STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D4525	A. BUILDING: _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERHOUSE BYRD SPRINGS	8020 BENAROYA LANE SOUTHWEST HUNTSVILLE, AL 35802

(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 July 28, 2022, an unannounced licensure survey and complaint investigation was conducted for this 113 bed Assisted Living Facility (ALF) with a census of 39. There were five (5) complaints investigated during this survey. LC#20220627019, LC#20220706029 and LC#20200824015 were investigated and portions of the complaints were substantiated. Deficiencies were cited as a result of the complaint investigations. LC#20201204015 and LC#20220216007 were not substantiated and no deficiencies were cited as a result of the complaint investigations. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities. The deficiencies cited pose a risk of harm to the residents and require a plan of correction.	A 000		
A 402	420-5-4-.04 (3) Personnel. (3) Employee Screening. (a) Prior to any resident contact, such as but not limited to assistance with activities of daily living, newly employed personnel shall have a physical examination certifying that the employee is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to residents through normal staff to resident contact. Employees who develop signs or symptoms of infectious skin lesions or diseases that would be capable of transmission to residents through normal staff to resident	A 402		

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A 402	Continued From page 1 contact shall not be permitted to have resident contact until free from such signs and symptoms. (b) Not more than 30 days prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis. (c) Vaccines. Assisted living facilities shall immunize employees in accordance with current recommended Centers for Disease Control and Prevention (CDC) guidelines (www.cdc.gov/vaccines). Any particular vaccination requirement may be waived or delayed by the State Health Officer in the event of a vaccine shortage. (d) An assisted living facility shall not hire an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to screen employees as required. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON SEPTEMBER 26, 2019. Findings: Review of employee files on July 27, 2022 revealed the following information. Employee Identifier (EI)#2 was hired at the facility on January 8, 2022. There was no physical examination certifying EI#2 was free of signs and symptoms of infectious skin lesions and diseases	A 402		

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A 402	Continued From page 2 that were capable of transmission to residents through normal staff to resident contact. The following employee files did not contain documentation of screening through the Alabama Department of Public Health Nurse Aide Abuse Registry prior to hire: EI#1 (date of hire July 18, 2022), EI#2 (date of hire January 8, 2022), EI#4 (date of hire April 5, 2022) and EI#8 (date of hire April 12, 2022). On July 27, 2022, EI#3, Business Office Manager, was unable to locate a complete physical examination for EI#2 as well as aide abuse registry screening for EI#1, EI#2, EI#4 and EI#8 prior to hire. The aide abuse registry screenings were completed by EI#3 during the onsite survey.	A 402		
A 403	420-5-4-.04 (4) Personnel. (4) Personnel Records. An assisted living facility shall maintain a personnel record for each employee. This record shall contain: (a) An application for employment which contains information regarding the employee's education, training, and experience. (b) Verification of current certification or licensure, if applicable. (c) Record of required physical examinations and vaccinations. (d) Verification the facility has not hired an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry.	A 403		

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A 403	Continued From page 3 (e) Date of hire. (f) Date of initial resident contact. (g) Date employment ceased. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to maintain complete employee files. Findings: Review of employee files on July 27, 2022 revealed there was no documented date of initial resident contact for EI#1, EI#2, EI#4, EI#8 and EI#10. In addition, no aide abuse registry screenings were documented for EI#1, EI#2, EI#4 and EI#8. Refer to deficiency 402 for additional information on aide abuse registry screenings. During an interview on July 27, 2022, EI#3 agreed the required information had not been documented.	A 403		
A 405	420-5-4-.04 (6) Personnel. (6) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained in the facility. In addition to any information otherwise required by the facility's policies and procedures, the facility	A 405		

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A 405	Continued From page 4 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. 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	A 405		

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A 405	Continued From page 5 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 of those courses or certifications offered by the American Heart Association or American Red Cross in CPR or AED utilization. (c) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training. (d) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure all employees received required initial training prior to resident contact. In addition, employees were not trained in special needs of residents. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON SEPTEMBER 26,	A 405		

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A 405	Continued From page 6 2019. Findings: Initial Training Prior to Resident Contact Review of employee files on July 27, 2022 revealed EI#2 had been employed at the facility since January 8, 2022. There was no documentation that EI#2 had completed training in the following: State law and rules for ALFs; identifying and reporting abuse, neglect and exploitation; basic first aid; advance directives; protecting resident confidentiality; resident fire and environmental safety; special needs of the elderly, mentally ill and mentally retarded; safety and nutritional needs of the elderly; identifying signs and symptoms of dementia. During an interview on July 27, 2022, EI#3 stated she (EI#3) was unsure if the training for EI#2 had been completed. Training in Special Needs of Residents One current resident of the facility had a gastrostomy tube. In addition, two residents of the facility had dialysis shunts and received dialysis three times weekly. Review of resident files on July 27, 2022 revealed EI#1, EI#2, EI#4, EI#8 and EI#10 had not been trained in these special needs of residents. During an interview on July 27, 2022, EI#3 agreed the special needs training had not been completed.	A 405		
A 504	420-5-4-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission of these rights. A copy of these rights	A 504		

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A 504	Continued From page 7 shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate. 1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility. 2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints. 3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy. 4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time. 5. Every resident shall have freedom to 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.	A 504		

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A 504	Continued From page 8 6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the premises, an individual account record for each resident shall be maintained by the administrator and an up-to-date record shall be maintained for all transactions. 7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so. 8. Every resident shall have the right to a reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals. 9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident. 10. Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to receive or reject medical care, dental care, or other health care services except those required to control communicable diseases. 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	A 504		

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A 504	Continued From page 9	A 504		

providing a higher level of care and no longer meets the eligibility and continued stay requirements in these rules, or for medical reasons the resident is considered by a physician to require an emergency relocation to a facility providing a more skilled level of care, or unless the resident engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record.

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

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

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

(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.

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A 504	Continued From page 10 (ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation; and (iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time without recourse. 15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges. 16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities. 17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll-free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll-free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area. 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	A 504		

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A 504	Continued From page 11 months, then the results of the most recent inspection and any resulting corrective action plan shall be posted. 19. Every resident shall have the right to 30 days prior written notice to both resident and sponsor of any increase of fees or charges. 20. Every resident shall have the right to 30 days prior written notice of any involuntary change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. 21. Every resident shall have the right to wear his or her own clothes, to keep and use his or her own personal possessions including toilet articles except for personal possessions too large to be stored in the resident's room. 22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings. 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours and to freely come and go from the home. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences 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.	A 504		

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A 504	Continued From page 12	A 504		

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to allow residents to freely come and go from home.

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

Findings:

The Alabama Department of Public Health (ADPH) received allegations residents and family members had to wait an extended length of time for a staff person to let them into the facility. One of the complainants reported, "No one to let visitors in as one family had to wait 45 minutes before someone opened the door for them to come into the building." Another complainant said there was no one monitoring the front door from 6:00 PM to 6:00 AM. The complainant said if someone should ring the door bell after 6:00 PM the nurse has to stop what she is doing to go to the lobby and open the door. Surveyors were able to substantiate the complaints during the onsite survey.

On July 26, 2022, EI#7 told the surveyors the front door is supposed to be locked at 5:00 PM. EI#7 said after hours the residents and family members have to ring the doorbell and wait for a staff person to let them in. During interviews with residents the surveyors were told if they go out for the evening they have to wait outside until someone comes to the door to let them in.

