		

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A 403	Continued From page 13 (f) Date of initial resident contact. (g) Date employment ceased. This Rule is not met as evidenced by: Based on record reviews and interview, personnel records were incomplete. Findings: Review of facility personnel records on the afternoon of November 29, 2022 revealed the following information. No date of hire was documented for EI#12 and EI#13. No date of initial resident contact was documented for EI#4, EI#12, EI#13 and EI#16. EI#5, Business Office Manager, agreed the required information had not been documented.	A 403		
A 405	420-5-4-.04 (6) Personnel. (6) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained in the facility. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on assisted living	A 405		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 405	Continued From page 14 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 environment safety. 10. Special needs of the elderly, mentally ill, and mentally retarded. 11. Safety and nutritional needs of the elderly. 12. Identifying signs and symptoms of dementia. (b) Cardiopulmonary Resuscitation. An assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of an assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the	A 405		

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	D3728	A. BUILDING: _____ B. WING _____	12/01/2022

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A 405	Continued From page 15 American Red Cross. New employees must obtain certification in CPR within 90 days of hire. An assisted living facility equipped with an automated external defibrillator (AED) shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or American Red Cross in CPR or AED utilization. (c) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training. (d) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above. This Rule is not met as evidenced by: Based on record reviews and interviews, employees were not trained as required in cardiopulmonary resuscitation (CPR) and in special needs of residents. Findings: Review of facility personnel records on the afternoon of November 29, 2022 revealed the following information. EI#4, EI#12, EI#13 and EI#16 did not have documentation of current certification in CPR. EI#5 did not provide documentation of CPR training when requested	A 405		

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A 405	Continued From page 16 by the surveyor. EI#4, EI#9, EI#10, EI#11, EI#12, EI#13 and EI#16 did not have documentation of training in diabetes. Multiple current residents of the facility had a diagnosis of diabetes mellitus. EI#4 and EI#5 both agreed the required training was not documented and confirmed staff had not received training in diabetes.	A 405		
A 504	420-5-4-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate. 1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility. 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.	A 504		

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A 504	Continued From page 17 4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time. 5. Every resident shall have freedom to participate in and benefit from social, religious, and community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. 6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the premises, an individual account record for each resident shall be maintained by the administrator and an up-to-date record shall be maintained for all transactions. 7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so. 8. Every resident shall have the right to a reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals. 9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident.	A 504		

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A 504	Continued From page 18 10. Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to receive or reject medical care, dental care, or other health care services except those required to control communicable diseases. 11. Every resident shall have the right to at least 30 days prior written notice of involuntary relocation or termination of residence from the facility unless the resident is a patient in a facility providing a higher level of care and no longer meets the eligibility and continued stay requirements in these rules, or for medical reasons the resident is considered by a physician to require an emergency relocation to a facility providing a more skilled level of care, or unless the resident engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record. 12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person without restraint, interference, coercion, discrimination, or reprisal. 13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file.	A 504		

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A 504	Continued From page 19 14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the facility, provided that: (i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care. (ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation; and (iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time without recourse. 15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges. 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	A 504		

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A 504	Continued From page 20	A 504		

Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll-free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll-free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area.

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

19. Every resident shall have the right to 30 days prior written notice to both resident and sponsor of any increase of fees or charges.

20. Every resident shall have the right to 30 days prior written notice of any involuntary change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents.

21. Every resident shall have the right to wear his or her own clothes, 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.

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A 504	Continued From page 21 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours and to freely come and go from the home. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide a safe and decent environment for residents at all times. In addition, the most recent state inspection report and resulting corrective action plan was not posted as required. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: Posting of State Inspection Report During a tour of the facility on the morning of November 29, 2022, the surveyor did not observe a posting of the most recent inspection and any resulting corrective action plan. EI#2 agreed this required information was not posted. Safe and Decent Environment The Alabama Department of Public Health received multiple complaints which included	A 504		

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A 504	Continued From page 22	A 504		

allegations that ineligible residents were retained at the facility, the call system was not properly utilized, odors were present and physician's orders were not obtained in accordance with State rules. The surveyor was able to substantiate these complaints and also identified the following additional noncompliant practices during the onsite survey.

The facility was not adequately staffed to meet the care and safety needs of all residents 24 hours a day,7 days a week. Refer to deficiency 401 for additional information.

Employees were not properly screened and did not receive required training prior to resident contact. Cardiopulmonary resuscitation certification was not completed for employees as required. Refer to deficiencies 402 and 405 for additional information.

An elopement of a resident was not investigated with appropriate measures implemented to prevent a recurrence. In fact, the resident did elope from the facility again. Refer to deficiency 508 for additional information.

Physician's orders were not obtained upon admission of a resident and one resident's physician was not notified when orders were needed. Refer to deficiency 601 for additional information.

Residents did not receive adequate health supervision to identify changes in status and care needs and implement appropriate interventions. Residents' facility care plans did not contain interventions to address the current care needs of the residents. Refer to deficiencies 604 and 611 for additional information.

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A 504	Continued From page 23 At least six residents were unable to understand and utilize the unit dose packaging system and protect themselves from medication errors. A resident who was severely visually impaired had no interventions in place to allow the resident to utilize the unit dose system. Residents who were confused and had the potential for elopement were retained without proper supervision to prevent elopement. Residents were unable to direct their own care. Refer to deficiencies 613 and 621 for additional information. Proper measures were not taken to prevent food contamination. Refer to deficiency 702 for additional information. Water accessible to residents was not maintained at a safe temperature. Refer to deficiency 1001 for additional information. Odors were present in the facility. Refer to deficiency 1001 for additional information. Fire drills, fire alarm inspections and sprinkler inspections were not performed as required. Fire extinguishers were not visually inspected as required. Refer to deficiencies 1101 and 1203 for additional information. The facility's call system was not fully functional due to failure of the facility to provide adequate staff to utilize the system. Refer to deficiency 1203 for additional information. These practices created an unsafe and unpleasant environment for residents and placed all residents of the facility at significant risk of harm.	A 504		

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A 508	Continued From page 24	A 508		
A 508	420.5.4-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in an assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review. 1. Incidents which require investigation are: (i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as bruising, pain, or injury that is not consistent with actions necessary in providing day to day care to a resident or for which medical treatment was sought. (ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid, including but not limited to: a physician ordered portable X-ray, a 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	A 508		

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A 508	Continued From page 25	A 508		

residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules.

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

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

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

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

(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

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A 508	Continued From page 26 substance that requires medical attention. (xiv) Any indication of malfunction of the sprinkler system, or fire alarm system. 2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following: (i) Names of all residents involved. (ii) Names of all staff involved including person in charge at the time of the incident. (iii) When the administrator was notified (date and time). (iv) Circumstances under which the incident occurred. (v) When the incident occurred (date and time). (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken. (viii) The extent and description of 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.	A 508		

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A 508	Continued From page 27 (xii) Date and time relatives or sponsor were notified. (xiii) Out-of-facility treatment. (xiv) Follow-up care. (xv) Outcome resolution. (xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future. (xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation. (xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request. (xix) The entire investigative file and documentation of all corrective action taken shall be retained for a period of not less than 3 years after the resident is discharged or dies. (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	A 508		

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A 508	Continued From page 28 death, EMS activation, or the need for medical attention as defined in these rules. (ii) Elopement by a resident. (iii) Suspected, alleged, confessed, or witnessed abuse, neglect, or exploitation of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file. (iv) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (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	A 508		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 508	Continued From page 29 substance that requires medical attention. (ix) Notifiable diseases and health conditions listed in Appendix I of the Alabama Administrative Code Sec. 420-4-1-.04. shall be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1-.04. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than 3 years. (x) Any indication of malfunction of the sprinkler system, or fire alarm system. 4. The report to the Department's Online Incident Reporting System shall include the following: (i) Facility name and direct phone number. (ii) Time and date of the report. (iii) Reporter's name. (iv) Name of resident(s), staff, or visitor(s) involved in the incident. (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).	A 508		

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	D3728	A. BUILDING: _____ B. WING _____	12/01/2022

