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SEAGRASS VILLAGE OF GULF SHORES	21298 COTTON CREEK DRIVE GULF SHORES, AL 36547

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments On June 23, 2022, an unannounced licensure survey was conducted for this 60 bed Assisted Living Facility with a census of 36. There was one complaint investigated during this survey. LC#220210427005 was substantiated with deficiencies cited as a result of the complaint investigation. 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 resulted in harm to at least four (4) residents and placed the remaining 32 residents at significant risk for harm.	A 000		
A 301	420-5-4-.03 (1) (a) (b) (c) (d) Administration. The Assisted Living Facility Governing Authority. (a) An assisted living facility shall have an identified sole proprietorship, corporation, partnership, limited partnership, or other business entity that is its governing authority, or it shall have a designated individual or group of designated individuals who serve as its governing authority. A facility must give complete information to the Department identifying: 1. Each person who has an ownership interest of 10 percent or more of the governing authority. 2. Each person or entity who has an ownership interest of 10 percent or more in the real property or building used by the assisted	A 301		

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A 301	Continued From page 1 living facility to offer its services. 3. Each officer and each director of the corporation if the governing authority is a corporation. 4. Each partner, including any limited partners, if the governing authority is a partnership. (b) The governing authority shall submit any changes to the information listed above to the Department within 15 days of the change. (c) Responsibility of Staff to Governing Authority. The administrator, medical staff, facility personnel, and all auxiliary organizations shall be directly or indirectly responsible to the governing authority. For the purposes of these rules, auxiliary organizations include but are not limited to licensed or certified outside providers, consultants, management companies that are not the facility license holder. (d) The governing authority is responsible for appointing and supervising the administrator who is responsible for overall management and the day-to-day operation of the facility. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the governing authority failed to ensure the facility operated in compliance with the State Board of Health (SBOH) rules for assisted living facilities (ALF). The administrator failed to	A 301		

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A 301	Continued From page 2	A 301		

adequately perform her duties as administrator to ensure the facility was managed responsibly. This failure resulted in the retention of residents whose level of care exceeded the facility's capabilities, poorly trained staff, the inability to meet residents' care and safety needs, the lack of health supervision, poorly developed resident care plans that were not current and did not address resident problem areas with appropriate care actions, and failure to maintain a safe environment from accidents and fire. These widespread failures resulted in actual harm for at least four residents (RI#1, RI#4, RI#5 and RI#6) and placed the remaining 32 residents at risk for significant harm due to the administrator's failure to apply the rules for the day to day operations of the facility.

Findings:

On June 23, 2022, a surveyor with the Alabama Department of Public Health (ADPH) conducted a licensure survey and complaint investigation at the facility. The survey was conducted based on a complaint received by the Alabama Department of Public Health regarding resident care issues. Once on site, the surveyor confirmed the facility had resident care and safety issues. The surveyor observed the administrator's failure to provide staff with effective plans of care and residents with adequate health observation resulting in harm to at least four (4) residents and a potentially unsafe environment for the remaining 32 residents. The surveyor requested an immediate plan of action to address these care and safety issues.

The following deficiencies were identified as a result of the governing authority's lack of oversight and the administrator's failure to apply the SBOH rules for the day to day operations of

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A 301	Continued From page 3 the facility. 302 - Facility policies for controlled medications and incident reporting and documentation did not meet the SBOH rules for ALFs. 405 - Employees were unable to demonstrate adequate training in multiple areas as required by the SBOH rules. 503 - Resident records were incomplete and were not kept current. 504 - The resident's right for confidentiality of medical records and a safe environment were not honored. 508 - Resident incidents with injury were not investigated or reported as required. 602 - Initial physician medical examinations were incomplete. 604 - Residents were not accurately assessed for changes in health status and personal care needs. 611 - Resident care plans did not address changes in health status and personal care needs. 613 - Residents were retained in the facility who were unable to protect themselves from medication errors. 616 - Resident medications kept in the custody of the facility were not unit dose packaged and/or properly labeled by a pharmacy. 617 - Expired medications and the medications of	A 301		

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A 301	Continued From page 4 discharged residents were not destroyed within 30 days. 621 - Residents with cognitive impairment were retained in the facility. 702 - Cleaning chemicals were stored on the same shelf as condiments. 703 - There was an inadequate supply of non-perishable foods available for all residents for at least three days. 1001 - The facility premises had areas of ponded water. 1002 - Flammable chemicals were stored in the laundry room. 1101 - Fire drill documents did not contain all of the required information. 1206 - Fire doors were propped open with rubber wedges.	A 301		
A 302	420-5-4-.03 (1) (e) Administration. Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). All residents shall be informed of new policies or changes in existing policies that may	A 302		

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A 302	Continued From page 5 have bearing on the residents. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies shall cover the following: (i) Facility responsibility to protect all residents from abuse, neglect, and exploitation. (ii) How allegations of abuse, neglect, and exploitation will be handled by the facility. (iii) Resident confidentiality. (iv) Admission and continued stay criteria. (v) Discharge criteria and notification procedures for residents and sponsors. (vi) Facility responsibility when a resident's personal belongings are lost. (vii) What services the facility is capable and not capable of providing. (viii) Medication management. (ix) Infection control. (x) Meal service, timing, menus and food preparation, storage, and handling. (xi) Fire safety and emergency plan, fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness. (xii) Staffing and conduct of staff while on duty.	A 302		

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A 302	Continued From page 6 (xiii) Oxygen administration and storage if used in the facility. (xiv) Dietary Policies. The dietitian, with the approval of the administrator, shall develop written policies and procedures for the guidance of all personnel handling food as outlined by the most current Food and Drug Administration Food Code published by the U.S. Department of Health and Human Services. The facility shall develop and implement dietary policies and procedures to meet the needs of the residents in the facility. In addition to other matters deemed necessary by the facility, dietary policies shall address: (I) Sanitation of dishes, utensils, and service equipment, and sanitary food preparation and handling. (II) The attire and cleanliness of staff members who prepare, handle, or serve food. (III) A schedule of meals, which shall include between-meal nourishment or snacks, and fluids. (IV) Food substitutions or alternatives. (V) Method to ensure an adequate dietary plan is implemented for any resident with a therapeutic diet or special dietary needs. (VI) Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food. (VII) Provision of necessary services to any resident requiring adaptive devices to eat.	A 302		

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A 302	Continued From page 7 (VIII) Procedure for the handling of potentially hazardous foods such as meat, milk, ice, and eggs. (IX) Storage of food. (X) Procedure for food service in the event of a disaster. Disaster menus shall be developed. The policy shall address how food will be obtained and maintained at safe temperatures if electricity is not available. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to have an appropriate policy and procedure for controlled medication management that was in accordance with the SBOH rules and regulations for ALF. This deficient practice had the potential to affect all 36 residents. Findings: On June 21, 2022, the facility's policy for controlled medications was reviewed with EI#10. The facility's policy documented that discontinued controlled medications could be given to the resident's sponsor. The rules require that all discontinued controlled medications be destroyed within 30 days. The only time controlled medications can be given to a resident's sponsor is if the resident is being discharged home or transferred to another facility. EI#10 agreed the policy was not in accordance with SBOH rules for ALFs. The facility's policy and procedure for resident incidents documented that the First Responder	A 302		

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A 302	Continued From page 8 Form would be destroyed after it was completed. EI#10 told the surveyor the First Responder Form was just a worksheet and was destroyed after the information was put into the computer incident report. The First Responder Form included most of the details that were expected by ADPH for the investigation of an incident along with key details for the incident report. The surveyor identified at least one resident incident with injury which did not have an investigation in the computer. EI#2 could not provide an investigation for RI#5's fall with head injury that was treated at the local emergency room on March 31, 2022.	A 302		
A 303	420-5-4-.03 (2) (a) Administration. The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an administrator shall meet all applicable statutory requirements. 4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences.	A 303		

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A 303	Continued From page 9 5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age. 6. The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character. 7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week. 8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment and adequate care being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement. 9. The facility administrator is responsible for ensuring that required training is provided to all staff. 10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting. 11. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when	A 303		

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A 303	Continued From page 10 needed. 12. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan. 13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained. This Rule is not met as evidenced by: Based on observation, record review, and interview, the administrator failed to ensure that the facility was operated in accordance with the SBOH rules and regulations for ALF. These widespread deficient practices resulted in actual harm for at least four residents (RI#1, RI#4, RI#5 and RI#6) and placed the remaining 32 residents at risk for significant harm. Findings: The administrator did not ensure adequate care and safety needs for all residents were not met as evidenced by deficiencies #302, #405, #602, #604, #611, #613, #616, #617, #702, #703, #1001, #1002, #1101, and #1206. The administrator did not ensure all employees were able to demonstrate adequate training in the areas of handwashing, medication management, admission, discharge, and continued stay criteria, SBOH rules and regulations for ALF, fire safety, resident safety, and the special needs of the elderly. Please see deficiencies #302, #405, #503, #504, #507, #508, #602, #604, #611, #613,	A 303		