On July 27, 2022 at 7:00 AM, the surveyors arrived at the facility for day 2 of the survey. The surveyors rang the door bell three (3) times and

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A 504	Continued From page 13 no one responded. The surveyor then called the facility main number and got a recording. At 7:15 AM, EI#1 arrived at the facility and escorted the surveyors into the facility. EI#1 told the surveyors the staff could not hear the doorbell when they were in the back of the building. EI#1 acknowledged she (EI#1) was aware of the problem and would be installing a doorbell that would activate the call light system so the front door would be opened promptly.	A 504		
A 508	420.5.4-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in an assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review. 1. Incidents which require investigation are: (i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as bruising, pain, or injury that is not consistent with actions necessary in providing day to day care to a resident or for which medical treatment was sought. (ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid, including but	A 508		

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A 508	Continued From page 14 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). (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.	A 508		

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A 508	Continued From page 15 (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). (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken.	A 508		

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A 508	Continued From page 16 (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 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.	A 508		

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A 508	Continued From page 17 (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 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,	A 508		

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A 508	Continued From page 18 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. (ii) Time and date of the report. (iii) Reporter's name. (iv) Name of resident(s), staff, or	A 508		

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A 508	Continued From page 19 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 interviews, the facility failed to report a medication error to the Department's Online Incident Reporting System (OIRS) within 24 hours of the incident and failed to investigate the medication error. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON SEPTEMBER 26, 2019. Findings: Interviews with staff and review of Resident Identifier (RI)#6's facility record on July 28, 2022 revealed the following information. RI#6 was admitted to the facility on April 8, 2022 with diagnoses which included atrial fibrillation, hypertension, stroke, restless legs, diabetes mellitus II and seasonal allergies. Refer to	A 508		

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A 508	Continued From page 20 deficiencies 601 and 604 for additional information on RI#6. As cited in deficiency 601, RI#6 did not receive medications as ordered at the facility on July 26 and 27, 2022 due to staff unaware RI#6 had returned to the facility from a family outing. Review of the ADPH OIRS on July 28, 2022 revealed this medication error had not been reported. When questioned on July 28, 2022, EI#1 stated the incident probably had not been reported and an investigation had not been initiated.	A 508		
A 601	420-5-4-.06 (1) Care of Residents. (1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician. (a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her choice. If the resident is unable to designate an attending physician, or does not wish to designate an attending physician, the facility shall assist the resident in identifying an attending physician who will serve the resident. A resident shall be permitted to change the designation of his or her attending physician at any time. Whenever a resident requires medical attention, an attempt shall first be made to contact the resident's attending physician, except in medical emergencies requiring activation of the local EMS system (911 or another emergency call). (b) Back-up Physician Support. Each assisted living facility shall have an agreement	A 601		

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A 601	Continued From page 21 with one or more duly licensed physicians to serve in those instances when a resident's own attending physician cannot be reached, and to provide temporary medical attention to any resident whose attending physician is temporarily not available. A nurse practitioner or physician's assistant shall not serve as the back-up physician in an assisted living facility. (c) All physician orders shall be written in accordance with community standards. If verbal orders are used, they are to be used infrequently. A physician verbal order shall only be accepted by an RN or LPN employed by the facility and authorized to do so by facility policy and procedures and state law. All verbal orders shall be reduced to writing on the physicians' order sheet by a licensed facility nurse and shall be dated and signed by the nurse receiving the order. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, or another practitioner who is responsible for the care of the resident and authorized to write orders by facility policy. All verbal orders must be authenticated within such time period as provided by facility policy, but in no case shall exceed 30 days following entry of the order. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to follow physicians' orders for medication assistance and care of residents. Findings:	A 601		

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A 601	Continued From page 22 During the three day onsite survey, multiple deficient practices were identified by surveyors which involved failure to provide medications to residents as ordered by the physicians. Review of resident records and interviews with staff revealed the following residents did not receive medications and care as ordered by their physicians' at the facility. RI#3 RI#3 was admitted to the facility on July 22, 2022 with diagnoses which included critical illness myopathy, left facial cellulitis, acute respiratory failure with fluid overload, acute kidney injury and congestive heart failure. RI#3 had physician's orders for Duoneb 1 vial in nebulizer twice daily and Pulmicort 1 vial in nebulizer twice daily. On July 25, 2022 and July 26, 2022, both the Duoneb and Pulmicort were documented on RI#3's Medication Assistance Record (MAR) at 4:00 PM as not given due to "med not available", with an additional entry which read "RSD (Resident Services Director)/designee notified". There was no documentation that RI#3's physician had been notified of the omitted medication doses. RI#6 RI#6 had resided at the facility since April 8, 2022. Refer to deficiencies 508 and 604 for additional information on RI#6. On July 26, 2022, surveyors were notified by staff that RI#6 was out of the facility with family members. On July 28, 2022, the surveyor was notified by EI#7 that RI#6 had returned to the facility on July 26, 2022 at 6:15 PM but had not received medications until July 27, 2022 at 4:00 PM because facility staff were not aware RI#6 had returned to the facility. Review of RI#6's MAR revealed all doses of	A 601		

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A 601	Continued From page 23 RI#6's medications from July 25, 2022 at 4:00 PM through July 27, 2022 at 8:00 AM were documented as "L" which was the symbol for "leave of absence". EI#7 explained RI#6 would often leave the facility with family and did not sign in and out as required. In addition, EI#7 reported facility staff had failed to notify the incoming shift of RI#6's return to the facility so that medications could be resumed. This was discussed with EI#1 on July 28, 2022. EI#1 stated the incident had been reported to her (EI#1) but she (EI#1) was unsure why the medications had not been resumed when RI#6 returned to the facility. Upon review of RI#6's MAR for July 2022, it was also noted that 17 doses of multivitamins had been refused by RI#6 and three doses of Lidoderm patches had been omitted (July 9, 10 and 11) due to "med not available" with a note which read "RSD/designee notified". There was no documentation that RI#6's physician was aware of the omitted medication doses. RI#9 RI#9 had a history of heart and kidney failure. RI#9 was currently being treated with Lasix 80 mg daily for bilateral venous stasis ulcers and edema of the lower extremities. On June 17, 2022, the nurse practitioner (CRNP) ordered daily weights and added daily blood pressure checks on July 9, 2022. According to the July 2022 MAR daily weights and blood pressures were not taken due to RI#9's refusal. EI#2 documented on the June 2022 monthly assessment RI#9 refused to be weighed, however, there was no documentation the CRNP had been notified the daily monitoring had not been done as ordered. RI#16	A 601		

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A 601	Continued From page 24 RI#16 was admitted to the facility on November 26, 2019 and had diagnoses which included sick sinus syndrome, atrial fibrillation, edema bilateral lower extremities, cellulitis bilateral lower extremities, atrioventricular block, hyperlipidemia, congestive heart failure, hypertension, diabetes mellitus II, hypothyroidism and chronic pain. RI#16 had a physician's order for sliding scale insulin to be administered according to the blood sugar level four times daily. On the afternoon of July 26, 2022, the surveyor observed EI#2 check a fingerstick blood sugar on RI#16 with a result of 197 which required 2 units of Humulin R insulin. No Humulin R insulin was available. EI#7 explained to the surveyor the following morning she (EI#7) had discarded RI#16's Humulin R due to being expired and failed to reorder a new bottle. When asked if RI#16's physician had been notified of the missed doses, EI#7 stated the physician had not been notified at that time. Review of RI#16's MAR for July 2022 revealed Combigan eye drops were scheduled twice daily for RI#16. Only two doses of the eye drops had been administered to RI#16 for the month of July 2022. All other doses were documented as "patient refused medication" but there was no documentation that RI#16's physician had been notified of the numerous omitted doses. In addition, on July 27, 2022 at 6:00 AM, there was no documentation of the fingerstick blood sugar result and sliding scale insulin dose scheduled on the MAR for RI#16. The documentation on RI#16's MAR for the 6:00 AM dose was "/" which was the symbol for "missed dose". On the morning of July 27, 2022, EI#7 reported to the surveyor that an "agency" nurse had worked the previous night and RI#6's blood sugar had not been checked to determine if sliding scale insulin	A 601		