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A 508	Continued From page 30 (ix) Action taken by the facility in response to the incident. This Rule is not met as evidenced by: Based on record reviews and interviews, facility staff failed to report and investigate an incident to the Department's Online Incident Reporting System (OIRS). THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON SEPTEMBER 25, 2019. Findings: RI#9 was admitted to the facility on August 5, 2022 with diagnoses which included burns to 10 percent of the body and atrial fibrillation. Refer to deficiencies 401, 611, 613 and 621 for additional information on RI#9. The Alabama Department of Public Health received an incident report from the facility on November 9, 2022 which documented the elopement of RI#9 from the facility. During the onsite survey, multiple staff members reported to the surveyor that RI#9 had also eloped from the facility in the weeks prior to the reported elopement. Staff reported RI#9 got lost in the stairwell of the facility and was found knocking on the door of the SCALF unit on the same property. During an interview on December 1, 2022, EI#4 confirmed this previous elopement by RI#9 and stated RI#9 did not know where he/she was at the time of the incident and was knocking on the door asking for help. EI#4 stated she (EI#4) had	A 508		

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A 508	Continued From page 31 not reported this elopement to the Department and had not investigated the incident as required.	A 508		
A 601	420-5-4-.06 (1) Care of Residents. (1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician. (a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her choice. If the resident is unable to designate an attending physician, or does not wish to designate an attending physician, the facility shall assist the resident in identifying an attending physician who will serve the resident. A resident shall be permitted to change the designation of his or her attending physician at any time. Whenever a resident requires medical attention, an attempt shall first be made to contact the resident's attending physician, except in medical emergencies requiring activation of the local EMS system (911 or another emergency call). (b) Back-up Physician Support. Each assisted living facility shall have an agreement with one or more duly licensed physicians to serve in those instances when a resident's own attending physician cannot be reached, and to provide temporary medical attention to any resident whose attending physician is temporarily not available. A nurse practitioner or physician's assistant shall not serve as the back-up physician in an assisted living facility. (c) All physician orders shall be written in accordance with community standards. If verbal orders are used, they are to be used infrequently.	A 601		

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A 601	Continued From page 32 A physician verbal order shall only be accepted by an RN or LPN employed by the facility and authorized to do so by facility policy and procedures and state law. All verbal orders shall be reduced to writing on the physicians' order sheet by a licensed facility nurse and shall be dated and signed by the nurse receiving the order. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, or another practitioner who is responsible for the care of the resident and authorized to write orders by facility policy. All verbal orders must be authenticated within such time period as provided by facility policy, but in no case shall exceed 30 days following entry of the order. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, at least one resident did not have orders for medications and oxygen upon admission to the facility. In addition, at least one resident was not provided the opportunity to receive medical attention from their attending physician when required. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged physician's orders were not provided according to State rules. The surveyor was able to substantiate this complaint during the onsite survey.	A 601		

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A 601	Continued From page 33 RI#5 RI#5 was admitted to the facility on September 24, 2022 with diagnoses which included chronic obstructive pulmonary disease, mixed anxiety and depression, hypothyroidism, osteoporosis and vitamin B12 deficiency. Refer to deficiencies 602 and 618 for additional information on RI#5. RI#5's Medical Health Statement/Plan of Care was dated May 23, 2022 and did not contain medication or oxygen orders for RI#5. The section of the Medical Health Statement titled Current Medications read "See attached". No attachment was present with the Medical Examination record. On December 1, 2022, the surveyor requested (from EI#4) medication and oxygen orders for RI#5 from the time of admission. EI#4 provided to the surveyor a list of medications from the pharmacy, with a "received" date of September 15, 2022. The list did not contain a physician's signature. EI#4 also provided medication orders for RI#5, signed by the nurse practitioner on November 15, 2022, almost two months after RI#5's admission to the facility. A signed physician's order for RI#5 to receive oxygen at 2 liters/minute via nasal cannula was also provided by EI#4. However, the oxygen order was dated April 14, 2021 and was not current. No physician's orders were provided to verify the oxygen and medications RI#5 was to receive at the time of admission to the facility. RI#7 RI#7 was admitted to the facility on June 28, 2019 and had diagnoses which included cerebrovascular accident, vascular dementia, deep vein thrombosis, hypertension, osteoarthritis, insomnia, heart failure, vitamin B12 deficiency and peripheral neuropathy. Refer to	A 601		

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A 601	Continued From page 34 deficiencies 602 and 604 for additional information on RI#7. On July 26, 2022, an order was written by a Certified Registered Nurse Practitioner (CRNP) for RI#7. The order read "...hypercholesterolemia...Atorvastatin 20 milligrams QD (every day)...". The CRNP who wrote the order did not work with RI#7's primary physician. On August 5, 2022, an order was written for RI#7 by a Physician Assistant-Certified (PA-C) which read "...Med changes as per patient request...DC (Discontinue) whatever statin medication (RI#7) is on due to myalgias and increased weakness...". RI#7 had reported to staff that these same side effects occurred when this type medication was taken previously and had refused to take any additional doses of the medication. The PA-C who wrote this order did work with RI#7's primary physician. On December 1, 2022, EI#10, LPN, was asked by the surveyor why the CRNP had written orders for RI#7. EI#10 explained that the nurse who was working on the unit would report resident issues/concerns to the CRNP during rounds and have the CRNP see that resident since the CRNP worked with the Medical Director for the facility. EI#10 acknowledged that the CRNP did not work with RI#7's physician and RI#7's primary physician should have been notified instead.	A 601		
A 602	420-5-4-.06 (2) (a) (b) (c) Care of Residents. (2) Medical Examination Record. (a) Initial Physical Examination. Not more than 30 days prior to admission of any resident to an assisted living facility, the resident or prospective resident shall be examined by a physician. For purposes of the initial physical examination only, a currently licensed physician	A 602		

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A 602	Continued From page 35 in good standing with the Medical Licensure Commission of any state may complete this physical assessment. The physician shall report his or her findings in writing to the facility. In addition to any information otherwise required by the facility's policies and procedures, and in addition to any other information the physician recommends or believes is pertinent, the initial physical examination record shall contain the following: 1. All of the physician's diagnoses, and the resident's baseline weight and vital signs. 2. Medication presently prescribed (name, dosage, and strength of drug, frequency, and route of administration). 3. A statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact. 4. Documentation of evaluation for tuberculosis within the previous 12 months. (b) Annual Physical Examination. In addition to the admission physical examination, 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:	A 602		

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A 602	Continued From page 36 1. The resident's weight and vital signs. 2. Changes in diagnoses. 3. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration). 4. Changes in treatment. (c) Change of Condition Physician Examinations. Changes in the resident's condition that require a physician examination and result in a change in diagnoses, medications, or treatments shall be reported to the facility and documented in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent, or recommended by the resident's treating physician, this physical examination shall contain a listing of the following: 1. New diagnoses. 2. Changes in condition. 3. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration). 4. Changes in treatment. This Rule is not met as evidenced by: Based on record reviews and interview, residents'	A 602		

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A 602	Continued From page 37 Medical Examination Records were incomplete or not present in the residents' facility records. In addition, a resident's Initial Physical Examination was not documented within 30 days prior to admission. Findings: Review of residents' facility records on December 1, 2022 revealed the following information. RI#5 had resided at the facility since September 24, 2022. Refer to deficiencies 601 and 618 for additional information on RI#5. RI#5's Initial Physical Examination was dated May 23, 2022 and did not contain RI#5's baseline respiratory rate. In addition, no medication and oxygen orders were present in RI#5's facility record at the time of admission. When questioned about RI#5's medical examination and orders on December 1, 2022, EI#4 stated RI#5 had been transferred from the independent living unit on the same campus and orders may have been written upon admission to independent living. At the request of the surveyor, medication and oxygen orders for RI#5 were obtained by EI#4; however, the oxygen order contained a date of April 14, 2021 and the medication orders were dated November 15, 2022, almost two months after RI#5's admission to the facility. Refer to deficiency 601 for additional information on RI#5's physicians' orders. RI#6 was admitted to the facility on March 12, 2022 with diagnoses which included atrial fibrillation, coronary disease, cognitive impairment, gastroesophageal reflux disorder, hypertension, insomnia, sleep apnea and transient leg weakness. RI#6's Initial Physican Examination, dated February 9, 2022, did not	A 602		

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A 602	Continued From page 38 contain RI#6's baseline pulse rate. RI#7 had resided at the facility since June 28, 2019. Refer to deficiencies 601 and 604 for additional information on RI#7. No Annual Physical Examination was found in RI#7's facility record for the year 2020. RI#8 was admitted to the facility on August 13, 2018 and had diagnoses which included severe recurrent major depression with psychotic features, dementia, hypertension, hypothyroidism, hyperlipidemia, osteopenia, vertigo, gastroesophageal reflux disorder and vitamin D deficiency. Refer to deficiencies 401, 604, 613 and 621 for additional information on RI#8. No Annual Physical Examination was found in RI#8's facility record for the year 2021. In addition, the Annual Physical Examinations for RI#8, dated October 18, 2022 and October 23, 2020, did not contain RI#8's temperature, pulse rate and respiratory rate. When the above missing items were discussed with EI#4 on December 1, 2022, EI#4 agreed the records were incomplete. EI#4 explained that items may not have been filed in the residents' facility records. EI#4 added that she (EI#4) had only been at the facility a few months and could not account for the missing items prior to that time.	A 602		
A 604	420-5-4-.06 (3) (a) (b) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility shall assess prospective residents for facility eligibility. This	A 604		