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A 303	Continued From page 11 #616, #617, #621, #702, #703, #1001, #1002, #1101, and #1206. The administrator did not ensure residents who required a higher level of care were discharged as evidenced by deficiencies #613 and #621. The administrator did not ensure residents' care/service plans were current and appropriate as evidenced by deficiency #611.	A 303		
A 405	420-5-4-.04 (6) Personnel. (6) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained in the facility. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on assisted living facilities. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire.	A 405		

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

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A 405	Continued From page 13	A 405		

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 observation, record review, and interview, the facility staff failed to demonstrate adequate training in the areas of state law and rules for assisted living facilities, facility policies and procedures, infection control, protecting resident confidentiality, fire safety, special needs of the elderly, incident investigation and reporting, resident safety, accurate resident assessments including identification of symptoms of dementia and depression. This deficient practice resulted in actual harm for at least four residents (RI#1, RI#4, RI#5 and RI#6) and placed the remaining 32 residents at risk for significant harm.

Findings:

On June 14, 15, 16, 21, 22, and 23, 2022, the surveyor identified that facility employees did not demonstrate adequate training in the following areas.

HANDWASHING/ INFECTION CONTROL - On June 15, 2022, between approximately 12:00 PM

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A 405	Continued From page 14 and 12:10 PM, the surveyor observed the cook wearing a cloth mask under their chin, with her mouth and nose uncovered, while plating resident food. The cook was observed to adjust her glasses several times and continue to plate food without washing her hands. The employees who were delivering plates to each dining room wore ill-fitting surgical type masks and repeatedly readjusted the ill- fitting masks by pulling on the front of the masks with their bare hands or gloved hands. There was no handwashing or glove changes observed after the employees adjusted their face masks, the employees continued to handle and serve plates of food to the residents in the dining rooms. On June 15, 2022, between approximately 3:20 PM and 3:30 PM, the surveyor observed that EI#11 did not wash or sanitize his hands before or after preparing and administering medications to RI#5, RI#9, and RI#15. EI#11 touched the medication cart keys, medication cart drawers, resident and medication room door handles, medication packets, water glasses, resident room faucet handles and the electronic medication administration record tablet, without ever washing or sanitizing his (EI#11) hands. FIRE SAFETY - During all the days of the survey, the surveyor observed the fire doors were propped open with rubber wedges. The fire doors were located in the two hour fire wall which separated the assisted living facility and the independent living facility. On June 15, 2022, at approximately 10:35 AM, the surveyor observed how difficult it was for EI#4 to try to forcibly close the fire doors with the rubber wedges in place. After several attempts, EI#4 was unable to kick the rubber wedges out from under the fire doors. The NFPA (Nation Fire Protection Association)	A 405		

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SEAGRASS VILLAGE OF GULF SHORES	21298 COTTON CREEK DRIVE GULF SHORES, AL 36547

(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 15 Life Safety Code 101 only allows the use of magnetic holding devices that release upon activation of the fire alarm, to be utilized for the purpose of holding fire doors open in a healthcare facility occupancy. On June 15, 2022, between approximately 10:35 AM and 11:00 AM, during the fire drill demonstration only two caregivers and a nurse were allowed to participate which was equivalent to the facility's usual staffing pattern on the night shift. EI#5 was observed to follow EI#7 from room to room evacuating residents together, instead of splitting up and working independently to quickly evacuate all 36 residents from the two story facility in a more timely manner. The surveyor observed that EI#5 and EI#7 did not place an item outside of each room to show which rooms had been evacuated. The surveyor was told by EI#2 that the facility had door hangers somewhere for the employees to put on the doors when the rooms were evacuated, but the door hangers could not be found at the time of the fire drill. EI#2 told the surveyor the facility had not developed a resident assistance list that identified which residents required more assistance with evacuation during an emergency. PLEASE NOTE: There were at least three residents (RI#6, RI#13, and RI#16) who lived on on the second floor who required wheelchairs for mobility and could not safely evacuate the facility utilizing the stairs. On June 15, 2022, The surveyor observed that RI#6 had not participated in the fire drill. RI#6 told the surveyor one reason RI#6 had not participated was because he/she had trouble ambulating long distances and did not have access to a wheelchair at the time of the fire drill.	A 405		

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A 405	Continued From page 16 RI#6 had been living in the facility since May 05, 2022, on the second floor without access to a wheelchair for evacuation from the facility in an emergency. RI#6 told the surveyor that he/she had severe pain and very limited mobility which prohibited RI#6 from walking long distances. On June 14, 2022, the surveyor and RI#1 observed eight (8) 17 ounce aerosol cans of flammable chemicals that were stored in a closet next to the dryers in the laundry room. The cans contained stainless steel cleaner. MEDICATION AWARENESS - On June 21, 2022, the surveyor and EI#2 reviewed the medication awareness assessments for June 2022, completed by EI#2 for RI#1, RI#2, RI#5, and RI#10. RI#2's self medication assessment dated June 10, 2022, documented that RI#2 was "fully capable" to self administer eye drops, ear drops, and a nasal spray. EI#2 told the surveyor RI#2 had not been able to demonstrate RI#2's ability to use those various types of medications because RI#2 did not have those types of medications. EI#2 told the surveyor RI#2's self medication assessment did not document if RI#2 was "fully capable" of managing RI#2's daily sliding scale insulin orders, the renal diet order, or if RI#2 could properly manage daily blood glucose monitoring. The June 2022 medication awareness assessments for RI#1, RI#5, and RI#10, documented each resident was determined to be "fully capable" to safely assist with their medications by community staff, which included unlicensed medication technicians.	A 405		

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On June 21, 2022, between approximately 4:00 PM and 4:37 PM, the surveyor and EI#2 tested RI#1, RI#5, and RI#10 for medication awareness. RI#1 and RI#5, were assessed to require medication administration by a nurse until the residents could be discharged to a higher level of care, due to cognitive impairment. RI#10 could not remember if RI#10 had received any medications that day, when in fact RI#10 had received medications at least once that day. Therefore, RI#10 could not protect himself/herself from medication errors.

ADMISSION, DISCHARGE, AND CONTINUED STAY POLICIES AND PROCEDURES

RI#1 - RI#1 was admitted to the facility on July 13, 2021, with diagnoses which included dementia. EI#7 told the surveyor RI#1 was described as "confused" and unable to find RI#1's apartment or common areas without assistance due to cognitive impairment. EI#2 told the surveyor RI#1's sponsor was going to take RI#1 out of the facility on June 30, 2022. However, the facility failed to identify RI#1's ineligible status and issue a 30 day discharge notice for RI#1 prior to the survey.

RI#2 was admitted to the facility on May 04, 2022. RI#2 was not eligible for admission to the facility due to the presence of a PermaCath dialysis catheter which protruded from the skin. RI#2 was not issued a 30 day discharge notice prior to the survey.

RI#5 was admitted to the facility on July 13, 2021, with unknown diagnoses. RI#5's record contained a physician progress note dated February 16, 2022, which documented RI#5 had diagnoses which included dementia. RI#5's physician

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described RI#5 as "... has significant mobility restrictions and dementia which make it difficult to travel to and from office visits... memory loss... cognitive impairments present...". The surveyor observed multiple written reminders hanging on the walls of RI#5's room reminding RI#5 to call for help. RI#5 was observed on each day of the survey sitting in the common sitting area all day long, watching the same television channel. The surveyor was told the family had requested RI#5 not be left alone in RI#5's room due to repeated falls. RI#5 did not have a 30 day discharge notice issued due to cognitive impairment prior to the survey.

RI#8 was readmitted to the facility on approximately June 10, 2022, following hospitalization and surgical repair for a left hip fracture on May 20, 2022. RI#8 was discharged from the hospital to a local rehabilitation facility before returning to the facility. RI#8's record included progress notes from the rehabilitation facility which documented RI#8 had diagnoses which also included dementia and diabetes. The therapy notes dated June 09, 2022, documented RI#8 had "decline" noted in "safe judgement, cognition, endurance, fine motor control, and upper extremity strength.". RI#8 was described as "disoriented to situation, decreased safety awareness, decreased awareness of deficits, decreased short term memory, assistance required to identify errors made, follows one step commands with increased time, impulsive and forgets that (RI#8) needs help when up with (rolling walker)...". RI#8 did not have a 30 day discharge notice issued prior to the survey.