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A 601	Continued From page 25 was needed. There was no documentation RI#6's physician had been notified of the omitted blood sugar and insulin dose. On July 28, 2022, surveyors discussed medication concerns with EI#1, newly hired Administrator. EI#1 stated she (EI#1) was aware there were multiple concerns with residents medications and she (EI#1) had already planned for a new pharmacy to provide services at the facility. EI#1 further explained the new pharmacy would conduct audits and training for all staff who provided medication assistance.	A 601		
A 604	420-5-4-.06 (3) (a) (b) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility shall assess prospective residents for facility eligibility. This assessment shall document identified care needs and serve as a baseline for future assessments. (b) Monthly Assessments. The facility shall assess each resident monthly and more often when necessary to identify changes in resident's status. In addition to other items that may be required by the facility's own policies and 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	A 604		

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A 604	Continued From page 26 half or greater weight loss in a period of three months or less, or a ten percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician. 3. Document identified changes in resident status. 4. Assess the appropriateness of each resident's plan of care. Any decline in resident status requires immediate implementation and documentation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, facility staff failed to provide adequate health supervision of residents. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON SEPTEMBER 26, 2019. Findings: Review of resident records during the three day onsite survey revealed numerous deficient practices related to resident assessments. This included monthly assessments and medication awareness testing. It was noted by surveyors that medication awareness testing was not	A 604		

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A 604	Continued From page 27	A 604		

consistently documented for residents and was not documented at all for some residents. Both EI#7, Licensed Practical Nurse (LPN) and EI#8, Medication Technician, stated they (EI#7 and EI#8) were unaware how to conduct medication awareness testing. The residents had not been properly assessed to determine their ability to correctly identify medications and protect themselves from medication errors. The following residents' records were reviewed and deficient practices identified.

RI#4

RI#4 was admitted to the facility on October 28, 2021, and did not have an assessment completed for eight (8) months. There had not been a monthly assessment or medication awareness testing documented until July 13, 2022. Refer to deficiency 615 for additional information on RI#4.

RI#5

RI#5 was admitted to the facility on April 19, 2021 and had diagnoses which included diabetes mellitus II, hyperglycemia, ischemic cardiomyopathy, end stage renal disease, aortic valve stenosis, mild dementia and cardiomegaly. Refer to deficiency 521 for additional information on RI#5. No monthly assessments and medication awareness testing had been documented for RI#5 to determine RI#5's needs and ability to safely reside in an assisted living facility.

RI#6

RI#6 had resided at the facility since April 8, 2022. Refer to deficiencies 508 and 601 for

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A 604	Continued From page 28	A 604		

additional information on RI#6. No monthly assessments and medication awareness testing were documented for RI#6 in May and June 2022.

RI#10

RI#10 had lived at the facility since November 2017. No monthly assessments or medication awareness testing were documented for the months of January - June 2022, for RI#10.

RI#14

RI#14 was admitted to the facility on September 10, 2021, with the following diagnoses, chronic kidney failure requiring dialysis 3 times a week, congestive heart failure, anemia, and exocrine pancreatic insufficiency. There was no record a monthly assessment or medication awareness testing had been completed for the last seven (7) months January - July 2022 for RI#14.

RI#15

RI#15 was admitted to the facility on December 23, 2021 and had diagnoses which included acute respiratory failure due to Covid-19, pulmonary embolism, hypertension, diabetes mellitus II and atrial fibrillation. RI#15's facility care plan, dated December 23, 2021, contained repeated documentation of RI#15's poor vision. However, there was no documentation of medication awareness testing to determine RI#15's ability to correctly identify medications and protect self from a medication error.

On July 28, 2022, surveyors discussed the health assessment concerns with EI#1, newly hired Administrator. EI#1 stated a new health and

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SUMMERHOUSE BYRD SPRINGS	8020 BENAROYA LANE SOUTHWEST HUNTSVILLE, AL 35802

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A 604	Continued From page 29 wellness director was being hired and the concerns would be addressed.	A 604		
A 611	420-5-4-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall be based on the initial medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be reviewed and updated based on the annual examination, and all other physician examinations, diagnoses, and recommendations of the resident's treating physician, and the resident's monthly assessments. The plan of care shall be developed and updated in cooperation with the resident and, if appropriate, the sponsor. All entries on the plan of care shall be accurately dated. 1. The plan shall at all times reflect the current condition of the resident and document 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:	A 611		

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A 611	Continued From page 30 2. A listing of the resident's individual needs or problems that require intervention by the facility. 3. A listing of interventions provided by the facility to address the resident's identified needs or problems. 4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider. 5. Activities of Daily Living. Residents of assisted living facilities shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident. (i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested. (ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips. (iii) Hair. Resident's hair shall be kept clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them	A 611		

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A 611	Continued From page 31 clean and well groomed. (vi) Personal Safety. Residents shall be provided assistance with personal safety. 6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to maintain resident care plans which addressed the current care needs of the residents with appropriate interventions. Also a copy of the outside provider's plan of care was not available for all residents. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON SEPTEMBER 26, 2019. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: Review of resident records during the onsite survey revealed only three (3) of seventeen (17) records reviewed contained a care plan for staff to follow in providing care to the residents. During interviews on July 28, 2022, both EI#11 and EI#12, Care Managers, stated they (EI#11 and EI#12) did not have access to care plans for residents. During an interview on July 27, 2022,	A 611		

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A 611	Continued From page 32 EI#7 stated EI#2 was responsible for resident care plans. During review of RI#3's facility record on July 26, 2022, no care plan was found. When the surveyor requested a care plan for RI#3, from EI#2, on July 26, 2022, EI#2 printed off a form titled Service Description-Full. The form contained an assessment of RI#3's functional status and needs but did not state who was responsible for assisting RI#3 with specific needs. The form was not signed. EI#2 stated to the surveyor she (EI#2) did not consider the form a care plan. The Alabama Department of Public Health received a complaint which alleged RI#7 had nine (9) falls since January. Surveyors were able to confirm RI#7's falls during the onsite survey. RI#7 was admitted to the facility on July 25, 2019 and had diagnoses which included Parkinson's disease, high blood pressure, gastroesophageal reflux disease, hyperlipidemia, vitamin D deficiency, arthritis and urinary incontinence. Surveyors observed RI#7 using a power wheelchair for mobility during the onsite survey. RI#7 had difficulty guiding the power wheelchair as evidenced by observing RI#7 bumping into a wall and numerous scrapes and wood damage to the door facings and baseboards as well as a hole in the wall of the bathroom which had been covered with wood boards. Staff reported RI#7 had hit tables in the dining room area and turned them over with the power wheelchair. EI#2 stated she (EI#2) had the speed on RI#7's power wheelchair adjusted as slow as possible to prevent RI#7 from bumping into objects. Review of RI#7's facility record and facility incident reports on July 28, 2022 revealed RI#7 had 12 documented incidents between January 29, 2022 and July 15, 2022. The incidents included 9 falls,	A 611		

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A 611	Continued From page 33 3 skin tears to the arms and a lamp fell on RI#7's head. One of the skin tears occurred when RI#7 was using the power wheelchair in the hallway and RI#7's arm got hung in the railing. In spite of the multiple incidents and falls sustained by RI#7, no care plan was found in RI#7's facility record. No interventions were documented to address the numerous falls and to protect RI#7 from further injury. RI#15 had resided at the facility since December 23, 2021. Refer to deficiency 604 for additional information on RI#15. RI#2 had resided at the facility since April 25, 2022 and had diagnoses which included coronary artery disease, hearing loss, gastroesophageal reflux disease, osteoarthritis, memory loss and constipation. Both RI#15 and RI#2 had Level of Care Assessment Worksheets on their facility records which addressed the residents' needs and functional status. The forms were filed in the section of the resident's file titled Care Plan and were documented upon the resident's admission to the facility but did not contain signatures. The forms did not state who was responsible for interventions related to the residents' care needs. The form for RI#15 did not address diabetes mellitus with signs and symptoms to monitor for and did not address the wound to RI#15's leg which home health managed. The form for RI#2 did not address RI#2's fall with appropriate interventions to prevent a recurrence. RI#9 was admitted to the facility on June 20, 2020, with a significant medical history of chronic renal failure and heart failure. On June 13, 2022, RI#9 developed leg swelling and blisters. The primary care provider (PCP) increased the Lasix to 80 mg daily and ordered home health for management. The Home Health Certification and	A 611		