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A 604	Continued From page 39 assessment shall document identified care needs and serve as a baseline for future assessments. (b) Monthly Assessments. The facility shall assess each resident monthly and more often when necessary to identify changes in resident's status. In addition to other items that may be required by the facility's own policies and procedures, the monthly assessment shall: 1. Assess the resident's ability to safely self-manage medications or safely self-administer medications with assistance. 2. Accurately weigh and record the weight of each resident. A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half or greater weight loss in a period of three months or less, or a ten percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician. 3. Document identified changes in resident status. 4. Assess the appropriateness of each resident's plan of care. Any decline in resident status requires immediate implementation and documentation of interventions or reassessment of existing interventions.	A 604		

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A 604	Continued From page 40	A 604		

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to provide adequate health supervision of residents.

Findings:

Review of residents' facility records on December 1, 2022 revealed the following information.

RI#1 was admitted to the facility on June 29, 2021 and had diagnoses which included anxiety, dementia, tremors, agitation due to dementia, migraines and chronic cough. Refer to deficiencies 401, 613 and 621 for additional information on RI#1. Medication awareness testing had not been documented for RI#1 since August 6, 2021. On July 14, 2021, RI#1 refused medication awareness testing. No monthly assessments were documented for RI#1 from August 2021 until July 2022.

RI#2 was admitted to the facility on May 23, 2019 and had diagnoses which included hypertensive disorder, Sjogrens syndrome and hypothyroidism. Refer to deficiencies 401, 621 and 1001 for additional information on RI#2. Medication awareness testing had not been documented for RI#2 since August 2021. Monthly assessments were not documented for RI#2 from August 2021 until July 2022.

RI#3 was admitted to the facility on February 15, 2022 and had diagnoses which included gastrointestinal bleeding, urinary tract infection, atrial flutter, hypokalemia, essential hypertension and hyperlipidemia. Refer to deficiencies 401, 611 and 613 for additional information on RI#3. In

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A 604	Continued From page 41 September 2022, RI#3 sustained a documented weight loss of 13.4 percent (146 pounds in August 2022 and 126.4 pounds in September 2022). This significant weight loss was not addressed with any interventions to prevent further weight loss or any notifications to RI#3's physician and sponsor. In fact, RI#3 continued to lose weight and weighed 123 pounds in October 2022. No weight was documented for RI#3 in November 2022 in spite of RI#3's weight loss. EI#10 explained that the difference in the weights for RI#3 was the weight of the wheelchair. EI#10 further explained that weights were not always obtained in the same location and the scales had to be moved from resident to resident. However, RI#3 was not reweighed to determine if the significant weight loss was due to an error in the weight of the wheelchair. RI#4 was admitted to the facility on May 15, 2022 and had diagnoses which included traumatic subdural hematoma, fractured rib, Crohns disease, Parkinson's disease, conduction disorder, essential hypertension, gastroesophageal reflux disorder, hypothyroidism and preglaucoma bilaterally. Refer to deficiencies 401 and 611 for additional information on RI#4. Medication awareness testing was not documented for RI#4. No monthly assessment was documented for RI#4 in June 2022. RI#7 had resided at the facility since June 28, 2019. Refer to deficiencies 601 and 602 for additional information on RI#7. Medication awareness testing had not been documented for RI#7 since August 2021. Monthly assessments were not documented for RI#7 in April 2021, June 2021 and from July 2021 until July 2022. No weights were documented for RI#7 in December 2021, January 2022, June 2022, July 2022 and	A 604		

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A 604	Continued From page 42 October 2022. RI#8 had resided at the facility since August 13, 2018. Refer to deficiencies 401, 602, 613 and 621 for additional information on RI#8. Medication awareness testing had not been documented for RI#8 since August 2021. Monthly assessments were not documented for RI#8 from August 2021 until July 2022. RI#10 was admitted to the facility on November 11, 2021 and had diagnoses which included hypertension, hyperlipidemia, hypothyroidism, chronic kidney disease and dementia. Refer to deficiencies 401, 613 and 621 for additional information on RI#10. Medication awareness testing had not been documented for RI#10. Monthly assessments were not documented for RI#10 from December 2021 until July 2022. RI#11 was admitted to the facility on April 30, 2022 with diagnoses which included heart disease, atrial fibrillation, chronic obstructive pulmonary disease, anemia, hyperlipidemia, hypothyroidism and constipation. Refer to deficiencies 401, 611, 613 and 621 for additional information on RI#11. Medication awareness testing had not been documented for RI#11. Residents were not assessed monthly to identify changes in their status and to develop appropriate interventions to address changes as they occurred. Significant weight loss was not addressed. Residents' ability to correctly identify their medications and protect themselves from medication errors was not assessed. In fact, multiple residents were retained at the facility who were unable to direct their care and were unsafe. (Refer to deficiency 613 for additional information.) EI#4 stated that she (EI#4) began	A 604		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 604	Continued From page 43 doing monthly vital signs and weights when she (EI#4) came to work at the facility but could not account for the resident assessments prior to that time. EI#4 also stated medication awareness testing would have been documented on individual forms that may not have been filed. These forms were not provided to the surveyor when requested.	A 604		
A 611	420-5-4-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall be based on the initial medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be reviewed and updated based on the annual examination, and all other physician examinations, diagnoses, and recommendations of the resident's treating physician, and the resident's monthly assessments. The plan of care shall be developed and updated in cooperation with the resident and, if appropriate, the sponsor. All entries on the plan of care shall be accurately dated. 1. The plan shall at all times reflect the current condition of the resident and document	A 611		

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A 611	Continued From page 44 the personal care and services required from the facility by the resident. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following: 2. A listing of the resident's individual needs or problems that require intervention by the facility. 3. A listing of interventions provided by the facility to address the resident's identified needs or problems. 4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider. 5. Activities of Daily Living. Residents of assisted living facilities shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident. (i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested. (ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips. (iii) Hair. Resident's hair shall be kept clean, neat, and well groomed.	A 611		

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A 611	Continued From page 45 (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be provided assistance with personal safety. 6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, residents' facility care plans were not current and did not contain interventions to meet the care and safety needs of the residents. Findings: Review of residents' facility records on December 1, 2022 revealed the following inadequate care plans. The care plan concerns were discussed with EI#4 on December 1, 2022. EI#4 agreed interventions were not current and sufficient to meet the care and safety needs of the residents. RI#3 RI#3 had resided at the facility since February 15, 2022. Refer to deficiencies 401, 604 and 613 for additional information on RI#3. EI#4 reported to	A 611		

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A 611	Continued From page 46 the surveyor that RI#3 had a diagnosis of macular degeneration and was severely visually impaired and unable to read name on medication packets. RI#3 sustained falls at the facility on the following dates: November 26, 2022; November 22, 2022; November 8, 2022 (2 falls); August 13, 2022; June 11, 2022. RI#3's facility care plan read under Interventions, "...I am at moderate or high risk for falls based on my fall assessment...I am blind...I read Braille...I am independent and manage my continence needs including the ability to change and dispose of incontinence products appropriately...". All interventions on RI#3's facility care plan were dated February 16, 2022, the day after RI#3 was admitted to the facility. On the morning of November 30, 2022, the surveyor observed RI#3 calling for assistance on his/her cell phone, stating he/she had been instructed by staff not to get up alone. RI#3's facility care plan had not been updated after each fall with new interventions to prevent recurrence. In addition, RI#3 had been instructed by staff not to get up alone but the intervention for staff to assist RI#3 at all times when out of bed had not been updated on RI#3's care plan. EI#4 explained to the surveyor that RI#3's falls were caused by visual impairment and Sight Savers had been contacted to assist with visual aides; however, Sight Savers requested an eye exam be done for RI#3 prior to consultation and the eye exam was not scheduled until January 20, 2023. At the request of the surveyor, medication awareness testing was conducted for RI#3 on November 30, 2022. RI#3 was unable to identify medications due to visual impairment and no interventions had been put in place to assist RI#3 with identifying medications and protecting self from medication errors.	A 611		