RI#10 was readmitted to the facility on June 09, 2022, after hospitalization with surgical treatment for normal pressure hydrocephalus and

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subsequent rehabilitation stay. RI#10's physician medical examination documented RI#10 required assistance with all activities of daily living, medications, had swallowing difficulties, required initiation with meals, and cues for safety with transferring. On May 31, 2022, RI#10's physician determined RI#10 was not competent due to "poor short term memory, poor long term memory, and consistent disorientation to situation.".
On June 21, 2022, RI#10 was unable to tell the surveyor if RI#10 had received any medications that day, when in fact RI#10 had taken medications that same morning.

INCIDENT INVESTIGATION AND REPORTING -
The facility's policy and procedure documented that the First Responder form would be destroyed after it was completed. EI#10 told the surveyor the First Responder form was just a worksheet and was destroyed after the information was put into the computer incident report. The First Responder form included most of the components expected for an investigation into incidents along with key details for the incident report. EI#2 could not provide an investigation for RI#5's fall with head injury which occurred on March 31, 2022.

The facility had not reported any incidents or positive Covid diagnoses to ADPH between October 27, 2021 and June 13, 2022. The surveyor identified at least one positive Covid diagnosis for RI#1 occurred in February 2022, and at least three resident incidents with injuries, including head injuries and a fractured hip, had occurred at the facility which had not been reported to ADPH. Please refer to deficiency #508 for additional details.

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A 405	Continued From page 20 RESIDENT SAFETY- On June 14, 2022, the surveyor observed RI#5 was pushed to the dining room by EI#13, Agency Cargiver, while RI#5 sat on the wheeled walker. RI#5's wheeled walker was clearly labeled, "Warning: Do Not Move Rollator While Seated". On June 22, 2022, EI#2, LPN, told the surveyor that residents without wheelchairs could be evacuated during an emergency while sitting on the wheeled walker and being pushed. SPECIAL NEEDS OF THE ELDERLY - Signs of depression and possible risk for self harm were not accurately identified by EI#2. On June 16, 2022, RI#6 attempted suicide by overdosing on medications. EI#2 told the surveyor RI#6 was always "upbeat and positive." On June 21, 2022, at approximately 4:00 PM, RI#10 told the surveyor and EI#2 "I wouldn't care if I died... my life is sh*t since they did that surgery...". On June 21, 2022 at approximately 4:20 PM, RI#11 exhibited signs of depression and complained, "I'm feeling lost... my memory is bad... ." RI#11 voiced concerns about his/her sponsor and EI#2 "laughing at (RI#11) being old and can't remember or do things...". The surveyor offered reassurance to RI#11 that the sponsor and EI#2 were not laughing at RI#11 and RI#11's current limitations. EI#2 told the surveyor, "RI#11 is always like that."	A 405		
A 503	420-5-4-.05 (3) (a) (b) (c) Records and Reports. (3) Resident Records.	A 503		

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A 503	Continued From page 21 (a) Records shall be current from the time of admission to the time of discharge or death and shall be retained in the facility for at least three years after a resident's death or discharge. (b) When an individual is admitted to an assisted living facility, records and information regarding the resident shall be protected from unauthorized disclosure. Employees and authorized agents of the Department shall be permitted to review all medical records and all other records to determine compliance with these rules. With the written consent of the resident, or with the written consent of the legal guardian of an incompetent resident, the local ombudsman shall be permitted access to all records regarding the resident. Records necessary to assess a resident's medical condition or to otherwise render good medical care shall be provided to the resident's treating physician or physicians or to the resident or to his or her legally authorized representative. A resident or his or her legal guardian may grant permission to any other individual to review the resident's confidential records by signing a standard release. (c) In addition to all records required for the provision of resident care, for each resident, the assisted living facility shall maintain on its premises the required documents listed below and any other documents required by the facility's policies and procedures: 1. Statement of resident rights signed by the resident. 2. Financial agreement.	A 503		

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A 503	Continued From page 22 3. Inventory of personal effects. 4. Admission record. 5. Incident investigations and reports involving the resident. In addition to the above documents, the facility shall also maintain on its premises any Advance Directive or Portable Physician Do Not Attempt Resuscitation (DNAR) Order that has been executed by the resident. NOTE: Under no circumstances shall the facility require or refuse to allow a resident to execute an Advance Directive or Portable Physician DNAR Order. Advance Directives shall be typewritten or legibly written in ink and may include the appointment of a health care proxy consistent with the specific language in the Natural Death Act (Code of Alabama 22-8A-1 et. seq). A Portable Physician DNAR Order shall follow the rule and form found in the Alabama Administrative Code 420-5-19 Appendix II. These records shall be protected from unauthorized disclosure. This Rule is not met as evidenced by: Based on record review and interview, the closed record for RI#12 was incomplete. Findings: On June 22, 2022, the closed record for RI#12 was reviewed with EI#1, EI#2, and EI#10. RI#12 was admitted to the facility on May 13, 2021. RI#12 was diagnosed with prostate cancer on approximately May 19, 2021, and died on July 23, 2021.	A 503		

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A 503	Continued From page 23 RI#12's closed record did not contain a listing of which records were electronic and which records were paper documents. RI#12's closed record did not contain a medication disposition form. RI#12's closed record did not have a care plan for the hospice services which RI#12 had started on May 19, 2021. RI#12's care plan did not document a decline in RI#12's condition. RI#12's hospice records were received via email on June 16, 2022, after the surveyor suggested that EI#2 contact the hospice agency and request RI#12's records.	A 503		
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.	A 504		

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A 504	Continued From page 24 3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy. 4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time. 5. Every resident shall have freedom to participate in and benefit from social, religious, and community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. 6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the premises, an individual account record for each resident shall be maintained by the administrator and an up-to-date record shall be maintained for all transactions. 7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so. 8. Every resident shall have the right to a reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals.	A 504		

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A 504	Continued From page 25 9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident. 10. Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to receive or reject medical care, dental care, or other health care services except those required to control communicable diseases. 11. Every resident shall have the right to at least 30 days prior written notice of involuntary relocation or termination of residence from the facility unless the resident is a patient in a facility providing a higher level of care and no longer meets the eligibility and continued stay requirements in these rules, or for medical reasons the resident is considered by a physician to require an emergency relocation to a facility providing a more skilled level of care, or unless the resident engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record. 12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person without restraint, interference, coercion, discrimination, or reprisal. 13. Every resident shall have the right to	A 504		

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

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

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

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

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A 504	Continued From page 27 admission, of all rules and regulations governing residents' conduct and responsibilities. 17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll-free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll-free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area. 18. All state inspection reports and any resulting corrective action plan from the past 24 months shall be posted in a prominent location. If there has been no inspection in the past 24 months, then the results of the most recent inspection and any resulting corrective action plan shall be posted. 19. Every resident shall have the right to 30 days prior written notice to both resident and sponsor of any increase of fees or charges. 20. Every resident shall have the right to 30 days prior written notice of any involuntary change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. 21. Every resident shall have the right to wear his or her own clothes, to keep and use his or her own personal possessions including toilet articles except for personal possessions too large	A 504		

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A 504	Continued From page 28 to be stored in the resident's room. 22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings. 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours and to freely come and go from the home. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all resident medical records were kept confidential. The facility also failed to provide a safe environment for all residents. This deficient practice resulted in actual harm for at least four residents (RI#1, RI#4, RI#5 and RI#6) and placed the remaining 32 residents at significant risk for harm. Findings: On June 14, 2022, the surveyor with EI#1 observed the medication cart and controlled medication log sitting unsupervised in the hallway. The controlled medication log book was left unsecured on top of the medication cart and was accessible to anyone who passed by. The controlled medication log contained medication	A 504		

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A 504	Continued From page 29	A 504		

records for RI#8, RI#9, RI#11, RI#15, RI#17, and RI#18. EI#1 agreed the controlled medication log should be locked in the medication cart when it was not being used.

RI#1 was admitted to the facility on July 13, 2021, with diagnoses which included dementia. RI#1 suffered a significant weight loss of 10.8 pounds or 6.3% of RI#1's total body weight (from 168.8 pounds to 158 pounds) in just 30 days between April 2022 and May 2022. EI#2 agreed there had been no physician notification for RI#1's significant weight loss and no care plan developed to address RI#1's significant weight loss.

RI#4 was admitted to the facility in August 2021 from a local Specialty Care Assisted Living Facility (SCALF). RI#4's record documented a physician progress note dated March 10, 2022, which documented RI#4 as "staying up all night sleeps during the day...memory loss ...cognitive impairments present... recent and remote memory with mild deficits... senile degeneration of the brain...".