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A 611	Continued From page 34 Plan of Care was not on file until requested by the surveyor on July 27, 2022. RI#9 had bilateral lower leg venous stasis ulcers which were being wrapped with unna boots by the home health nurse twice a week. Despite these problems a plan of care had not been developed to reflect the current condition of RI#9. On July 28, 2022, surveyors discussed with EI#1, newly hired Adminstrator, the lack of care plans for residents. EI#1 stated she (EI#1) had only been at the facility for a week but was hiring a new health and wellness director and would address the concerns about care plans.	A 611		
A 614	420-5-4-.06 (5)(f)(g)(6)(7)(a)-(i) Care of Residents. (f) A resident may self-manage his or her medications. For the purposes of these rules, self-manage shall mean the resident is capable of maintaining possession and control of his or her medications, who does maintain possession and control of his or her medications, and self-administers his or her medications without creating an unreasonable risk to health and safety. (g) A resident that cannot self-manage his or her own medication without creating an unreasonable risk to health and safety may be assisted with self-administration of medication by any assisted living facility staff, including staff members who hold no professional licensure provided: 1. The resident can and does identify his or her name on the medication package and has a reasonable understanding of the unit dose packaging system in use by the facility such that	A 614		

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A 614	Continued From page 35	A 614		

the resident could protect himself or herself from medication errors when unit dose packages are brought to the resident by facility staff. The resident shall have the opportunity to demonstrate his or her ability to correctly utilize the unit dose package system at every opportunity for medication use.

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

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

(b) Physically assisting a resident by opening or helping to open a container holding medications.

(c) Offering liquids to a resident to assist that resident in ingesting oral medications.

(d) Physically bringing a container of medication to a resident.

(7) Assistance with self-administration of medications shall under no circumstances include any of the following practices:

(a) Medication administration as defined in
these rules.

(b) Determining the amount of medication to be given. If a medication is not

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available in unit dose packaging, unlicensed facility staff may measure the prescribed amount of medication only under the direction and control of the resident, provided that the resident is capable of determining the amount of medication to be given.

(c) Giving a resident injections of any kind.

(d) Telling or reminding a resident that it is time to take a PRN, or as needed medication.

(e) Placing medications in a feeding tube.

(f) Giving enemas or suppositories.

(g) Crushing or splitting medications, provided
that a physician has ordered a specific medication to be crushed or split and the resident is capable of self-managing his or her own medication or the resident is capable of medication self-administration with assistance and would be capable of crushing or splitting his or her own medications but for limitations of mobility or dexterity, may be assisted with crushing or splitting medications by unlicensed staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff.

(h) Mixing medications with food or liquids, provided that a physician has ordered a medication to be mixed with food or liquid and the

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A 614	Continued From page 37 resident is capable of self-managing his or her own medications or the resident is capable of medication self-administration with assistance and would be capable of mixing his or her own medications with food or liquid but for limitations of mobility or dexterity, may be assisted with mixing medications with food or liquid by unlicensed staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. (i) Assisting with self-administration of eye drops, eardrops, nose drops, inhalers, nebulizers, or topical medications, provided that a resident who is capable of self-managing his or her own medication or a resident who is capable of medication self-administration with assistance and who would be capable of self-administration of his or her own medications but for limitations of mobility or dexterity, may be assisted with eye drops, ear drops, nose drops, inhalers, nebulizers, or topical medications by unlicensed facility staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. This Rule is not met as evidenced by: Based on observations, interviews and record review, a resident was unable to correctly utilize the unit dose package system and protect self from a medication error.	A 614		

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A 614	Continued From page 38 Findings: Review of resident records on July 27, 2022 revealed the following information. RI#15 had resided at the facility since December 23, 2021. Refer to deficiencies 604 and 611 for additional information on RI#15. On the afternoon of July 27, 2022, medication awareness testing was performed on RI#15 by EI#8, at the request of the surveyor. RI#15 was presented with a packet containing RI#15's medication and a packet with a name "Sunshine Ray". When asked which medication should be taken, RI#15 replied, "I can't see them. You know I can't see. You know what I take." EI#8 called EI#7, LPN, to administer the medication to RI#15. As cited in deficiency 604, there was no documentation of medication awareness testing of RI#15 to assess RI#15's ability to correctly identify medications and protect self from a medication error. RI#15 had likely been administered medications by unlicensed staff at the facility without the ability to protect self. On July 28, 2022, surveyors discussed RI#15's inability to identify medications with EI#1. EI#1 stated they would work with RI#15 to develop an acceptable method for RI#15 to identify medications. EI#1 further stated licensed staff would administer RI#15's medications until RI#15 was able to correctly utilize the unit dose package system.	A 614		
A 615	420-5-4-.06 (7) (j) Care of Residents. (j) All medications administered to	A 615		

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A 615	Continued From page 39 residents and all medications self-administered with assistance of facility staff in an assisted living facility shall be contemporaneously recorded on a standard medication administration or medication assistance record. "Contemporaneously recorded" means recorded at the same time or immediately after medications are administered. The medication administration or medication assistance record shall include at least the following: 1. The name of the resident to whom the medication was administered or assisted. 2. The name of the medication administered or assisted. 3. The dosage of the medication administered or assisted. 4. The method of administration or assistance. 5. The site of injection or application, if the medication was injected or applied. 6. The date and time of the medication administration or assistance. 7. Any adverse reaction to the medication. 8. The printed name, initials, and written signature of the individual administering the medication or assisting the resident with self-administration of the medication. This Rule is not met as evidenced by:	A 615		

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A 615	Continued From page 40 Based on observation, record review, and interviews, the facility staff failed to record the application site of a transdermal patch on the MAR. Findings: On July 26, 2022, the surveyor visited with RI#4 in her/his room. RI#4 was lying in bed and said she/he had pain every where and required pain pills and patches. RI#4 was admitted to the facility on October 28, 2021, with diagnoses to include, systemic lupus and chronic pain syndrome. On December 11, 2021, RI#4 was admitted to hospice services due to chronic kidney disease and heart failure. RI#4 was to have a Fentanyl patch 25 micrograms/hour applied every 72 hours. The application site of the Fentanyl patch was not recorded on the July 2022 MAR to indicate the old patch was removed before the new patch was applied, as well as, the rotation of sites. The surveyor informed EI#1 on July 28, 2022, the Site Code Key was not on the MAR.	A 615		
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.	A 616		

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A 616	Continued From page 41 (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. (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	A 616		

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A 616	Continued From page 42 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 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, interview and record review, the facility failed to maintain pharmacy packaging for a resident's medications. Findings: Review of resident records on July 27, 2022 revealed the following information. RI#2 had resided at the facility since April 25, 2022. Refer to deficiencies 611 and 618 for additional information on RI#2. On the morning of July 26, 2022, the surveyor	A 616		

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	D4525	A. BUILDING: _____ B. WING _____	07/28/2022

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SUMMERHOUSE BYRD SPRINGS	8020 BENAROYA LANE SOUTHWEST HUNTSVILLE, AL 35802