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A 611	Continued From page 47 RI#4 RI#4 had resided at the facility since May 15, 2022. Refer to deficiencies 401 and 604 for additional information on RI#4. RI#4 sustained falls at the facility on the following dates: November 7, 2022; November 2, 2022; September 12, 2022; June 22, 2022; June 2, 2022; May 18, 2022. RI#4 had an unsteady gait and tremors, used a walker for ambulation outside the room and would hold to walls and furniture for support when ambulating inside their room. RI#4's facility care plan read, "I am at moderate or high risk for falls based on my fall assessment. Date Initiated: 05/16/2022...I require staff monitoring for falls on a daily basis. Date Initiated: 10/11/2022...My caregivers will remind me to use call device for assistance as needed. Date Initiated: 05/16/2022...My caregivers will remind me to use assistive devices...Date Initiated: 05/16/2022...Staff will provide me with a safe environment: clutter free; support/assistive devices are available and in good repair; personal items and call device within reach. Date Initiated: 05/16/2022...I will be encouraged to wear my glasses, and they will ensure that the glasses are clean and in good repair. Date Initiated: 10/11/2022...". RI#4's facility care plan did not included updated interventions after each fall to prevent a recurrence. RI#9 RI#9 had resided at the facility since August 5, 2022. Refer to deficiencies 401, 508, 613 and 621 for additional information on RI#9. RI#9 had one documented elopement from the facility and one reported elopement from the facility since admission. RI#9 was unable to successfully	A 611		

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A 611	Continued From page 48	A 611		

complete medication awareness testing on November 30, 2022 and to protect self from a medication error. RI#9's facility care plan read as follows under Interventions: "...I wander inside the community but do not leave the building. I can be easily redirected. I may be confused at times and may be a potential for unintended exit. Date Initiated: 08/09/2022. My caregivers will observe my location in the community...". There were no specific interventions and activity program documented to address RI#9's wandering behaviors and elopements and to prevent a recurrence.

RI#11

RI#11 had resided at the facility since April 30, 2022. Refer to deficiencies 401, 604, 613 and 621 for additional information on RI#11. RI#11 sustained falls at the facility on November 21 and 22, 2022. RI#11 was noted during the onsite survey to be pleasantly confused and unable to direct care. RI#11 required assistance of one or two people with repositioning in wheelchair, toileting, dressing, bathing, transfers and mobility. On November 29, 2022, RI#11 was found sitting alone in the wheelchair in his/her room, sliding down in the chair. RI#11 did not assist with repositioning in the wheelchair and had to be manually pulled up to a sitting position. EI#10 reported this had occurred before with RI#11 and was a concern for falls due to RI#11 potentially sliding out of wheelchair while unattended. RI#11's facility care plan, dated May 5, 2022, read as follows, "...I am at moderate or high risk for falls based on my fall assessment...I am able to ambulate independently...I am independent with transfers...I am independent in grooming myself...I am independent with dressing...I require no assistance in an evacuation other than

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A 611	Continued From page 49 prompting instructions...I am independent and manage my continence needs including the ability to change and dispose of incontinence products appropriately...". Both EI#4 and EI#10 reported RI#11 had declined recently. RI#11's facility care plan had not been updated to reflect the decline in RI#11's condition and increased need for assistance with activities of daily living to ensure RI#11 was safe.	A 611		
A 613	420-5-4-.06 (5) (a) (b) (c) (d) (e) Care of Residents. (5) Medications. (a) Medications as defined in these rules, may be administered to a resident of an assisted living facility only after the drugs have been prescribed specifically for the resident by an individual currently licensed to prescribe medications in Alabama. A currently licensed physician in good standing with the Medical Licensure Commission of any state may prescribe medications to a resident of an assisted living facility only during the initial physical examination. (b) A physician order is required for a resident to manage and have custody of his or her own medications. (c) A resident may have custody of and manage over the counter topical medications with the written approval of a physician. A physician order is not required for over the counter topical medications that are self-administered by residents and approved by the physician for resident possession.	A 613		

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A 613	Continued From page 50 (d) Nothing in these rules shall preclude a facility from using a licensed nurse employed by the facility or nursing agency to administer medication to any resident. An RN or LPN shall administer medications to residents in the assisted living facility only in accordance with physician orders and the Nurse Practice Act. (e) A resident who is incapable of recognizing his or her name, or understanding the facility unit dose medication system, or does not have the ability to protect himself or herself from a medication error shall require medication administration. Medication administration shall be provided only by a physician or by an RN or LPN. If the resident cannot understand or be trained to understand the unit dose medication system used by the facility or cannot protect himself or herself from medication errors by facility staff, the resident will be appropriately discharged. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, residents of the facility were unable to understand and utilize the unit dose medication system and unable to protect themselves from medication errors. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged residents of the facility did not meet the criteria for ALF residents. The surveyor was able to substantiate this complaint during the onsite survey.	A 613		

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A 613	Continued From page 51 During interviews on November 29 and 30, 2022, all staff interviewed reported that multiple residents of the facility were confused and frequently had to be redirected. At the request of the surveyor, medication awareness testing was conducted for the following residents by EI#4 on November 30, 2022. The residents were provided with a medication packet containing their own name and one with a different name. The residents were then asked to identify if either medication was theirs and if they would take the medication that was not theirs. Following the medication awareness testing, EI#4 agreed with the surveyor that these residents were unable to properly utilize the unit dose system and protect themselves from medication errors. EI#4 also stated medication awareness testing may not have been done for all residents monthly as required to determine if the residents were able to protect themselves. It was noted by the surveyor that licensed staff were currently administering medications to residents of the facility. RI#1 RI#1 had resided at the facility since June 29, 2021. Refer to deficiencies 401, 604 and 621 for additional information on RI#1. RI#1 ambulated about the facility independently, was frequently noted to be confused and would become agitated at times. When presented with the two medication packets, RI#1 was able to identify his/her own name but was unsure if he/she should take the medication that was not their own. RI#1 seemed confused by the process and became agitated due to the questions. RI#3 RI#3 had resided at the facility since February 15,	A 613		

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A 613	Continued From page 52 2022. Refer to deficiencies 401, 604 and 611 for additional information on RI#3. EI#4 reported RI#3 had a diagnosis of macular degeneration and was severely visually impaired. RI#3's facility care plan documented RI#3 was blind. When presented with two medication packets, RI#3 stated he/she was unable to see the printed name on the packets to identify his/her own medications. Although RI#3 had resided at the facility for more than nine months, no system had been put in place for RI#3 to identify his/her medications and protect self from medication errors. RI#8 RI#8 had resided at the facility since August 13, 2018. Refer to deficiencies 401, 602, 604 and 621 for additional information on RI#8. When presented with two packets of medication, RI#8 was able to identify names on the packets. EI#4 had to repeatedly ask RI#8 "Would you take this medicine even though your name is not on it?" to coach RI#8 into saying he/she would not take the medications without his/her name. RI#8 was focused on a pink pill in the packet which RI#8 stated he/she did not want to take. RI#9 RI#9 had resided at the facility since August 5, 2022. Refer to deficiencies 401, 508, 611 and 621 for additional information on RI#9. RI#9 had eloped from the facility two times since admission. When presented with two medication packets, RI#9 was able to identify his/her name and knew that he/she used a patch (blood pressure). RI#9 seemed cautious of the medication system and EI#4 had to repeatedly ask RI#9 about the packet without RI#9's name.	A 613		

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A 613	Continued From page 53 RI#9 eventually said he/she would not take any medications. EI#4 reported RI#9 had a history of refusing medications which resulted in the patch for blood pressure placed on RI#9's back to prevent RI#9 from removing the patch. RI#10 RI#10 had resided at the facility since November 11, 2021. Refer to deficiencies 401, 604 and 621 for additional information on RI#10. RI#10 was observed frequently wandering about the facility and ambulated independently. RI#10 was confused and would often ask where his/her room was. When presented with two medication packets, RI#10 appeared confused by the process but was able to identify his/her name. RI#10 was unsure if he/she should take the medications that did not contain his/her name. RI#11 RI#11 had resided at the facility since April 30, 2022. Refer to deficiencies 401, 604, 611 and 621 for additional information on RI#11. RI#11 was noted to be confused during the onsite survey. When presented with two medication packets, RI#11 was unable to identify his/her own packet. All six of these residents were at increased risk of a medication error by staff due to their inability to protect themselves and were currently unsafe in the assisted living facility.	A 613		
A 617	420-5-4-.06 (8) Care of Residents. (8) Disposal of Medications. 1. Controlled substances and legend	A 617		