RI#4's record documented RI#4 suffered harm from a significant weight loss of 19.2 pounds or 11% of RI#4's total body weight (from 174 pounds to 154.8 pounds) in just 30 days between May 2022 and June 2022. EI#2 verified the facility had not notified RI#4's physician of the significant weight loss. RI#4's significant weight loss had not been addressed on RI#4's care/service plan and there were no care actions documented to prevent further weight loss.

RI#5 was admitted to the facility on July 13, 2021 with unknown diagnoses. RI#5 had a physician's progress note dated February 16, 2022, which

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A 504	Continued From page 30 described RI#5 as having significant mobility restrictions and dementia. RI#5's record documented RI#5 had "poor cognition for personal safety" and had suffered harm by fracturing RI#5's left hip during two different falls while living in the facility. RI#5 fractured his/her left hip during falls documented in October 2021 and May 2022. RI#5's record also documented RI#5 suffered harm from a significant weight loss of 27.6 pounds or 20% of RI#5's total body weight (from 136.2 pounds to 108.6 pounds) in just 30 days between February 2022 and March 2022. EI#2 verified there had been no physician notification of RI#5's significant weight loss and no updates to the care/service plan to address RI#5's significant weight loss. On June 14, 2022, EI#2 told the surveyor the facility had made an agreement with RI#5's family to have RI#5 sit in the common area of the facility instead of sitting alone in RI#5's room for safety purposes. RI#5 was observed by the surveyor to sit in the common living room throughout each day of the survey when RI#5 wasn't in the dining room for meals. RI#5 was placed in a soft chair and was frequently observed to be asleep in the chair in the common living room. RI#5's most current care/service plan dated May 2022, did not document any fall interventions or the agreement with RI#5's family. On June 21, 2022, at approximately 4:37 PM, the surveyor and EI#2 tested RI#5 for medication awareness. RI#5, was assessed to require medication administration by a nurse until RI#5 could be discharged to a higher level of care due to cognitive impairment.	A 504		

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A 504	Continued From page 31 RI#6 was admitted to the facility on May 05, 2022. RI#6 had diagnoses which included embolytic stroke, rheumatoid arthritis, and diverticulosis. On June 15, 2022, the surveyor observed RI#6 had severely limited mobility due to severe joint pain and deformities. RI#6 told the surveyor he/she was unable to ambulate long distances and did not currently have a wheelchair available for long distances. RI#6 also told the surveyor that over the past few days, he/she had eaten several food items he/she (RI#6) shouldn't have and now he/she was suffering from multiple episodes of diarrhea. RI#6's most current care/service plan dated June 2022, did not have interventions to address any of these personal care and safety needs. RI#6 suffered harm as the result of attempted suicide by medication overdose on June 16, 2022. RI#6 spent several days in a hospital intensive care unit and recovered from the attempted suicide.	A 504		
A 507	420-5-4-.05 (3) (g) Records and Reports. (g) Admission Record. A permanent record shall be developed for each resident upon his or her admission to the facility and updated as necessary to remain current. This record shall be typewritten or legibly written in ink. In addition to any information otherwise required by the facility's policies and procedures, it shall include the resident's: 1. Name. 2. Date of birth. 3. Sex. 4. Marital status.	A 507		

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A 507	Continued From page 32 5. Social security number. 6. Veteran status. 7. Name, address, and contact information of the resident's sponsor, responsible party, or closest living relative. 8. Name, address, and contact information of any person or agency providing assistance to the resident. 9. Name, address, and contact information of the resident's attending physician. 10. Preferred pharmacy or pharmacist. 11. Date of admission. 12. Date of discharge. 13. Facility, setting, or location to which discharged. 14. Date of death. 15. Cause of death, if known. 16. Religious preferences. 17. Information from insurance policies regarding funeral arrangements and burial provisions. 18. Written documentation that the facility has devised a plan to transfer the resident to a hospital, nursing home, specialty care assisted living facility, or other appropriate setting	A 507		

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A 507	Continued From page 33 if and when the facility becomes unable to meet the resident's needs. The resident's preference, if any, with respect to any particular hospital, nursing home, or specialty care assisted living facility shall be recorded. The facility shall keep written documentation that demonstrates the transfer plan has been thoroughly explained to the resident or sponsor, as appropriate, and that the resident or sponsor understands the transfer plan. 19. The written documentation of the procedure to follow in case of serious illness, accident, or death to the resident (including the name and telephone number of the physician to be called, the names and telephone numbers and addresses of family members or sponsor to be contacted, the resident's or, if appropriate, the sponsor's wishes with respect to disposition of personal effects, and the name and telephone number of the funeral home to be contacted). This Rule is not met as evidenced by: Based on record review and interview, the facility failed to accurately document resident admission and discharge dates. This deficient practice had the potential to affect all 36 residents living in the facility. Findings: On June 22, 2022, the surveyor reviewed the following resident records with EI#1, EI#2, and EI#10. RI#1's record documented RI#1 was admitted to the facility on May 20, 2021, with a pureed diet	A 507		

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A 507	Continued From page 34 and thickened liquids. However after further review, it was determined that RI#1 was actually admitted to the independent living facility on May 20, 2021 and wasn't admitted to the Assisted Living Facility (ALF) until July 13, 2021. EI#1, EI#2, and EI#10 agreed RI#1's record did not accurately reflect RI#1's actual admission to the ALF. RI#1's records from the independent living facility had been mixed with RI#1's ALF records. RI#12's closed record did not contain documentation of RI#12's discharge date or the date of RI#12's death. EI#2 told the surveyor RI#12 passed away with hospice services. RI#12's hospice record documented RI#12 died on July 23, 2021.	A 507		
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	A 508		

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A 508	Continued From page 35 treatment was sought. (ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid, including but not limited to: a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office. (iii) The onset of wandering behavior by any resident who is not fully cognitively intact. (iv) Elopement by a resident. (v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. (vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules. (vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules. (viii) An outbreak (for purposes of these rules, an outbreak is considered to be two 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).	A 508		

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A 508	Continued From page 36 (ix) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (xi) An unplanned occurrence that results in media attention. (xii) A medication error, overdose, or over sedation. (xiii) Ingestion by a resident of a toxic substance that requires medical attention. (xiv) Any indication of malfunction of the sprinkler system, or fire alarm system. 2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following: (i) Names of all residents involved. (ii) Names of all staff involved including person in charge at the time of the incident. (iii) When the administrator was notified (date and time). (iv) Circumstances under which the incident occurred. (v) When the incident occurred (date and time).	A 508		

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A 508	Continued From page 37 (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken. (viii) The extent and description of injury, if any, to the affected resident or residents. (ix) Immediate treatment rendered. (x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified. (xi) Names, telephone numbers, and addresses of witnesses. (xii) Date and time relatives or sponsor were notified. (xiii) Out-of-facility treatment. (xiv) Follow-up care. (xv) Outcome resolution. (xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future. (xvii) The investigative file includes the 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	A 508		

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A 508	Continued From page 38	A 508		

representatives of the Department upon request.

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

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

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

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

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gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility.

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

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

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

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

(ix) Notifiable diseases and health conditions listed in Appendix I 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.

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A 508	Continued From page 40 (ii) Time and date of the report. (iii) Reporter's name. (iv) Name of resident(s), staff, or visitor(s) involved in the incident. (v) Names of staff on duty at the time of the incident. (vi) Date and time of the incident. (vii) A brief description of the incident. (viii) Any injury or injuries to resident(s). (ix) Action taken by the facility in response to the incident. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to properly investigate and report resident incidents with injuries and required disease reports to ADPH. Findings: On June 14, 2022, the surveyor prepared for the facility's pending survey. As part of the survey preparation the surveyor reviewed the Online Incident Report tracking system (OIRS) maintained by the ADPH for each licensed facility. The surveyor noted the facility had not reported	A 508		

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A 508	Continued From page 41 any incidents or disease outbreaks since approximately October 26, 2021. On June 22, 2022, the following resident records were reviewed with EI#1, EI#2, and EI#10. RI#1's record documented RI#1 was diagnosed with Covid 19 in February 2022. There was no OIRS disease report submitted to ADPH by the facility for RI#1's positive Covid 19 diagnosis. RI#8's record documented RI#8 suffered a fall with head injury and was sent to the local emergency room on March 02, 2022. There was no online report of the fall with injury and treatment by the emergency room to ADPH. RI#8's record documented RI#8 had a fall in the facility (date unknown) with surgical repair of RI#8's fractured left hip on May 20, 2022. There was no online report of the fall with injury and treatment by the local hospital to ADPH. RI#14's record documented RI#14 was Covid positive on February 04, 2022, however there was no online report submitted to ADPH. EI#2 told the surveyor she had been submitting Covid Disease reports to an online website that she thought was ADPH. EI#2 was unaware she was required to report resident incidents including disease outbreaks to the ADPH ALF ORIS. EI#2 had been the administrative designee for the facility during the past six to eight months while the facility attempted to find a permanent administrator replacement.	A 508		
A 602	420-5-4-.06 (2) (a) (b) (c) Care of Residents.	A 602		