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A 616	Continued From page 43 observed the medication cart with EI#7. In the top drawer of the cart was a medication packet labeled for RI#2 which had been torn and taped together. Medications were inside the taped packet. When asked about the packet, EI#7 explained as follows. RI#2 received medications at 6:00 AM and at 8:00 AM. However, the medications for both times were packaged in the same packet and had to be opened at 6:00 AM to give the doses due at that time and the remaining doses resealed to be given at 8:00 AM. The accepted time frame for administration of a medication was 1 hour before the scheduled time or 1 hour after the scheduled time. All medications in the packet could not be administered at the same time unless they were administered exactly at 7:00 AM. Other residents medications were packaged in the same manner and it was not reasonable for staff to be able to assist with each of the residents' medications exactly at 7:00 AM. The rooster picture on the medication packet indicated early morning medications which were generally scheduled at 6:00 AM. The taped packet contained a rooster picture and was labeled with five medications: Aspirin enteric coated 81 milligrams; Fish Oil 1000/300 milligrams; Magnesium Oxide 400 milligrams; Myrbetriq 50 milligrams; Pantoprazole 40 milligrams. Review of RI#2's physician's orders and MAR revealed the following information. No times were written, in the physician's orders, for the five medications to be administered. RI#2's MAR contained the following scheduled times for the five medications to be given: Aspirin 8:00 AM; Fish Oil 8:00 AM; Magnesium Oxide 8:00 AM; Myrbetriq 6:00 AM; Pantoprazole 6:00 AM. With the method of medication packaging	A 616		

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A 616	Continued From page 44 currently in use at the facility, staff were required to open medications packaged by the pharmacy, determine which medications were to be given at the scheduled time, remove the medications and repackage the medications remaining in the packet. This was an unsafe practice which placed residents at risk of medication errors. This unsafe medication practice was discussed with EI#1, newly hired Administrator, on July 28, 2022. EI#1 stated she (EI#1) was not aware of this practice but stated she (EI#1) had already planned for a new pharmacy to provide medications to residents at the facility. EI#1 further explained the new pharmacy would conduct audits and training for all staff who provided medication assistance.	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	A 617		

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A 617	Continued From page 45 pharmacy, prescription number, date, resident's name and strength of the medication, and the amount. This statement shall be maintained in a file for at least three years. 3. When medications are destroyed on the premises of the assisted living facility, a record shall be made and retained for at least 3 years. This record shall include: the name of the assisted living facility, the method of disposal, the pharmacy, the prescription number, the name of the resident, the name, strength, and dosage of the medication, and the amount and the reason for the disposal. This record shall be signed and dated by the individual performing the destruction and by at least one witness. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to properly document disposal of medications upon discharge of a resident. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON SEPTEMBER 26, 2019. Findings: On July 28, 2022 at 11:20 AM, the surveyor requested the Business Office Manager, EI#3, provide the discharge record for RI#17. The surveyor reviewed the records and could not find the disposal of medications for RI#17. EI#3 told the surveyor RI#17 was discharged on December 21, 2020, to a long term care facility. EI#3 said the family was not happy when RI#17 left and she (EI#3) did not think the family took the	A 617		

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A 617	Continued From page 46 medications with them. The surveyor also reviewed the medication destruction logs with EI#8, Med Tech, but there were no records for RI#17. EI#8 said she (EI#8) was not aware this documentation was to be maintained in a file for at least three (3) years.	A 617		
A 618	420-5-4-.06 (9) Care of Residents. (9) Oxygen Therapy. (a) A resident of an assisted living facility that requires oxygen therapy shall self-manage his or her own oxygen therapy or self-administer his or her own oxygen therapy with assistance of facility staff. A resident that cannot safely self-manage or self-administer his or her own oxygen therapy with assistance shall have oxygen administered only by a physician, RN, or LPN. A resident that cannot direct his or her administration of oxygen and cannot be taught to direct his or her administration of oxygen shall be appropriately discharged. (b) Oxygen use including date, time, rate, and proper function of the equipment shall be documented on the medication administration or medication assistance record at least once per shift unless oxygen therapy is self-managed by the resident. (c) If a resident receives oxygen therapy in a facility: 1. All oxygen equipment, such as tubing, masks, and nasal cannula shall be maintained in a safe and sanitary condition. 2. All oxygen tanks shall be safely	A 618		

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A 618	Continued From page 47 maintained and stored. 3. The facility shall require safe use of oxygen therapy. No smoking and appropriate precautionary signs shall be posted. 4. The facility shall ensure that each resident using oxygen therapy maintains an adequate supply of oxygen. Refer to National Fire Protection Association (NFPA) 99 for oxygen storage requirements. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, residents' oxygen use was not documented by facility staff. Findings: RI#2 had resided at the facility since April 25, 2022. Refer to deficiencies 611 and 616 for additional information on RI#2. RI#3 had resided at the facility since July 22, 2022. Refer to deficiencies 601, 611 and 620 for additional information on RI#3. Both RI#2 and RI#3 used oxygen at the facility and both residents were unable to demonstrate/verbalize correct usage of oxygen. Review of residents' MARs, on July 27, 2022, revealed RI#2 and RI#3 did not have oxygen usage, including date, time, rate and proper function of the equipment, documented on their facility MARs for the month of July 2022. On July 27, 2022, EI#7 informed the surveyor residents' oxygen was not listed on their MARs and the residents' use of oxygen was not documented on their MARs, even though staff assisted with	A 618		

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A 618	Continued From page 48 residents' oxygen usage. On July 28, 2022, EI#1 agreed the oxygen usage should be documented by facility staff on residents' MARs.	A 618		
A 620	420-5-4-.06 (11) (a) Care of Residents. (11) Admission and Retention of Residents. Residents admitted to and retained in assisted living facilities must meet all eligibility and continued stay requirements specified in these rules. (a) Admission 1. An assisted living facility shall not admit any individual who: (i) Is receiving or requires skilled nursing care. (ii) Has a wound that requires care beyond basic first aid. (iii) Lacks the ability to make decisions related to personal safety. (iv) Cannot direct his or her care. (v) Has behaviors that may be dangerous to themselves or others. (vi) Cannot safely self-manage medications or self-administer medications with assistance. (vii) Is receiving or in need of hospice services. (viii) Cannot safely reside in the	A 620		

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A 620	Continued From page 49 facility unless his or her egress from the facility is restricted. (ix) Is diagnosed with acute infectious pulmonary disease, such as influenza, or active tuberculosis, or with other diseases capable of transmission to other individuals through normal person-to-person contact. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility admitted a resident who did not meet the admission criteria for an assisted living facility. Findings: Review of resident records on July 26, 2022 revealed the following information. RI#3 had resided at the facility since July 22, 2022. Refer to deficiencies 601, 611 and 618 for additional information on RI#3. Upon admission to the facility, RI#3 had a gastrostomy tube in place. The following notes were entered in RI#3's facility record: Medical Exam and Plan of Care, dated July 20, 2022, "patient is able to care for PEG tube" (written in a different handwriting than other entries on the Medical Exam); Level of Care Assessment Worksheet, dated July 21, 2022, prior to admission, "Has feeding tube that needs to be cleaned and flushed...has not been shown to clean or flush it, nurse has been doing it, stated...doesn't know how to clean or flush"; ALF Monthly Assessment, dated July 22, 2022, "Resident came in with g-tube intact (not using)...G-tube unassessable". There were no	A 620		

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A 620	Continued From page 50	A 620		

physician's orders for routine flushing of the tube to prevent clogging and no physician's orders for cleaning and care of the tube. It was also noted that the Service Description-Full, dated July 23, 2022, did not address RI#3's gastrostomy tube, even though a section was titled Special Needs Care.

On July 26, 27 and 28, 2022, the surveyor observed RI#3's gastrostomy tube in the upper abdomen. Each day there was a soiled gauze pad around the tube. When interviewed on July 27, 2022, RI#3 stated he/she had not been trained to care for the tube although the paperwork indicated he/she had been taught. RI#3 denied knowing how to clean around the tube, apply a gauze dressing and flush the tube and added he/she had no supplies to perform any care of the tube. RI#3 stated a home health nurse came out after admission to the facility and was supposed to come back to bring supplies, including a syringe for flushing. However, no care was provided to the tube by the home health nurse, according to RI#3. RI#3 also stated a friend (who was a nurse) came to the facility and changed the dressing around the tube one time. RI#3 informed the surveyor he/she had an appointment with the physician in one week and he/she would insist at that time that the tube be removed.