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A 617	Continued From page 54 drugs dispensed to residents, that are expired or unused because the medication is discontinued or because the resident dies, shall be destroyed within 30 days. Unused legend drugs that are not expired may be donated to a charitable clinic pursuant to Alabama Administrative Code, Chapter 420-11-11. Under no circumstances should expired, discontinued, or unused medications be stored or housed in the facility beyond 30 days. 2. Medications of residents who are discharged or transferred to another facility shall be returned to the residents. The responsible party will sign a statement that these medications have been received. The statement shall list the pharmacy, prescription number, date, resident's name and strength of the medication, and the amount. This statement shall be maintained in a file for at least three years. 3. When medications are destroyed on the premises of the assisted living facility, a record shall be made and retained for at least 3 years. This record shall include: the name of the assisted living facility, the method of disposal, the pharmacy, the prescription number, the name of the resident, the name, strength, and dosage of the medication, and the amount and the reason for the disposal. This record shall be signed and dated by the individual performing the destruction and by at least one witness. This Rule is not met as evidenced by: Based on record review and interview, documentation of medication disposition, following the death of a resident, was incomplete.	A 617		

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A 617	Continued From page 55 Findings: RI#12 was admitted to the facility on April 29, 2019 and had diagnoses which included pancreatic cancer, congestive heart failure, chronic obstructive pulmonary disease, atrial fibrillation and neuropathy. RI#12 passed away at the facility on October 21, 2022. A Medication Disposition Form, dated November 1, 2022, documented destruction of RI#12's medications. However, the form did not include the facility name and the method of destruction. EI#4 agreed the form was incomplete.	A 617		
A 618	420-5-4-.06 (9) Care of Residents. (9) Oxygen Therapy. (a) A resident of an assisted living facility that requires oxygen therapy shall self-manage his or her own oxygen therapy or self-administer his or her own oxygen therapy with assistance of facility staff. A resident that cannot safely self-manage or self-administer his or her own oxygen therapy with assistance shall have oxygen administered only by a physician, RN, or LPN. A resident that cannot direct his or her administration of oxygen and cannot be taught to direct his or her administration of oxygen shall be appropriately discharged. (b) Oxygen use including date, time, rate, and proper function of the equipment shall be documented on the medication administration or medication assistance record at least once per shift unless oxygen therapy is self-managed by the resident.	A 618		

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A 618	Continued From page 56 (c) If a resident receives oxygen therapy in a facility: 1. All oxygen equipment, such as tubing, masks, and nasal cannula shall be maintained in a safe and sanitary condition. 2. All oxygen tanks shall be safely maintained and stored. 3. The facility shall require safe use of oxygen therapy. No smoking and appropriate precautionary signs shall be posted. 4. The facility shall ensure that each resident using oxygen therapy maintains an adequate supply of oxygen. Refer to National Fire Protection Association (NFPA) 99 for oxygen storage requirements. This Rule is not met as evidenced by: Based on observation, interviews and record review, a resident's oxygen use was not documented on the medication assistance record (MAR) as required. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON SEPTEMBER 25, 2019. Findings: RI#5 had resided at the facility since September 24, 2022. Refer to deficiencies 601 and 602 for additional information on RI#5. During the onsite survey RI#5 was observed using oxygen per nasal cannula at 2 liters/minute. RI#5 was physically unable to manage oxygen therapy	A 618		

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MORNINGSIDE OF VESTAVIA HILLS	2435 COLUMBIANA ROAD BIRMINGHAM, AL 35216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 618	Continued From page 57 independently and required the assistance of facility staff to maintain the oxygen. On the morning of November 30, 2022, EI#10, LPN, was observed assisting RI#5 with care of oxygen. RI#5's oxygen use was not documented on RI#5's MAR to include date, time, rate and proper function of the equipment at least once per shift. EI#10 stated RI#5's oxygen use was not documented on the MAR even though staff assisted with the oxygen.	A 618		
A 621	420-5-4-.06 (11) (b) Care of Residents. (b) Retention 1. An assisted living facility shall not allow any resident to return to the assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the facility is licensed to provide or the facility is capable of providing. 2. An assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility. 3. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in an assisted living facility. 4. An assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless: (i) The individual is capable of performing and does perform all tasks related to	A 621		

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A 621	Continued From page 58 his or her own care; OR (ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity BUT the individual has sufficient cognitive ability to direct his or her own care AND the individual is able to direct others and does direct others to provide the physical assistance needed to complete such tasks, AND the facility staff is capable of providing such assistance and does provide such assistance. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. 5. If a resident of an assisted living facility is diagnosed with a terminal illness other than dementia and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90 days. If the facility is unable or becomes unable to meet the needs of a resident receiving hospice care, or if a resident receiving hospice care requires care beyond what the facility may lawfully provide pursuant to this section, then the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for assisted living facilities. The facility would in all cases remain responsible for ensuring the appropriate delivery of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident.	A 621		

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A 621	Continued From page 59 6. All skilled services provided in the facility, such as but not limited to wound care or insertion of a urinary catheter, shall be provided by the staff of properly licensed or certified agencies. Skilled services shall not be delegated to facility staff. 7. Residents that develop acute infectious pulmonary disease, such as active tuberculosis, or other diseases capable of transmission to other individuals through normal person-to-person contact shall be immediately transferred to an appropriate level of care until certified by a physician to be free of a contagious condition. 8. No assisted living facility shall be operated in whole or in part in a manner that prevents free and unhindered egress from the facility by any of its residents. 9. An assisted living facility shall not retain any resident who cannot safely reside in the facility unless his or her egress from the facility is restricted. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility retained residents who were unsafe in an assisted living facility, were unable to direct their care and whose behaviors placed them at risk of harm. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings:	A 621		

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A 621	Continued From page 60 The Alabama Department of Public Health received a complaint which alleged residents at the facility did not meet the criteria for residents of an ALF. The surveyor was able to substantiate the complaint during the onsite survey. Residents were retained at the facility who were unable to direct their care, were unsafe or were unable to protect themselves from a medication error by facility staff. Refer to deficiency 613 for additional information on these residents. RI#1 RI#1 had resided at the facility since June 29, 2021. Refer to deficiencies 401, 604 and 613 for additional information on RI#1. RI#1 was observed during the survey wandering about the facility and frequently confused as well as agitated at times. A Short Portable Mental Status Questionnaire (SPMSQ) was documented for RI#1 on July 30, 2021. RI#1 answered all 10 questions incorrectly and had a score which indicated "Severe Intellectual Impairment". A Daily Nursing Note, dated August 3, 2021, documented RI#1 became combative and scratched staff when staff attempted to collect his/her dirty laundry after assisting RI#1 with a shower. RI#1's facility care plan read as follows, "...I request the staff to administer my medications to me...I have memory loss. Date Initiated: 07/29/2021...I have cognitive impairment. Date Initiated: 07/29/2021...I am moderately confused and may have some unpredictable behaviors or require moderate emotional support. Date Initiated: 07/29/2021...". RI#1 was unable to pass medication awareness testing on November 30, 2022. RI#2	A 621		

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A 621	Continued From page 61 RI#2 had resided at the facility since May 23, 2019. Refer to deficiencies 401, 604 and 1001 for additional information on RI#2. RI#2 ambulated with a walker. During the onsite survey, a strong urine odor was noted in RI#2's room and in the hallway leading to RI#2's room. Multiple staff reported to the surveyor that RI#2 was incontinent of urine and would not allow staff to change bed linens, launder soiled clothing and linens or properly clean RI#2's room. Staff would try to clean as possible when RI#2 was out of the room. In addition, staff reported RI#2 refused to allow staff to assist RI#2 with bathing. The facility was unable to meet RI#2's care needs due to RI#2's refusal of care. These behaviors placed RI#2 at risk of skin breakdown or infections and created an unpleasant environment for other residents as well as for visitors at the facility. RI#8 RI#8 had resided at the facility since August 13, 2018. Refer to deficiencies 401, 602, 604 and 613 for additional information on RI#8. RI#8 ambulated independently but was unsteady. Staff reported RI#8 was frequently confused. A visit note for RI#8, from behavioral health staff, on October 10, 2022 documented under Mental Status Exam, "...Associations impaired. Insight impaired. Judgement impaired. Orientation Oriented to: Person. Attention/Concentration Alert/Impaired. Recent and remote memory grossly impaired. Fund of Knowledge Moderately impaired...". On November 30, 2022, RI#8 was unable to pass medication awareness testing and protect self from medication errors. EI#4 reported pills had been found under a flowerpot in RI#8's room which she (EI#4) believed were pills that RI#8 had not taken when provided to him/her, although RI#8's Medical Health Statement/Plan of	A 621		