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A 602	Continued From page 42 (2) Medical Examination Record. (a) Initial Physical Examination. Not more than 30 days prior to admission of any resident to an assisted living facility, the resident or prospective resident shall be examined by a physician. For purposes of the initial physical examination only, a currently licensed physician in good standing with the Medical Licensure Commission of any state may complete this physical assessment. The physician shall report his or her findings in writing to the facility. In addition to any information otherwise required by the facility's policies and procedures, and in addition to any other information the physician recommends or believes is pertinent, the initial physical examination record shall contain the following: 1. All of the physician's diagnoses, and the resident's baseline weight and vital signs. 2. Medication presently prescribed (name, dosage, and strength of drug, frequency, and route of administration). 3. A statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact. 4. Documentation of evaluation for tuberculosis within the previous 12 months. (b) Annual Physical Examination. In addition to the admission physical examination, each resident shall be examined annually by a physician, and findings from the annual physical	A 602		

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A 602	Continued From page 43 examination shall be documented with a copy placed in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent, or recommended by the resident's attending physician, the annual physical examination shall contain the following: 1. The resident's weight and vital signs. 2. Changes in diagnoses. 3. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration). 4. Changes in treatment. (c) Change of Condition Physician Examinations. Changes in the resident's condition that require a physician examination and result in a change in diagnoses, medications, or treatments shall be reported to the facility and documented in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent, or recommended by the resident's treating physician, this physical examination shall contain a listing of the following: 1. New diagnoses. 2. Changes in condition. 3. Changes in medications prescribed (name, dosage, and strength of drug, frequency,	A 602		

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A 602	Continued From page 44 and route of administration). 4. Changes in treatment. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure initial medical examinations were completed with all the required documentation. This deficient practice had the potential to affect all 36 residents living in the facility. Findings: On June 22, 2022, the following resident records were reviewed with EI#1, EI#2, and EI#10. RI#1 RI#1 was admitted to the facility on July 13, 2021. RI#1's initial medical examination had no medications listed, even though RI#1's medication administration record contained the following routinely scheduled medications; Amlodipine, Aspirin, Plavix, Donepezil, Flonase nasal spray, Genteal eye drops, Irbesartan, Latanoprost eye drops, Namenda, Metroprolol, Omeprazole, Sertaline, Simbrinza eye drops, Tamsulosin, and Tolterodine. RI#2 RI#2 was admitted to the facility on May 05, 2022, with only Major Depressive disorder documented on RI#2's medical examination form. RI#2 was receiving dialysis treatments three times a week and RI#2 was taking medications routinely to treat gout and nerve pain. RI#2's medical examination form also did not document RI#2's PermaCath for dialysis treatments.	A 602		

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A 602	Continued From page 45 RI#5 RI#5 was admitted to the facility on July 13, 2021. RI#5's only dated physician medical examination form was dated May 04, 2022, and documented "see attached" under the headings of medications and diagnoses. However, there were no additional documents "attached" to the physician's medical examination. RI#5's record contained a second physician's medical examination which documented RI#5's medications and "see attached" under diagnoses, however the medical examination had no dates documented on the form or the physician signature. Therefore, the facility did not have documentation of a complete, initial medical examination within 30 days of admission as required. RI#6 RI#6 was admitted to the facility on May 05, 2022. RI#6's physician medical examination dated May 04, 2022, documented, "see attached" under the heading of medications. There was no additional medication documentation attached to the physician medical examination. RI#11 RI#11 was admitted to the facility on May 15, 2021. RI#11's physician medical examination dated June 24, 2021, was not completed within 30 days of admission. The medical examination dated June 24, 2021, was incomplete in the following areas - temperature (blank) - pulse (blank) - weight (blank), and there was no tuberculosis screening or chest x-ray results. The physician's statement regarding the resident being free of infectious diseases was also left incomplete on the June 24, 2021 exam.	A 602		

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A 604	Continued From page 46	A 604		
A 604	420-5-4-.06 (3) (a) (b) Care of Residents.	A 604		

(3) Health Supervision.

(a) Initial Assessment. No more than 30 days prior to admission, the facility shall assess prospective residents for facility eligibility. This assessment shall document identified care needs and serve as a baseline for future assessments.

(b) Monthly Assessments. The facility shall assess each resident monthly and more often when necessary to identify changes in resident's status. In addition to other items that may be required by the facility's own policies and 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

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A 604	Continued From page 47 resident's plan of care. Any decline in resident status requires immediate implementation and documentation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to properly assess each resident's ability to direct their individual care needs on a monthly basis. This deficient practice placed six (6) residents at significant risk for harm. Findings: On June 22, 2022, the following records were reviewed with EI#1, EI#2, and EI#10. RI#1 The June 2022 medication awareness assessment completed by EI#2, LPN, for RI#1, documented RI#1 was determined to be "fully capable" to safely assist with his/her medications by community staff, which included unlicensed medication technicians. On June 21, 2022, at approximately 4:15 PM, the surveyor and EI#2 tested RI#1 for medication awareness. EI#2 told the surveyor she was "surprised that (RI#1) did as well as (RI#1) did" during the medication awareness testing. RI#1 was assessed to require medication administration by a nurse until the resident could be discharged to a higher level of care due to cognitive impairment. RI#2	A 604		

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A 604	Continued From page 48 RI#2's self medication assessment dated June 10, 2022, completed by EI#2 documented RI#2 was "fully capable" to self administer eye drops, ear drops, and a nasal spray. However, EI#2 told the surveyor RI#2 had not been able to demonstrate his/her ability to use those types of medications because RI#2 did not have those medications ordered. EI#2 told the surveyor RI#2's self medication assessment did not document whether or not RI#2 was "fully capable" of managing RI#2's daily sliding scale insulin orders, RI#2's renal diet order or if RI#2 could properly manage his/her daily blood glucose monitoring. RI#5 The June 2022 medication awareness assessment for RI#5 completed by EI#2 documented RI#5 was determined to be "fully capable" to safely assist with his/her medications by community staff, which included unlicensed medication technicians. On June 14, 2022, EI#2 told the surveyor the facility made an agreement with RI#5's family to have RI#5 sit in the common area of the facility instead of alone in RI#5's room due to falls. RI#5 was observed by the surveyor to sit in the common living room through out each day of the survey except when RI#5 was eating in the dining room. RI#5 was placed in a soft chair and was frequently observed to be asleep in the chair in the common living room. On June 21, 2022, at approximately 4:37 PM, the surveyor and EI#2 tested RI#5 for medication awareness. RI#5 was assessed to require medication administration by a nurse until RI#5 could be discharged to a higher level of care due to cognitive impairment. RI#5's record	A 604		

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A 604	Continued From page 49	A 604		

documented RI#5 had "poor cognition for personal safety" and had suffered actual harm by fracturing RI#5's left hip during two different falls while living in the facility. RI#5 fractured their left hip during falls documented in October 2021 and May 2022.

RI#6
RI#6 was admitted to the facility on May 05, 2022. On June 15, 2022, the surveyor observed RI#6 had severely limited mobility due to severe joint pain. RI#6 told the surveyor he/she was unable to ambulate long distances and did not have a wheelchair to use for long distances or evacuation from the second floor in case of an emergency.

RI#10
The June 2022 medication awareness assessment completed by EI#2 for RI#10, documented RI#10 was determined to be "fully capable" to safely assist with his/her medications by community staff, which included unlicensed medication technicians.

On June 21, 2022, at approximately 4:00 PM, RI#10 told the surveyor and EI#2 he/she could not remember if he/she (RI#10) had received any medications that day. Based on documentation, RI#10 had received medications at least once that day. RI#10 could not protect himself/herself from medication errors.

On June 21, 2022, at approximately 4:00 PM, RI#10 told the surveyor and EI#2 "I wouldn't care if I died... my life is sh*t since they did that surgery...". EI#2, LPN, did not voice any concerns about RI#10's comments which could be caused by an undiagnosed or worsening depression and possible self harm.