When interviewed on July 26, 2022, EI#7 stated RI#3 did not know how to care for the gastrostomy tube but would probably be able to physically care for the tube if trained and supplies provided.

RI#3's gastrostomy tube required cleaning around the site and maintenance of a gauze dressing as well as monitoring of the open wound (insertion

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A 620	Continued From page 51 site) for signs and symptoms of infection. The tube was not being flushed routinely to prevent clogging. RI#3 was unable or unwilling to verbalize or demonstrate care of the gastrostomy tube. RI#3 was also unable or unwilling to direct the care of the gastrostomy tube. RI#3 was admitted to the facility in need of skilled care which the facility was not licensed to provide and the resident was unable or unwilling to provide or direct the care. On July 28, 2022, EI#1 stated RI#3 had been instructed on care of the gastrostomy tube prior to admission to the facility.	A 620		
A 621	420-5-4-.06 (11) (b) Care of Residents. (b) Retention 1. An assisted living facility shall not allow any resident to return to the assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the facility is licensed to provide or the facility is capable of providing. 2. An assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility. 3. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in an assisted living facility. 4. An assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days	A 621		

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A 621	Continued From page 52 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 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	A 621		

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A 621	Continued From page 53 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. 9. An assisted living facility shall not retain any resident who cannot safely reside in the facility unless his or her egress from the facility is restricted. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility retained a resident who did not meet the criteria for an assisted living facility. Findings: Review of resident records on July 27 and 28,	A 621		

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A 621	Continued From page 54 2022 revealed the following information. RI#5 had resided at the facility since April 19, 2021. Refer to deficiency 604 for additional information on RI#5. RI#5 received dialysis outside the facility three days per week. RI#5 received fingerstick blood sugars and sliding scale insulin twice daily at the facility. On July 18, 2022 the following Resident Note was written in RI#5's facility record: "The resident was encouraged by 5 different staff members to shower prior to going to dialysis...stated at 0813...would later closer to the time of...appointment. It is now 10 AM and resident is still refusing to shower and...ride for dialysis arrives and leaves here at 11 AM...Son arrived at facility and was able to get...up showered and dressed for dialysis...becoming increasingly difficult to provide care...is lying in bed, not getting up to use bathroom and refusing to get up to be cleaned by staff...have spoken to son a few times about this issue. Dialysis center has called and stated that (he/she) got off bus covered in feces or wet several times and they would call for (him/her) to be returned to facility if (he/she) arrives like that again and (he/she) will not get...dialysis. Spoke to son and (resident) about this issue and (he/she) just chuckled and made a joke. Will continue to observe". On July 26, 2022, around 12:15 PM, the surveyor observed RI#5 with EI#7 in RI#5's room. RI#5's room smelled of feces upon entering. RI#5's shirt contained large blood stains which EI#7 stated were from dialysis the day before. RI#5 was in bed and spoke very little. Fingerstick blood sugar had just been checked and insulin given by EI#7, approximately 5 minutes prior to the visit. When questioned about the blood sugar and insulin, EI#5 answered all questions "don't know" and it appeared RI#5 wanted to be left alone. Dried feces were noted on RI#5's heels and bed linens.	A 621		

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A 621	Continued From page 55 On July 26, 2022, around 4:15 PM, the surveyor observed EI#2 check a fingerstick blood sugar and administer insulin to RI#5. At the request of the surveyor, EI#2 asked RI#5 to identify insulin dose. RI#5 opened eyes briefly, glanced at syringe and stated "yeah". RI#5 did not seem to comprehend the task he/she was asked to complete and did not appear interested in participating. RI#5's room again smelled of feces and RI#5 was again in the bed. On the morning of July 27, 2022, EI#11 reported to the surveyor that RI#5 frequently refused baths and assistance with toileting and would leave feces on self. EI#11 also stated RI#5 had refused a bath multiple times that morning prior to leaving for dialysis but eventually let EI#11 assist with bath after being encouraged by son. EI#7 confirmed RI#5 would refuse baths and assistance with toileting and would frequently leave feces on self. RI#5 had repeatedly refused baths and toileting assistance to the extent that RI#5's dialysis treatments were at risk of being canceled. RI#5 participated very little in medication assistance and identification of medications, making it difficult or impossible to determine if RI#5 could protect self from a medication error. This refusal of care by RI#5 placed RI#5 at risk of serious health conditions if dialysis was canceled. In addition, RI#5 was at risk of medication errors and skin breakdown and was in an unsanitary environment. No 30-day discharge notice had been issued to RI#5 at the time of the survey. On July 28, 2022, EI#1 stated the facility would assess RI#5's noncompliance and determine what level of care would be appropriate for RI#5.	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 56	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 57 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 58	A 702		

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.

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A 702	Continued From page 59 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 60	A 702		

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.

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A 702	Continued From page 61 (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 observations and interviews, the facility failed to follow proper food handling procedures in the dining room. Findings: On July 26, 2022 at 12:00 noon, the surveyor observed the care managers (EI#10 and EI#12) engaged in the handling of the food in the dining room. At 12:15 PM, EI#1, Administrator, confirmed the care managers have direct resident contact and should be wearing aprons while serving the food. EI#1 immediately went into the kitchen and provided EI#10 and EI#12 with aprons. The care managers were observed wearing the aprons while in the dining room	A 702		

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A 702	Continued From page 62 throughout the survey.	A 702		
A 703	420-5-4-.07 (3) Food Service. (3) Dietary Service. (a) Number of Meals. No fewer than three meals shall be provided each 24 hours. Food service shall be provided in a resident's room during temporary illness if necessary. The diet shall be well-balanced, palatable, properly prepared, and sufficient in quantity and quality to meet the nutritional needs of the residents in accordance with Dietary Reference Intakes of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The food must be adapted in type and preparation to the habits, preferences, and physical abilities of the residents. (b) Timing of Meals. A time schedule for serving meals to residents and personnel shall be established. Meals shall be served approximately five hours apart with no more than 14 hours between the evening meal and breakfast. The time schedule of meals shall be posted with the menu. The facility shall make evening snacks 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	A 703		

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A 703	Continued From page 63 document the adjustment of its menu to accommodate the resident's needs. (d) Alternate food selections or substitutes shall be made available to all residents. (e) A facility shall not obtain food from charitable organizations. A facility shall not avoid serving a meal by sending or transporting residents to missions, soup kitchens, or other charitable facilities for meals. (f) The amount of food on hand shall be sufficient to serve three meals per day to all residents for 3 days. Non-perishable food and potable water shall be maintained in the facility in sufficient quantity to serve three meals per day to all residents for 3 days. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to offer the residents their food preferences and adapt the menu to their eating habits. In addition, snacks were not consistently served and the residents were not notified of menu changes in advance. Findings: FOOD PREFERENCES and EATING HABITS: During interviews with EI#7, LPN, and EI#8, Med Tech, on July 26, 2022 the surveyor learned there were two (2) residents (RI#10 and RI#11) who frequently requested second helpings.	A 703		