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A 621	Continued From page 62 Care, dated October 18, 2022, read "...Ability to manage medications...Administer by Licensed Nurse...". RI#8's facility care plan read as follows, "...I request the staff to administer my medications to me. Date Initiated: 01/21/2020...I have cognitive impairment. Date Initiated: 10/09/2020...I have mild confusion but am generally cooperative. I may be disoriented to some spheres at times. Date Initiated: 10/09/2020...". RI#8 was unsafe and at risk of medication error due to confusion and noncompliance with medications. RI#9 RI#9 had resided at the facility since August 5, 2022 and had eloped from the facility at least two times since admission. Refer to deficiencies 401, 508, 611 and 613 for additional information on RI#9. RI#9 was unable to pass medication awareness testing on November 30, 2022. RI#9's Medical Health Statement/Plan of Care, dated August 1, 2022, read "...Ability to manage medication: Administer by Licensed Nurse...". RI#9's facility care plan read as follows, "...I may be confused at times and may be a potential for unintended exit. Date Initiated: 08/09/2022...I have memory loss. Date Initiated: 08/09/2022...I have cognitive impairment. Date Initiated: 08/09/2022...I have mild confusion but am generally cooperative. I may be disoriented to some spheres at times...". A Physician Communication Sheet for RI#9, dated November 9, 2022, read "...Resident noted to be confused found wandering outside of the facility this morning, (RI#9) did not notify staff (RI#9) was leaving the building...Send out to E.R. for evaluation for confusion and wandering...". An Incident Report Form for RI#9, dated November 9, 2022, read, "...Resident was found wandering	A 621		

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A 621	Continued From page 63	A 621		

outside of the building this morning by an employee that was pulling into the parking lot...Resident uncooperative for vital signs assessment...". Two staff members reported to the surveyor that RI#9 had previously eloped from the facility and became lost and disoriented in the stairwell. The resident was found knocking on the door of the specialty care assisted living facility. RI#9 was at high risk of further elopement and was currently unsafe in ALF unit.

RI#10

RI#10 had resided at the facility since November 11, 2021. Refer to deficiencies 401, 604 and 613 for additional information on RI#10. RI#10 was noted during the onsite survey to be frequently disoriented, requiring redirection from staff to locate room or attend appropriate daily activities. RI#10's Medical Health Statement/Plan of Care, dated October 18, 2022, read "...Ability to manage medications: Administer by Licensed Nurse...". RI#10 was unable to pass medication awareness testing on November 30, 2022. RI#10's facility care plan read as follows, "...I have memory loss. Date Initiated: 11/18/2021...I have cognitive impairment. Date Initiated: 11/18/2021...I am moderately confused and may have some unpredictable behaviors or require moderate emotional support, Date Initiated: 11/18/2021...". RI#10 was unsafe in the ALF unit and was at risk of medication error due to inability to direct his/her own care.

RI#11

RI#11 had resided at the facility since April 30, 2022. Refer to deficiencies 401, 604, 611 and 613 for additional information on RI#11. RI#11 had recently declined and sustained two falls at the

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A 621	Continued From page 64 facility in November 2022. RI#11 required assistance with transfers and ambulation and would slide down if left in a wheelchair alone. RI#11's Medical Health Statement/Plan of Care, dated April 27, 2022, read "...Ability to manage medications: Administer by Licensed Nurse...". RI#11's facility care plan read as follows, "...I have memory loss. Date Initiated: 05/05/2022...I have cognitive impairment. Date Initiated: 05/05/2022...I have mild confusion but am generally cooperative. I may be disoriented to some spheres at times. Date Initiated: 05/05/2022...". RI#11 was unable to pass medication awareness testing on November 30, 2022 and was unsafe in the ALF unit. These residents were currently unsafe in the assisted living facility due to altered mental status/confusion, inability to direct their care including medications or behaviors which were not managed. The facility was not staffed to manage wandering behaviors and to prevent elopements. Medication awareness testing had not been provided monthly to properly assess the residents and to determine their ability to safely reside in the facility. At the time the surveyor entered the facility, on November 29, 2022, EI#4 reported no 30-day discharge notices had been issued to any residents of the facility. On December 1, 2022, EI#4 reported a 30-day discharge notice had been issued to RI#11. The discharge notice was not provided to the surveyor. Nurses were scheduled to administer medications to all residents. A plan of action was obtained for increased staffing and for management of RI#9's wandering behaviors.	A 621		
A 702	420-5-4-.07 (2) Food Service	A 702		

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A 702	Continued From page 65 (2) Food Handling Procedures. (a) Dish and Utensils Washing, Disinfection, and Storage. 1. Wash water shall be changed with sufficient frequency to avoid gross contamination, and final rinse water shall be kept clean and clear. 2. Hand washed repeated service and multi-service utensils and dishes, after washing and rinsing, shall be sanitized by either of the following methods: (i) Utensils and dishes shall be completely immersed for a period of not less than 30 seconds in water that is at least 171 degrees Fahrenheit (pouring scalding water over utensils and dishes does not meet this requirement); or (ii) A cold water sanitizer. A sanitizing solution shall be used in accordance with manufacturer's instructions. Utensils and dishes shall be completely immersed for a period of not less than 10 seconds in a clean solution containing not less than 50 ppm, and not more than 200 ppm, of available chlorine bleach, or 30 seconds in 12.5 ppm of iodine or the amount of time set by the manufacturer in a 200 ppm quaternary ammonium solution. Water temperature must be at least 75 degrees Fahrenheit. Water temperatures and chemical concentrations shall be monitored and documented prior to dishwashing. A record of each test shall be maintained for at least three months. 3. Dishes and utensils shall be allowed	A 702		

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A 702	Continued From page 66 to air dry. 4. After washing, rinsing, sanitizing, and air-drying, all repeated use service ware (utensils and dishes) shall be stored in a clean, dry place that is protected from pests, dust, splash, and other contaminants. Utensils shall be handled in such a way as to prevent contamination from hands and clothing. 5. The results from the use of dishwashing machines shall be equivalent to those obtained from the method outlined above, as documented in material provided from the manufacturer and kept on file at the facility. (b) Ice. Crushed or chipped ice shall be protected from splash, drip, and hand contamination during storage and service. The ice scoop may be stored in the ice bin in a manner to prevent ice from coming into contact with the handle, or it may be stored in an airtight container outside the ice bin. (c) Protection of Food from Contamination. 1. Food and food ingredients shall be stored, handled, and served so as to be protected from pests, dust, rodents, droplet infection, unsanitary handling, overhead leakage, sewage back flow, and any other contamination. Sugar, syrup, and condiment receptacles shall be provided with lids and shall be kept covered when not in use. 2. Medications, biologicals, poisons, detergents, and cleaning supplies shall not be kept in the refrigerator or in other areas used for	A 702		

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A 702	Continued From page 67 storage of food. 3. Food shall not be stored on the floor. All food and food ingredients stored on shelving must be placed on shelving that is at least six inches above the floor. 4. Refrigerators shall maintain a maximum temperature of 41 degrees Fahrenheit. Freezers shall be maintained at a maximum temperature of 0 degrees Fahrenheit. Thermometers shall remain in refrigerators and freezers at all times. 5. All leftover foods shall be labeled and dated with a "use by date", so that it may be consumed or discarded by that date, which is no more than 3 days from the date it was prepared. 6. All food products shall be used by the manufacturer's indicated date or discarded. 7. Food shall be prepared either in the licensed facility or another location even when that location is not part of the licensed facility. All food preparation areas used by the facility shall be subject to the same inspections as though part of the licensed facility. The licensed facility is responsible to ensure adequate equipment and measures are used to ensure that food is not contaminated in transport and that foods that are transported are held and served at the appropriate temperatures at all times. 8. Hot food shall be maintained at a minimum of 135 degrees Fahrenheit and cold foods at a maximum 41 degrees Fahrenheit. 9. Frozen food items (raw and cooked)	A 702		

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A 702	Continued From page 68	A 702		

shall be thawed under refrigeration or under running water prior to preparation. Frozen food may also be thawed as part of the cooking process when indicated by package directions. Raw meats shall be stored below and away from vegetables, fruits, and other foods to prevent contamination (meat juices dripping on other foods).

10. Laundry shall not be brought through the food preparation or service area.

(d) Storage and Service of Milk and Ice Cream.

1. Milk and fluid milk products shall be served only from the original containers in which they were received from the distributor. This shall not apply to cream for coffee, cereals, and milk for milk drinks which may be dispensed from a readily cleanable container approved for such use.