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A 604	Continued From page 50 RI#11 On June 21, 2022 at approximately 4:20 PM, RI#11 exhibited signs of depression and complained, "I'm feeling lost... my memory is bad...". RI#11 voiced concerns about his/her sponsor and about EI#2 "laughing at (RI#11) being old and can't remember or do things...". The surveyor offered reassurance to RI#11 that his/her sponsor and EI#2 were not laughing at RI#11 and RI#11's current limitations. EI#2 told the surveyor "(RI#11) is always like that." EI#2 did not voice any concerns about RI#11's comments which could be caused by an undiagnosed or worsening depression.	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	A 611		

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A 611	Continued From page 51 shall be developed and updated in cooperation with the resident and, if appropriate, the sponsor. All entries on the plan of care shall be accurately dated. 1. The plan shall at all times reflect the current condition of the resident and document the personal care and services required from the facility by the resident. In addition to other items that may be required by the facility's own policies 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.	A 611		

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A 611	Continued From page 52 (ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips. (iii) Hair. Resident's hair shall be kept clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (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 record review and interview, the facility failed to have care plans that addressed individual resident care needs. This deficient practice resulted in actual harm for at least four residents (RI#1, RI#4, RI#5 and RI#6) and placed the remaining 32 residents at risk for significant harm. Findings: On June 22, 2022, the following records were reviewed with EI#1, EI#2, and EI#10. The	A 611		

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A 611	Continued From page 53	A 611		

surveyor noted that each care/resident service plan was a basic standardized form with options to circle under each category. The care/service plans were completed approximately each month by EI#2, LPN. The forms did not include addendums for special needs like oxygen, falls, weight loss, etc. The service plans also did not address individual care and safety needs.

RI#1
RI#1 was admitted to the facility on July 13, 2021, with diagnoses which included dementia. RI#1 suffered a significant weight loss of 10.8 pounds or 6.3% of RI#1's total body weight (from 168.8 pounds to 158 pounds) in just 30 days between April 2022 and May 2022. EI#2 agreed there had been no physician notification for RI#1's significant weight loss and no care plan interventions documented to address RI#1's significant weight loss.

RI#2
RI#2 was admitted to the facility on May 04, 2022, with diagnoses which included major depressive disorder. RI#2 received dialysis treatments three times a week, had a PermaCath dialysis catheter, and required a renal diet. RI#2's record documented RI#2 had been observed by employees to smoke on RI#2's balcony and RI#2's apartment had been noted with a smoky odor. RI#2's care/service plan did not address RI#2's renal diet, dialysis catheter care needs or non-compliance with the facility's non-smoking policy.

RI#4
RI#4 was admitted to the facility in August 2021 from a local Specialty Care Assisted Living Facility (SCALF). RI#4's record documented a physician progress note dated March 10, 2022,

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which documented the following: "staying up all night sleeps during the day...memory loss ...cognitive impairments present... recent and remote memory with mild deficits... senile degeneration of the brain...". RI#4's record documented RI#4 had suffered a significant weight loss of 19.2 pounds or 11% of RI#4's total body weight (from 174 pounds to 154.8 pounds) in just 30 days between May 2022 and June 2022. EI#2 ,LPN, verified the facility had not notified RI#4's physician of RI#4's significant weight loss. RI#4's significant weight loss had not been addressed with interventions on RI#4's care/service plan. There were no interventions in place to prevent further weight loss.

RI#5
RI#5 was admitted to the facility on July 13, 2021, with unknown diagnoses. RI#5 had a physician's progress note dated February 16, 2022, which described RI#5 as having significant mobility restrictions and dementia. RI#5's record documented RI#5 had "poor cognition for personal safety" and had suffered actual harm by fracturing RI#5's left hip during two different falls while living in the facility. RI#5 fractured his/her left hip during falls documented in October 2021 and May 2022.

RI#5's record also documented RI#5 suffered a significant weight loss of 27.6 pounds or 20% of RI#5's total body weight (from 136.2 pounds to 108.6 pounds) in just 30 days between February 2022 and March 2022. EI#2 verified there had been no physician notification of RI#5's significant weight loss or care/service plan interventions to address RI#5's significant weight loss and to prevent further weight loss.

On June 14, 2022, EI#2, LPN, told the surveyor

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A 611	Continued From page 55 the facility had made an agreement with RI#5's family to have RI#5 sit in the common area of the facility instead of alone in RI#5's room due to falls. RI#5 was observed by the surveyor sitting in the common living room all day long except when RI#5 was eating in the dining room. RI#5 was placed in a soft chair and was frequently observed to be asleep in the chair in the common living room. RI#5's most current care/service plan dated May 2022, did not document any fall interventions or the agreement with RI#5's family. On June 21, 2022, at approximately 4:37 PM, the surveyor and EI#2 tested RI#5 for medication awareness. RI#5, was assessed to require medication administration by a nurse until RI#5 could be discharged to a higher level of care due to cognitive impairment. RI#6 RI#6 was admitted to the facility on May 05, 2022. RI#6 had diagnoses which included embolytic stroke, rheumatoid arthritis, and diverticulosis. On June 15, 2022, the surveyor observed RI#6 had severely limited mobility due to severe joint pain and deformities. RI#6 told the surveyor he/she was unable to ambulate long distances and did not currently have a wheelchair available for long distances. RI#6 also told the surveyor he/she had eaten some food items in the past few days that he/she (RI#6) shouldn't have eaten. RI#6 said those foods had caused RI#6 to suffer multiple episodes of diarrhea. RI#6's most current care/service plan dated June 2022, did not have interventions to address any of these personal care and safety needs for RI#6. RI#6 attempted suicide by medication overdose on June 16, 2022. RI#6 spent several days in a hospital intensive care unit and eventually recovered from the attempted suicide.	A 611		

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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. (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	A 613		

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A 613	Continued From page 57	A 613		

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:
Base on observation, record review, and interview, the facility failed to identify residents who were unable to protect themselves from medication errors. This deficient practice affected at least 4 residents and placed the remaining 32 residents at risk for harm.

Findings:

On June 22, 2022, the following records and observations were reviewed with EI#1, EI#2, and EI#10.

RI#1
The June 2022 medication awareness assessment completed by EI#2 for RI#1, documented RI#1 was determined to be "fully capable" to safely assist with his/her medications by community staff, which included unlicensed medication technicians.

On June 21, 2022, at approximately 4:15 PM , the surveyor and EI#2 tested RI#1 for medication awareness. EI#2, LPN, told the surveyor she was surprised RI#1 performed as well as RI#1 did during the medication awareness testing. RI#1 was assessed to require medication administration by a nurse until the resident could

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A 613	Continued From page 58	A 613		

be discharged to a higher level of care due to cognitive impairment.

RI#1 was going to discharge home with RI#1's sponsor on June 30, 2022.

RI#5
RI#5's June 2022 medication awareness assessment completed by EI#2 documented RI#5 was determined to be "fully capable" to safely assist with his/her medications by community staff, which included unlicensed medication technicians. RI#5's record documented RI#5 had "poor cognition for personal safety".

On June 21, 2022, at approximately 4:37 PM, the surveyor and EI#2, LPN, tested RI#5 for medication awareness. RI#5, was assessed to require medication administration by a nurse until RI#5 could be discharged to a higher level of care due to cognitive impairment.

RI#5 was issued a 30 day discharge notice by the facility on June 22, 2022.

RI#10
The June 2022 medication awareness assessment completed by EI#2 for RI#10, documented RI#10 was determined to be "fully capable" to safely assist with his/her medications by community staff, which included unlicensed medication technicians.

On June 16, 2022, RI#10 was identified by EI#2 "to be more confused than normal" and was sent to the local emergency room for evaluation.