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A 703	Continued From page 64 RI#10 was interviewed on July 26, 2022 at 12:25 PM, while seated in the dining room. RI#10 had cleaned his/her plate and told the surveyor he/she was still hungry. RI#10 ordered a sandwich and it was promptly served by EI#4. RI#10 told the surveyor the kitchen runs out of the food he/she requested at least once a week. RI#10 also stated he/she had to wait about 20 minutes to get a second helping. RI#11 told the surveyor on July 26, 2022, he/she had a big appetite and would request second helpings sometimes. RI#11 told the surveyor he/she was able to get second helpings but sometimes they run out of what he/she requested. RI#11 said this happens about once a week. RI#11 also said the residents have to wait on second helpings until everyone is served. RI#11 explained he/she would get extra food to go so he/she would have food available at night. RI#11 stated he/she would like to have additional vegetable choices. RI#11 explained he/she could not chew the green salad and did not like beets, however, another vegetable option was not on the lunch menu for July 26, 2022. RI#8 and RI#12 were on a consistent carbohydrate diet to control their diabetes. Both residents complained they were tired of fruit cocktail and would like to have something else as a low sugar alternative. The surveyor observed fruit cocktail was offered as the diabetic dessert on July 26 and again on July 27, 2022. RI#4 told the surveyor she/he was a "picky eater" and had trouble finding something to eat from the menu. The surveyor discussed the above concerns with the Culinary Manager, EI#4 on the morning of	A 703		

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A 703	Continued From page 65 July 27, 2022. EI#4 explained she (EI#4) had to estimate the number of entrees to prepare daily and sometimes she (EI#4) did run short on what the residents wanted to eat. SNACKS: During resident and staff interviews the surveyors were told snacks are not readily available after the evening meal. EI#4, Culinary Manager, told the surveyor she (EI#4) prepares a snack cart to be taken around to the residents. However, EI#4 said she recently became aware the agency staff was not retrieving the snack cart from the kitchen and delivering to residents door to door in the evening. MENU CHANGES: The staff and residents informed the surveyor the residents are not notified in advance of menu changes. RI#13 told the surveyor the kitchen does not serve what is on the menu. On July 26, 2022, the Lunch menu listed "Baked Salmon." However, the surveyor observed salmon was not served. EI#4, told the surveyor she (EI#4) substituted catfish for the salmon. EI#4 explained she (EI#4) wrote the substitution on the menu posted in the kitchen but not on the resident's Weekly Menu. On July 28, 2022, EI#1 assured the surveyors these dietary concerns would be addressed with EI#4 and changes would be made to suit the residents food habits and preferences.	A 703		
A 804	420-5-4-.08 (4) Physical Facilities. (4) Food Service Facilities.	A 804		

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A 804	Continued From page 66 (a) Floors. Floors in food service areas shall be of such construction as to be easily cleaned, sound, smooth, non-absorbent, without cracks or crevices, and shall be provided with approved and conveniently located facilities for the disposal of floor wash water. (b) Walls and Ceilings. Walls and ceilings of food service areas shall be of tight and substantial construction, and smoothly finished. The walls and ceilings shall be without horizontal ledges and shall be washable up to the highest level reached by splash and spray. Roofs and walls shall be maintained free of leaks. All openings to the exterior shall be provided with doors or windows which prevent the entrance of rain or dust during inclement weather. (c) Screens or Outside Openings. Openings to the outside shall be effectively screened, or suitable provisions made equal to screening (such as fly fans). Screen doors shall be equipped with self-closing devices. (d) Lighting. The kitchen, dishwashing area and the dining room shall have adequate light. (e) Ventilation. Vent/exhaust hoods, vented to the outdoors, shall be provided over cooking surfaces to aid in removing cooking odors. Existing recirculating vent hoods in Family facilities may remain in use when filters are cleaned or replaced regularly to prevent excess grease accumulation. Group assisted living facilities with residential stoves may use a residential hood sized for the stove. Commercial exhaust hoods shall be installed when	A 804		

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A 804	Continued From page 67	A 804		

commercial cooking equipment is used. Congregate facilities shall use a commercial exhaust hood system.

(f) Employee Toilet Facilities. Toilet rooms, if provided, shall not open directly into any room or space in which food is prepared, stored, displayed, or served, nor into any room in which utensils are washed or stored. Toilet rooms shall include a lavatory and shall be well lighted and ventilated.

(g) Hand Washing Facilities. Each Group and Congregate assisted living facility shall provide a hand washing lavatory in the kitchens which shall be equipped with a soap dispenser and a supply of soap, disposable towels, and hot and cold running water through a mixing valve or combination faucet. The use of a common towel and common bar soap is prohibited. Hands shall not be washed in sinks where food is prepared. Existing Group and Congregate facilities that enlarge or renovate kitchens shall install a hand wash sink.

(h) Refrigeration Facilities. Adequate refrigeration facilities, automatic in operation for the storage of perishable foods shall be provided. Refrigeration shall be maintained at 41 degrees Fahrenheit or less. All refrigerators shall be provided with thermometers. All refrigerators shall be kept clean.

(i) Equipment and Utensil Construction. Equipment and utensils, except single service utensils, shall be so constructed as to be easily cleaned and shall be kept in good repair. No cadmium plated, lead, or readily corrodible utensils or equipment shall be used.

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A 804	Continued From page 68 (j) Separation of Kitchen from Resident Rooms and Sleeping Quarters. Any room used for sleeping quarters shall be separated from the food service area by a solid wall with no direct openings. Sleeping accommodations shall not be permitted within the food service area. (k) Clean Rooms. Floors, walls, and ceilings of rooms in the food service area shall be clean and free of an accumulation of rubbish, dust, grease, dirt, etc. (l) Clean Equipment. Equipment in the food service area shall be clean and free of dust, grease, dirt, etc. (m) Clean Counters, Tables, Tablecloths, and Napkins. Tables and counters, which are used for food service, shall be kept clean. Tablecloths and cloth napkins shall be laundered after each use. (n) Location and Space Requirements. Food service facilities shall be located in a specifically designated area and shall include the following rooms and space: kitchen, dishwashing, food storage, and dining room. (o) Equipment. Minimum equipment in the kitchen shall include the following: 1. Range. In a Family or Group assisted living facility, a residential use range is permitted. A Congregate assisted living facility shall have a heavy-duty range suitable for institutional use with double oven, or equivalent.	A 804		

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A 804	Continued From page 69 2. Refrigerator. A Family or Group assisted living facility may use a residential refrigerator. A Congregate assisted living facility shall have a heavy duty refrigerator suitable for institutional use. 3. Fire extinguisher. A five-pound type BC for residential hoods, and K type for commercial hoods. 4. Dishwashing. The dishwashing equipment for Family and Group assisted living facilities shall be either residential type using cold water sanitizers or commercial type with a booster water heater. Dishwashing equipment for all Congregate assisted living facilities shall be commercial type using a booster water heater or an automatic dispensing sanitizing chemical system. 5. A three-compartment sink with a booster heater or chemical sanitizing system for the third compartment shall be provided in Congregate assisted living facilities. 6. Garbage cans with cover. (p) Food Storage. A well-ventilated, cool food storage room, pantry, or cabinets shall be provided. Adequate shelving, bins, suitable cans, and raised platforms shall be provided and kept clean. Perishable food shall be stored at least six inches above the floor. The storeroom shall be of such construction as to prevent the invasion of rodents and insects, the seepage of dust and water, leakage, or any other source of contamination. (q) Dining Room. A resident dining room,	A 804		

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A 804	Continued From page 70 or rooms, shall be provided which is large enough to seat not less than 100 percent of the bed capacity. (r) Water Heating Equipment. Equipment for heating an ample supply of water, under pressure, for all washing purposes shall be provided. Hot water shall be piped to all hand-washing facilities, and to each compartment of all dishwashing and laundry sinks. Water heaters shall be automatic type. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to keep the beverage counter and cabinets clean and in good repair in the dining room. Findings: The surveyor inspected the food service area on July 26, 2022. The top of the beverage counter had dark colored grime all along the edges and inside the corners. The water source tubing to the coffee maker had a white residue and dark grime on it. There was a pull out upper cabinet draw that was broken and had a dark moldy appearance inside of it. A lower cabinet door was cracked and peeling from what appeared to be water damage. On July 28, 2022, this was brought to the attention of EI#1, Administrator. EI#1 stated she (EI#1) was already aware of the unacceptable condition of the counter top and cabinets and she (EI#1) said plans were being made to tear them out and will be replaced.	A 804		

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A 901	Continued From page 71	A 901		
A 901	420-5-4-.09 (1) (2) Laundry.	A 901		

(1) General.