2. Milk and fluid milk products shall be stored in such a manner that bottles or containers, from which the milk or milk product is to be poured or drunk, will not become contaminated from drip or contact with foods. Milk shall be maintained and stored at a maximum temperature of 41 degrees Fahrenheit and shall not be served at a temperature warmer than 45 degrees Fahrenheit unless specifically requested to be served at a warmer temperature by a resident.

3. Contaminating substances shall not be stored with or over open containers of ice cream. Ice cream dippers, spatulas, and other serving utensils shall be cleaned between uses.

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A 702	Continued From page 69 (e) Kitchen Garbage and Trash Handling. 1. Kitchen garbage and trash shall be placed in suitable containers with tight-fitting lids and properly stored pending removal. Kitchen garbage and trash shall not be allowed to accumulate in the kitchen and shall be removed from the premises at frequent intervals. 2. After being emptied, all garbage cans and trash cans shall be washed and dried before reuse. (f) Employees' Cleanliness. 1. Employees engaged in the handling, preparation, and serving of food shall wear clean clothing at all times. Employees shall wear hair restraints, for example, hairnets, headbands, caps, or other adequate means to prevent contamination of food from hair. Employees whose duties include contact with residents shall change clothing or wear a clean covering over clothing before handling, preparing, or serving food. 2. Employees handling food shall wash their hands thoroughly before starting work each day, immediately after contact with any soiled matter, and before returning to work after each visit to the rest room. 3. Street clothing not worn by the employee shall be stored in lockers, dressing rooms, or closets designated for staff use. (g) Live Fowl or Animals. Live fowl or	A 702		

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A 702	Continued From page 70 animals shall not be allowed in the food service area. (h) Smoking and Spitting. Smoking, other use of tobacco products, and spitting within the food service area shall be prohibited for all staff, residents, and visitors. (i) Dining in Kitchen. Dining in the kitchen shall not be permitted in congregate assisted living facilities. (j) Paper for Food Wrapping. Only new paper, foil, or plastic wrap shall be used for wrapping of foods. (k) Laundering of clothing shall not be permitted in food preparation or service areas. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to follow proper food handling procedures. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged food was not being handled properly to prevent contamination. The surveyor was able to substantiate this complaint during the onsite survey. During the breakfast meal and again during the noon meal on November 30, 2022, the surveyor observed EI#14, Resident Assistant, serving food to residents. EI#14 was not wearing a clean	A 702		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 702	Continued From page 71 covering over her (EI#14's) clothing. EI#14 was observed that same morning providing care to residents. EI#4 stated staff had not been provided with aprons to wear when serving food. During a tour of the kitchen on the afternoon of November 30, 2022, the surveyor observed scoops inside the flour, sugar and corn meal canisters. The scoops were partially covered by the food ingredients causing a risk of contamination when the scoops were used. EI#6, Dietary Manager, stated the scoops would be removed.	A 702		
A 703	420-5-4-.07 (3) Food Service. (3) Dietary Service. (a) Number of Meals. No fewer than three meals shall be provided each 24 hours. Food service shall be provided in a resident's room during temporary illness if necessary. The diet shall be well-balanced, palatable, properly prepared, and sufficient in quantity and quality to meet the nutritional needs of the residents in accordance with Dietary Reference Intakes of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The food must be adapted in type and preparation to the habits, preferences, and physical abilities of the residents. (b) Timing of Meals. A time schedule for serving meals to residents and personnel shall be established. Meals shall be served approximately five hours apart with no more than 14 hours between the evening meal and breakfast. The time schedule of meals shall be posted with the menu. The facility shall make evening snacks	A 703		

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A 703	Continued From page 72 available after service of the evening meal. The facility shall provide fluids throughout the day and shall make between-meal nourishment (snacks) available. (c) Menu. The menu shall be planned and written at least 1 week in advance. The current week's menu shall be posted in the food service area and shall be kept on file for the following 2 weeks. For any resident with a physician's order for a therapeutic diet, the facility shall have a copy of the diet and the facility shall document the adjustment of its menu to accommodate the resident's needs. (d) Alternate food selections or substitutes shall be made available to all residents. (e) A facility shall not obtain food from charitable organizations. A facility shall not avoid serving a meal by sending or transporting residents to missions, soup kitchens, or other charitable facilities for meals. (f) The amount of food on hand shall be sufficient to serve three meals per day to all residents for 3 days. Non-perishable food and potable water shall be maintained in the facility in sufficient quantity to serve three meals per day to all residents for 3 days. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to post menus as required and failed to maintain an adequate supply of potable water.	A 703		

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A 703	Continued From page 73 Findings: During a tour of the kitchen on November 30, 2022, no weekly menu was posted in the food service area. A daily menu was posted. EI#6 acknowledged the weekly menu had not been posted as required. Also, during the kitchen tour on November 30, 2022 with EI#6, the surveyor asked to see the facility's supply of potable water. EI#6 showed the surveyor approximately 20 twelve-ounce bottles of water in the kitchen and stated there had been more water but it had been used. The potable water on hand at the facility was inadequate to supply all residents of the facility for three days.	A 703		
A1001	420-5-4-.10 (1) Sanitation and Housekeeping. (1) Sanitation. (a) Water Supply. 1. If at all possible, all water shall be obtained from a public water supply. If it is impossible to connect to a public water system, the private water supply shall meet the approval of the local County Health Department. 2. Water under pressure of not less than 15 pounds per square inch shall be piped within the building to all sinks, toilets, lavatories, tubs, showers, and other fixtures requiring water. Tubs, showers, sinks, lavatories, and other fixtures used by residents shall have hot water supplied. Hot water accessible to residents shall in no case exceed 110 degrees Fahrenheit. (b) Disposal of Liquid and Human	A1001		

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A1001	Continued From page 74 Wastes. 1. There shall be installed within the building a properly designed waste disposal system, connecting to all fixtures to which water under pressure is piped. 2. All liquid and human waste, including floor wash water and liquid waste from refrigerators, shall be disposed through trapped drains into a public sewer in localities where such system is available. 3. In localities where a public sanitary sewer is not available, liquid and human waste shall be disposed through trapped drains into a sewage disposal system approved by the local County Health Department. The sewage disposal system shall be of a size and capacity based on the number of residents and personnel housed and employed in the institution. Where the sewage disposal system is installed at an existing facility prior to granting of a license, it shall be inspected and approved by the local County Health Department. (c) Premises. The premises shall be kept neat and clean. The property shall be free of rubbish, weeds, ponded water, or other conditions that may create a health, safety, or sanitation hazard. (d) Control of Insects, Rodents and Other Pests. Each facility shall be kept free of ants, flies, roaches, rodents, and other pests. Proper and lawful methods for their eradication or control shall be used. Droppings shall be evidence of infestation by pests.	A1001		

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A1001	Continued From page 75 (e) Toilet Room Cleanliness. Floors, walls, ceilings, and fixtures of all toilet rooms shall be kept clean and free of objectionable odors. These rooms shall be kept free of an accumulation of rubbish, cleaning supplies, and toiletry articles. The use of a common towel and common bar soap is prohibited. (f) Garbage Disposal. 1. Garbage must be kept in water-tight suitable containers with tight-fitting covers. Garbage containers must be emptied at frequent intervals and shall be thoroughly cleaned and aired before using again. 2. Garbage and waste shall be disposed of in accordance with local and state regulations. (g) Control of odors. The facility shall be free of objectionable odors. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain proper water temperatures and failed to keep the facility free of objectionable odors. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint of foul odors in the facility. The surveyor was able to substantiate this	A1001		

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A1001	Continued From page 76 complaint during the onsite survey. Multiple times during the onsite survey, a strong urine odor was noted in RI#2's room as well as in the hallway leading to RI#2's room. Staff reported to the surveyor that RI#2 frequently refused to let them (staff) assist with bathing and laundry and was incontinent of urine. Refer to deficiency 621 for additional information on RI#2. On the morning of November 29, 2022, the surveyor checked a water temperature in the facility's Beauty Salon. The temperature was 118 degrees Fahrenheit, well above the allowed safe temperature of 110 degrees Fahrenheit. The water temperature was adjusted by maintenance and rechecked by the surveyor that afternoon with a result of 110 degrees Fahrenheit.	A1001		
A1101	420-5-4-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift of Group and Congregate facilities. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior	A1101		