On June 21, 2022, at approximately 4:00 PM, RI#10 told the surveyor and EI#2 that he/she

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A 613	Continued From page 59 could not remember if he/she (RI#10) had received any medications that day. RI#10 had received medications at least once that day. RI#10 was assessed to be unable to protect himself/herself from medication errors.	A 613		
A 616	420-5-4-.06 (7) (k) (l) (m) (n) (o) Care of Residents. (k) Medications kept under the control or custody of an assisted living facility shall be packaged by the pharmacy and shall be maintained by the facility in unit dose packaging. Medications kept under the control or custody of an assisted living facility that are not available in unit dose packaging must be packaged by the pharmacy and administered by a physician, RN, or LPN or self-administered with assistance under the total control and direction of the resident. (l) Unless a resident can and does self-manage his or her own medications, an assisted living facility shall require each resident to use a single pharmacy. This does not apply to emergency pharmacy services. All residents need not use the same pharmacy that is used by other residents unless express policy of the assisted living facility provides otherwise and all residents are informed of such policy and provided a copy of such policy prior to or at the time of admission. The assisted living facility shall require pharmacies used for medication supply for residents not self-managing their medications to review all ordered medication regimens for possible errors or adverse drug interactions and to advise the facility and the prescribing health care provider when these are detected.	A 616		

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A 616	Continued From page 60 (m) If controlled substances prescribed for residents of any assisted living facility are kept in the custody of the assisted living facility, they shall be stored in a manner that is compliant with state and federal laws, the requirements of the Alabama State Board of Pharmacy, and any requirements prescribed by the State Board of Health. At a minimum, controlled substances in the custody of the facility shall be stored using a double lock system, under proper temperature and humidity controls and permit only authorized personnel access. The facility shall maintain a system to account for all controlled substances in its possession. All other medications in the custody of the facility shall be stored using at least a single lock, under proper temperature and humidity controls and permit only authorized personnel access. This shall include medications stored in a resident's room when the staff and not the resident have access to the medications. Medications may be kept in the custody of an individual resident who can safely manage his or her medications. Such medications may be stored in a locked container accessible only to the resident and staff, or may be stored and secured in the resident's living quarters, if the room is single occupancy and has a locking entrance. (n) Medication administration or medication assistance records and written physician orders for all over-the-counter drugs, legend drugs, and controlled substances shall be retained for a period of not less than three years. They shall be made available for inspection at reasonable times by residents, anyone authorized by the resident, and by the sponsors of residents. (o) Labeling of Drugs and Medicines. All containers of prescribed medicines and drugs	A 616		

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A 616	Continued From page 61 shall be labeled in accordance with the rules of the Alabama State Board of Pharmacy and shall include appropriate cautionary labels, such as, "Shake Well," or "For External Use Only." This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure all medications kept in the custody of the facility were unit dose packaged and properly labeled by a pharmacy. This deficient practice placed all 36 residents at risk for harm. Findings: On June 21, 2022, at approximately 1:18 PM, the surveyor with EI#8 observed the following medications were not unit dose packaged and/or did not have an appropriate pharmacy label. There was a multi-dose bottle with One A Day multivitamins that was not labeled by the pharmacy. RI#7 Vitamin D3 gel caps that were not unit dose packaged or properly labeled by the pharmacy. Colon Health gel caps that were not unit dose packaged or labeled by a pharmacy. RI#18 A roll-on bottle of Biofreeze without a pharmacy label. A multidose bottle of Low dose aspirin without a pharmacy label. A multidose bottle of Solife A multidose bottle of Fluoxetine.	A 616		

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A 616	Continued From page 62 A multidose bottle of Atorvastatin.	A 616		
A 617	420-5-4-.06 (8) Care of Residents. (8) Disposal of Medications. 1. Controlled substances and legend 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.	A 617		

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A 617	Continued From page 63 This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure expired medications and the medications of discharged residents were destroyed within 30 days. This deficiency placed all 36 residents at risk for harm. Findings: On June 21, 2022, at approximately 1:18 PM, the surveyor with EI#8 observed the following: Expired medications were still stored with the residents' other medications in the medication cart. RI#4 - Zinc oxide ointment that was to be discarded after January 09, 2022. RI#19 - Siltussin liquid cough syrup that was to be discarded after May 02, 2022. There was a bottle of Polyethylene Glycol for RI#20 who had been discharged on April 19, 2022.	A 617		
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.	A 621		

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A 621	Continued From page 64 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 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	A 621		

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A 621	Continued From page 65 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. 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.	A 621		

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A 621	Continued From page 66 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 observation, record review, and interview, the facility did not identify and admitted or retained residents who did not meet admission or continued stay criteria. This deficient practice placed all 36 residents at risk for significant harm. Findings: RI#1 was admitted to the facility on July 13, 2021, with diagnoses which included dementia. EI#7 told the surveyor RI#1 was described as "confused" and unable to find RI#1's apartment or common areas without assistance due to cognitive impairment. EI#2 told the surveyor RI#1's sponsor was going to take RI#1 out of the facility on June 30, 2022. However, the facility had not identified and documented that RI#1 was ineligible for continued stay and had not issued a 30 day discharge notice to RI#1's sponsor prior to the survey. RI#1's sponsor was discharging RI#1 from the facility on June 30, 2022. RI#2 was admitted to the facility on May 04, 2022. RI#2 was not eligible for admission to the facility due to the presence of a PermaCath dialysis catheter which protruded from RI#2's skin. RI#2 did not have a 30 day discharge notice prior to the survey. On June 22, 2022, RI#2 was issued a 30 day discharge notice by the facility. RI#5 was admitted to the facility on July 13, 2021,	A 621		

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A 621	Continued From page 67	A 621		

with unknown diagnoses. RI#5's record contained a physician progress note dated February 16, 2022, which documented RI#5 had diagnoses which included dementia. RI#5's physician described RI#5 as follows: "... has significant mobility restrictions and dementia which make it difficult to travel to and from office visits... memory loss... cognitive impairments present...". The surveyor observed multiple written reminders to "call for help" hanging on the walls of RI#5's room. RI#5 sat in the common sitting area all day long watching the same television channel. The surveyor was told the family had requested that RI#5 not be left alone in RI#5's room due to repeated falls. RI#5 did not have a 30 day discharge notice issued to RI#5's sponsor prior to the survey.

On June 21, 2022, at approximately 4:37 PM, the surveyor and EI#2 tested RI#5 for medication awareness. RI#5 did not pass the medication awareness test due to cognitive impairment and required a nurse for safe administration of RI#5's medications until RI#5 could be discharged to a higher level of care.

On June 22, 2022, RI#5's sponsor was given a 30 day discharge notice for RI#5.

RI#8 was readmitted to the facility on approximately June 10, 2022, following hospitalization and surgical repair for a left hip fracture on May 20, 2022. RI#8 was discharged from the hospital to a local rehabilitation facility before returning to the facility. RI#8's record included progress notes from the rehabilitation facility which documented that RI#8 had diagnoses which also included dementia and diabetes. RI#8's therapy notes dated June 09, 2022, documented RI#8 had "decline" noted in

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A 621	Continued From page 68 "safe judgement, cognition, endurance, fine motor control, and upper extremity strength.". RI#8 was described as "disoriented to situation, decreased safety awareness, decreased awareness of deficits, decreased short term memory, assistance required to identify errors made, follows one step commands with increased time, impulsive and forgets that (RI#8) needs help when up with (rolling walker)...". RI#8 had not been identified by the facility as ineligible for continued stay and did not have a 30 day discharge notice issued to RI#8's sponsor prior to the survey. RI#8's family had notified the facility that RI#8 was being discharged or transferred to another facility on June 30, 2022. RI#10 was readmitted to the facility on June 09, 2022, after hospitalization with surgical treatment for normal pressure hydrocephalus and a subsequent rehabilitation stay. RI#10's physician medical examination documented RI#10 required assistance with all activities of daily living, required medication assistance, had swallowing difficulties, required initiation with meals, and cues for safety with transferring. On May 31, 2022, RI#10's physician determined RI#10 was not competent due to "poor short term memory, poor long term memory, and consistent disorientation to situation.". On June 21, 2022, at approximately 4:00 PM, RI#10 was unable to tell the surveyor if RI#10 had received any medications that day and therefore RI#10 could not protect himself/herself from medication errors. RI#10 had not been identified by the facility to be unable to protect RI#10 from medication errors.	A 621		

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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 69	A 702		
A 702	420-5-4-.07 (2) Food Service (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.	A 702		

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A 702	Continued From page 70 3. Dishes and utensils shall be allowed 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,	A 702		

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A 702	Continued From page 71 detergents, and cleaning supplies shall not be kept in the refrigerator or in other areas used for 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.	A 702		

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A 702	Continued From page 72 9. Frozen food items (raw and cooked) 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	A 702		

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A 702	Continued From page 73 cream. Ice cream dippers, spatulas, and other serving utensils shall be cleaned between uses. (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.	A 702		

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A 702	Continued From page 74 (g) Live Fowl or Animals. Live fowl or 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 observation and interview, the facility failed to store cleaning chemicals separate from food items. This deficient practice placed all 36 residents at significant risk for harm. Findings: On June 14, 2022, at approximately 10:25 AM, the surveyor observed the sanitizing bucket stored on a cart in the dining room. The sanitizing bucket was on the same shelf as various condiments that were later used by the residents in the dining room. This observation was verified with EI#1 later that same day.	A 702		

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A 703	Continued From page 75	A 703		
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 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.	A 703		

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A 703	Continued From page 76 (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 observation and interview, the facility failed to have adequate supplies of potable water and non-perishable food items to feed 36 residents for at least three days. This deficient practice placed all 36 residents at risk for significant harm. Findings: On June 14, 2022, at approximately 10:25 AM, the surveyor with EI#12 observed the emergency food items stored by the facility. There were only 85 gallons of water when the facility actually required at least 108 gallons of water for the 36 residents living in the facility. EI#12 told the surveyor there were approximately 25 residents living in the facility.	A 703		