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

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

(2) Location and Space Requirements.

(a) Each assisted living facility shall have laundering facilities unless commercial laundries are used. An on-site laundry shall be located in a specifically designated area, and there shall be adequate rooms and spaces for sorting, processing, and storage of soiled material. Laundry rooms in Group and Congregate facilities shall not open directly into resident rooms or food service areas. Domestic washers and dryers which are for the exclusive use of residents may be provided in resident areas, provided they are installed in such a manner that they do not cause a sanitation problem or offensive odors.

(b) Each assisted living facility shall have a system in place to keep clean linen and dirty linen separated and to prevent the reuse of dirty linen before it is cleaned. Dirty linens and clothing shall not be stored, even temporarily, in the area set aside for clean linen.

(c) Ventilation of Laundry. Provisions shall be made for proper mechanical ventilation

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A 901	Continued From page 72 of the laundry, if located within the assisted living facility. Provisions shall also be made to prevent the re-circulation of air in commercial equipment laundries into the heating and air conditioning systems outside the laundry area. (d) Lint Traps. Adequate, effective, and clean lint traps shall be used in all dryers. This Rule is not met as evidenced by: Based on observations and interviews, the residents' laundry room did not have working dryers. Findings: During the initial tour of the facility on the morning of July 26, 2022, the surveyor observed a laundry room used only by the residents. A resident was in the laundry room at the time and she/he told the surveyor some residents prefer to do their own laundry. The room had two (2) washing machines and two (2) dryers. However, one (1) dryer had an "out of order" sign on it and the other dryer had the knob pulled off. The afternoon of July 26, 2022, RI#12 told the surveyor he/she tried to fix the out of order dryer but was unsuccessful. The surveyor brought this to the attention of EI#1 and the next day EI#1 told the surveyors one (1) of the dryers had been repaired.	A 901		
A1001	420-5-4-.10 (1) Sanitation and Housekeeping. (1) Sanitation.	A1001		

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A1001	Continued From page 73 (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 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	A1001		

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A1001	Continued From page 74	A1001		

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.

(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.

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A1001	Continued From page 75 (g) Control of odors. The facility shall be free of objectionable odors. This Rule is not met as evidenced by: Based on observations and interviews, the facility was not kept free from objectionable odors. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint on June 27, 2022, from an anonymous employee that alleged a resident (RI#9) had a strong smell of urine in her/his room and out into the hallway. The surveyors were able to substantiate this complaint. On July 26, 2022, the surveyor visited with RI#9 in her/his room. RI#9's sitting room and bedroom had a strong smell of urine. RI#9 told the surveyor she/he believed the smell was coming from the dirty carpet in the hallway. The surveyors were told by other residents the smell was drifting into the hallway and it was very offensive to them. The surveyors also learned from employee interviews RI#9 would urinate on herself/himself and would refuse to bathe and change clothes as needed. EI#1, Administrator, told the surveyors she (EI#1) was aware of this problem and had already started to address it with RI#9 and her/his family. In addition, RI#5 had a smell of feces in her/his room each time the surveyor visited during the onsite survey. Refer to deficiencies 604 and 621	A1001		

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A1001	Continued From page 76 for additional information on RI#5. Staff reported to the surveyors that RI#5 was noncompliant with bathing and toileting and would leave feces on self. Dried feces was noted on RI#5 as well as on RI#5's bed linens during the onsite survey. On July 28, 2022, EI#1 stated she (EI#1) was unaware of RI#5's noncompliance and odors but would address the issue.	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 supplies. (b) Bathtubs and Lavatories. Bathtubs and lavatories shall be kept clean and in proper working order, and shall not be used for laundering. (c) Resident Bedrooms. Resident bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance. (d) General Storage. 1. Broken beds, extra mattresses, mop buckets, and dust rags shall not be kept in hallways, closets, corners, or occupied resident rooms. Such items must be stored neatly and orderly in designated storage rooms.	A1002		

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A1002	Continued From page 77 2. The use of attics for storage of combustible materials shall be prohibited unless protected by an automatic sprinkler system and then only in small quantities so as not to create a hazardous condition. 3. Basements used for storage shall meet acceptable standards for storage and shall be designed and constructed in a manner that protects against fire hazards. 4. Flammable materials such as gasoline, motor fuels, lighter fluid, turpentine, acetone, and oil-based paint shall not be stored in the facility. Unless prohibited by a facility's own policies, however, a cognitively intact resident who uses lighter fluid to fill a personal cigarette lighter, or one who uses flammable materials such as paint or glue in connection with a personal hobby, may store small quantities of those materials in a safe and secure manner within his or her own room. 5. Poisonous or External Use Substances. Facility cleaning supplies and poisons shall be attended at all times or shall be kept in a secure area. This Rule is not met as evidenced by: Based on observations and interviews, housekeeping and maintenance failed to provide services necessary to maintain a sanitary and comfortable interior for the residents. In addition, poisonous substances were not kept secure at all times. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.	A1002		

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A1002	Continued From page 78 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON SEPTEMBER 26, 2019. Findings: The Alabama Department of Public Health received complaints from residents, family members, and employees that alleged the facility was dirty and not being cleaned by housekeeping. Surveyors were able to substantiate these complaints during the onsite survey. Numerous housekeeping and maintenance issues were found. Housekeeping/Maintenance Deficiencies: Several dead bugs were seen in a resident's kitchen sink and bathroom. On July 26, 2022, RI#9 told the surveyor they had been there for several days. The entire laundry room floor was dirty in need of sweeping and mopping. The tile floor had a black sticky residue. Boxes and crates were stored on the floor. The vent on the ceiling was coated in dust. The carpet outside the laundry room was saturated with water. On July 26, 2022 at 9:00 AM, EI#8, Med Tech, told the surveyor she (EI#8) thought the water was coming from the ceiling where the air condition unit had stopped up and overflowed on the carpet. EI#8 also said this water problem had occurred last week as well. EI#8 placed a standing sign warning "Caution Wet Floor" on the wet carpet. The ceiling outside the laundry room had water	A1002		

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A1002	Continued From page 79 stains and was peeling. The carpet in resident rooms 60, 82 and 83 was stained and in need of cleaning. The carpet throughout the entire facility was badly stained. EI#1 acknowledged the carpet in the facility was unacceptable and new "flooring" had been ordered and was expected to be installed in September 2022. Unsecured Poisonous Substances: During the initial tour on the morning of July 26, 2022, the surveyor observed the housekeeping storage room and employee laundry room doors wide open. The signage on the door read, "Employee Laundry Please Keep This Door Locked At All Times." The surveyor saw cleaning supplies on the housekeeping cart and large containers (5 gallon) of concentrated detergents (liquid oxygen bleach) in the laundry room. The laundry product was labeled as a dangerous hazardous substance. The surveyor showed the open doors and unsecured chemicals to EI#12, Care Manager, and she (EI#12) told the surveyor the doors are supposed to be closed.	A1002		
A1101	420-5-4-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place.	A1101		

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A1101	Continued From page 80 (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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A1101	Continued From page 81 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. This Rule is not met as evidenced by:	A1101		

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A1101	Continued From page 82 Based on record reviews and interview, the sprinkler system had not been inspected at least semiannually. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON SEPTEMBER 26, 2019. Findings: The facility's fire and safety documentation was reviewed on July 27, 2022. The sprinkler system had not been inspected for the current year 2022. The last sprinkler inspection report on file was nine (9) months ago on October 4, 2021. EI#1 acknowledged the systems were to be inspected at least twice a year and stated she (EI#1) would schedule an inspection with the sprinkler company as soon as possible. CONNIE CHERRY, REGISTERED NURSE DEBRA FREEMAN, REGISTERED NURSE	A1101		