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A1101	Continued From page 77 as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the currently adopted Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs. (d) Roller latches are prohibited on doors separating corridors from adjacent spaces. (e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that: 1. Minimizes leaks and spills. 2. Adequately protects against inappropriate access. 3. Complies with the requirements of the currently adopted Life Safety Code. (f) Fire Alarm and Sprinkler System. 1. Fire Alarm System. Where fire alarm systems are required, a corridor smoke detection system shall be installed on each floor, including areas open to the exit access corridor, to comply with NFPA 72, connected to the facility's fire	A1101		

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A1101	Continued From page 78 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 observations, record reviews and interviews, the facility failed to perform fire drills as required. In addition, sprinkler and fire alarm inspections were not documented semi-annually as required. Findings: On the afternoon of November 29, 2022, the surveyor reviewed the facility's fire drill reports	A1101		

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A1101	Continued From page 79 and fire alarm and sprinkler inspection reports for 2021 and 2022. No fire drills were documented during the following months of 2021 and 2022: October 2021, November 2021, December 2021, June 2022, August 2022, September 2022. In addition, fire drills were not documented quarterly for the following quarters in 2021 and 2022: fourth quarter 2021, second quarter 2022, third quarter 2022. Sprinkler inspections were documented on August 20, 2021 and on August 31, 2022 (one year apart) with only one documented for each year in 2021 and 2022. Fire alarm inspections were documented on March 4, 2021 and on January 19, 2022 (ten months apart) with the most recent fire alarm inspection being documented over ten months ago. EI#2 and EI#4 reported the facility did not currently have a maintenance director and some of the fire drills and inspections may have been missed.	A1101		
A1203	420-5-4-.12 (5) Physical Environment. (5) General Building Requirements - Family, Group, and Congregate. (a) Structural Soundness and Repair. The building shall be structurally sound, free from leaks and excessive moisture, in good repair, and painted with sufficient frequency to be reasonably attractive inside and out. The interior and exterior of the building shall be kept clean and orderly. (b) Temperature to be Maintained. The facility shall maintain a comfortable temperature. A comfortable range is between 71-81 degrees Fahrenheit.	A1203		

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A1203	Continued From page 80 (c) Lighting. Each resident's room shall have artificial light adequate for reading and other uses as needed. All entrances, hallways, stairways, inclines, ramps, cellars, attics, storerooms, kitchens, laundries, and service units shall have sufficient artificial lighting to prevent accidents and promote efficiency of service. Night lights shall be provided in all hallways, stairways, and bathrooms. (d) Screens. All screen doors and operable windows shall be equipped with tight-fitting, full-length insect screens. Screen doors shall be equipped with self-closing devices. (e) Emergency Lighting. 1. All assisted living facilities shall provide emergency artificial lighting to adequately illuminate halls, corridors, kitchens, dining areas, and stairwells in case of electrical power failure. As a minimum, dry cell battery-operated lighting shall be provided to light such spaces. 2. Emergency lighting must provide illumination in accordance with the currently adopted Life Safety Code for at least 90 minutes. (f) Floors. 1. All floors shall be level, smooth and free of cracks, and finished so as to be easily kept clean. The basic requirement for floor finishes shall be wall-to-wall with such finishes as paint, stain, sealer, carpet, sheet vinyl, vinyl tile, hard tile, or other appropriate floor finish. 2. Any differences in floor levels shall	A1203		

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A1203	Continued From page 81	A1203		

not prevent a resident from navigating safely throughout the facility.

(g) Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface and shall be kept clean and in good repair.

(h) Windows. Operable windows shall be so constructed and maintained so that they fit snugly, and are capable of being opened and closed easily.

(i) Ceiling Height. Each room occupied by residents shall have a ceiling height of eight feet or more. Existing facilities with ceiling heights less than eight feet shall be acceptable when the height complies with the codes.

(j) Handrails. If handrails are installed in halls or corridors, the handrails shall be mounted at 30-36 inches above the floor and returned to the wall at each end.

(k) Stairways. Stairways shall be well lighted, kept in good repair, and have handrails. Open space under stairs shall not be used for storage purpose. All walls and doors under stairs shall meet the same fire rating as the stairwell.

(l) Doors.

1. In each new assisted living facility, doors of resident bathrooms connected to resident bedrooms shall swing into the bedroom.

2. Bedroom and bathroom doors may be equipped with hardware that will permit a resident to lock himself within the room, provided

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A1203	Continued From page 82	A1203		

a master key is readily accessible for the staff at a central location.

3. Resident bedroom and other exit access doors in each assisted living facility shall be at least three feet wide. Bedroom doors in Family assisted living facilities shall not be less than 32 inches wide.

4. Exterior egress doors except the main entry/exit door, may be equipped with a delayed egress locking system installed in accordance with NFPA 101. Other special locking arrangements are permitted only in specialty care assisted living facilities.

5. Exit doors swinging outward shall swing out over a landing having a minimum length and width equal to the door's width at the same level as the floor level, except existing doors shall not have more than a four inch step down. Exit doors of Family facilities may swing inward.

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

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

1. Each fire extinguisher shall receive

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A1203	Continued From page 83 an annual inspection with maintenance, and recharging when necessary, by a fire equipment servicing representative. An annual servicing tag shall be attached to the extinguisher reflecting the name of the servicing company, representative, day, month, and year of maintenance. 2. A visual inspection of each fire extinguisher shall be conducted monthly by designated staff of the facility and documented on the attached extinguisher tag by the designated staff person. (o) Call System. Except in Family facilities, a central electric or electronic call system shall be conveniently provided for each resident, usable in bedrooms and bathrooms. The call system shall be certified to meet the applicable Underwriters Laboratories standard. (p) Manufactured homes/mobile homes are not permitted. (q) Fireplaces and inserts, shall be inspected and cleaned annually, and shall comply with the currently adopted building code. Openings shall be protected with screens, or doors. (r) Exit marking. In Group and Congregate facilities, a sign bearing the word "EXIT" in plain legible block letters shall be placed at each exit. Additional signs shall be placed in corridors and passageways wherever necessary to indicate the direction of exit. Letters of signs shall be at least four inches high. All exit and directional signs shall be kept clearly legible by continuous internal electric illumination and have battery back-up or emergency power.	A1203		

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A1203	Continued From page 84 (s) Heating, Lighting, and other Service Equipment. 1. Central or individual room gas heating systems shall be of the enclosed flame type equipped with automatic flame shut-off control and shall be vented directly to the outside. Heating units of any type shall be located to avoid direct contact with any combustible material and shall be maintained in accordance with manufacturer's recommendation. 2. Open flame and portable heaters are prohibited in assisted living facilities. This does not apply to a fire place with gas logs protected as noted elsewhere in these rules. 3. Lighting shall be restricted to electricity. Electric wiring, motors, and other electrical equipment in all assisted living facilities shall be in accordance with local electrical codes and the NFPA National Electrical Code. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to maintain a functional call system and failed to perform monthly visual inspections of fire extinguishers as required. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: During a tour of the facility on the morning of November 29, 2022, the surveyor observed the fire extinguisher servicing tags. Multiple tags	A1203		

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MORNINGSIDE OF VESTAVIA HILLS	2435 COLUMBIANA ROAD BIRMINGHAM, AL 35216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1203	Continued From page 85 contained a date of September 22, 2022 as the last date for a monthly visual inspection. EI#4 agreed the fire extinguishers had not been inspected properly. The Alabama Department of Public Health received a complaint which alleged residents' call lights were not being answered properly by staff. The surveyor was able to substantiate the complaint and identified a deficient practice affecting the facility call system during the onsite survey. On the morning of November 29, 2022 the surveyor entered the facility around 7:00 AM. No staff members were available in the front lobby area of the facility and no one was noted to be on duty at the front desk until around 7:30 AM that morning. Around noon on November 29, 2022, the surveyor interviewed EI#4 and EI#20, Receptionist, regarding the facility's call system. EI#4 explained that the residents carry pendants which are used to activate the call system when assistance is needed. The calls do not sound but are received as a message on the computer at the front desk. Someone is assigned to work the desk at all times and must check the computer to receive the calls. The person who receives the call is responsible to notify the RA to check on the resident. The surveyor pointed out that no one was available at the front desk for at least 30 minutes this morning, causing a lapse in the effectiveness of the call system and potentially placing residents at risk of harm if no one is available to assist them when needed. Also, refer to deficiency 401 for additional information on failure of the facility to answer RI#3's call light. EI#2 acknowledged the fault with the call system and immediately put a new system in place to ensure residents calls were received.	A1203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D3728	A. BUILDING: _____ B. WING _____	12/01/2022

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A1203	Continued From page 86 CONNIE CHERRY, REGISTERED NURSE	A1203		