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A 703	Continued From page 77 The facility's disaster menu documented the following food items; pork and beans for one meal, cereal for three meals, and chicken for one meal. There were no cans of pork and beans and no canned chicken. There were only four (4) bags of cereal. The cereal bags were not labeled and were approximately 36 ounces based on the inventory sheet, which was posted on the shelf with the emergency food items. According to the inventory sheet seven (7) 36 ounce bags of cereal were required for 40 servings. On June 14, 2022, at approximately 12:00 PM, the surveyor and EI#2 observed the facility kitchen also provided lunch meals for at least 30 independent living residents as well.	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 78 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 79 (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 observation and interview, the facility had ponded water located close to the facility in two different areas. This deficient practice promotes unwanted pests and wildlife, that can carry diseases transmissible to humans. This deficient practice placed all 36 residents at risk for significant harm. Findings: On June 15, 2022, the surveyor with EI#4 observed two (2) areas of ponded water in close proximity to the facility. One area by the front	A1001		

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A1001	Continued From page 80 entrance drive was considered to be property owned by the subdivision where the facility was located. The ponded water covered an area approximately 20 feet wide by 20 feet long and was at least four inches deep in most areas. There were numerous small fish observed in the water and no evidence of circulating water. There were weeds and tall grass observed around the edges of the ponded water. EI#4 told the surveyor the ponded water was not actually on the facility's property, but the ponded water was located on the facility's side of the entrance driveway. EI#4 told the surveyor the ponded water had been somewhat managed by the subdivision where the facility was located. On June 15, 2022, EI#4 and the surveyor observed a second area of ponded water on the back side of the facility's property which covered an area approximately 35 feet wide by 20 feet long. The ponded water was at least six (6) inches deep in most areas with numerous small fish and four (4) wild ducks observed. There was no evidence of circulating water. The grass and weeds had been trimmed. EI#4 told the surveyor electricity had been run for a circulating pump, however, the water pump had not been installed as originally planned by the facility.	A1001		
A1002	420-5-4-.10 (2) Sanitation and Housekeeping. (2) Housekeeping and Physical Plant Maintenance. The facility must provide a safe, functional, sanitary, decent, and comfortable environment for residents, staff, and the public. (a) Equipment and Supplies. The home shall maintain an adequate quantity of housekeeping and maintenance equipment and	A1002		

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A1002	Continued From page 81 supplies. (b) Bathtubs and Lavatories. Bathtubs and lavatories shall be kept clean and in proper working order, and shall not be used for laundering. (c) Resident Bedrooms. Resident bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance. (d) General Storage. 1. Broken beds, extra mattresses, mop buckets, and dust rags shall not be kept in hallways, closets, corners, or occupied resident rooms. Such items must be stored neatly and orderly in designated storage rooms. 2. The use of attics for storage of combustible materials shall be prohibited unless protected by an automatic sprinkler system and then only in small quantities so as not to create a hazardous condition. 3. Basements used for storage shall meet acceptable standards for storage and shall be designed and constructed in a manner that protects against fire hazards. 4. Flammable materials such as gasoline, motor fuels, lighter fluid, turpentine, acetone, and oil-based paint shall not be stored in the facility. Unless prohibited by a facility's own policies, however, a cognitively intact resident who uses lighter fluid to fill a personal cigarette lighter, or one who uses flammable materials such as paint or glue in connection with a	A1002		

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A1002	Continued From page 82 personal hobby, may store small quantities of those materials in a safe and secure manner within his or her own room. 5. Poisonous or External Use Substances. Facility cleaning supplies and poisons shall be attended at all times or shall be kept in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the facility stored flammable chemicals in a laundry room closet. This deficient practice placed all 36 residents at risk for significant harm. Findings: On June 14, 2022, at approximately 11:00 AM, the surveyor with EI#1 observed at least eight (8) 17 ounce cans of stainless steel cleaner in aerosol cans. The labels on the cans of stainless steel cleaner documented the contents included gas under pressure and could explode if heated. The eight cans of stainless steel cleaner were being stored in a closet next to the facility's commercial dryers.	A1002		
A1101	420-5-4-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous	A1101		

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A1101	Continued From page 83 place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift of Group and Congregate facilities. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the currently adopted Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty 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.	A1101		

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	D0227	A. BUILDING: _____ B. WING _____	06/23/2022

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A1101	Continued From page 84 3. Complies with the requirements of the currently adopted Life Safety Code. (f) Fire Alarm and Sprinkler System. 1. Fire Alarm System. Where fire alarm systems are required, a corridor smoke detection system shall be installed on each floor, including areas open to the exit access corridor, to comply with NFPA 72, connected to the facility's fire alarm system. In lieu of corridor smoke detection, smoke detectors connected to the building fire alarm system may be installed in each resident's room, open areas, and at smoke doors (except that corridor smoke detection shall not be deleted when its use is dictated by other requirements). 2. Fire alarm and sprinkler system outages of more than 4 hours require evacuation of the facility or the establishment of a continuous fire watch. The fire watch procedure must be coordinated with the Department and the local Fire Marshal. Outages and fire watch documentation shall be reported to the Department within 12 hours or no later than the 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.	A1101		

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A1101	Continued From page 85 This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure fire drills were properly performed and documented. This deficient practice placed all 36 residents at risk for significant harm. Findings: On June 15, 2022, the surveyor reviewed the fire drill documentation with EI#4. The facility fire drill documents did not contain documented evidence that the residents participated in the monthly fire drills. There was no fire drill documentation for January 2022. The fire drill documentation did not document if fire doors, horns, and strobes functioned properly during the monthly drills. There was also no documentation that the facility verified the fire alarm signal had been received by the facility's monitoring company each month. EI#4 told the surveyor he did not have any additional documentation available regarding the above fire safety concerns.	A1101		
A1206	420-5-4-.12 (8) Physical Environment. (8) Building Requirements - Congregate Assisted Living Facility. (a) General. Congregate assisted living facilities licensed, constructed, or renovated under the currently adopted codes shall comply with the building code and the requirements for limited care facilities in the "New Health Care Occupancies" Chapter of the Life Safety Code (excluding NFPA 101A, Alternative Approaches to Life Safety). Facilities, or portions of facilities,	A1206		

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A1206	Continued From page 86 built under previously adopted editions of the codes shall comply with the currently adopted Life Safety Code Chapter for Existing Residential Board and Care Occupancies, Impractical Evacuation Capability, thereby requiring compliance with the requirements for limited care facilities in the "Existing Health Care Occupancies" Chapter for the Life Safety Code (excluding NFPA 101A Alternative Approaches to Life Safety). (b) Exit doors. Panic hardware shall be installed on all exit doors. (c) Corridors and Passageways. Corridors and passageways shall be unobstructed and shall not lead through any room or space used for a purpose that may obstruct free passage. (d) In new construction, the temperature of hot water accessible to residents shall be automatically regulated by tempering valves and a circulating pump system, unless the water heater is dedicated to resident use. (e) Utility rooms shall be provided for each floor of Congregate assisted living facilities. The following equipment shall be provided: 1. Paper towel holder with an adequate supply of paper towels. 2. Wall cabinet or shelves. 3. Table or counter. 4. Soap dispenser with soap.	A1206		

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A1206	Continued From page 87 5. Sink - counter top, wall or floor mounted. 6. Space and facilities for cleaning equipment and supplies. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire doors functioned in accordance with the NFPA 101 Life Safety Code. This deficient practice placed all 36 residents at risk for significant harm. Findings: On June 14, 15, 16, 21, 22, and 23, of 2022, the surveyor observed that two fire doors, located in the two hour fire separation wall, were propped open with rubber wedges. The fire doors and the door frame had tags that showed the doors and the frame were both rated for one and three quarters of an hour. The fire wall and doors were supposed to provide a two-hour fire barrier between the assisted living facility and the independent living facility. The rubber wedges were placed between the bottom of the fire door and the floor. The surveyor and EI#4 observed there were no magnetic holding devices in place for these two fire doors. On June 23, 2022, at approximately 10:35 AM, the surveyor observed EI#4 try to close the fire doors during the fire drill demonstration. EI#4 was unable to remove the rubber wedges by kicking them with his foot or close the fire doors by forcibly pulling on the two fire doors. EI#4 agreed the fire doors were supposed to remain	A1206		

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A1206	Continued From page 88 closed at all times, but had been propped open for resident and employee convenience. TONYA AVENATTI, REGISTERED NURSE	A1206		