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	D4985	A. BUILDING: _____ B. WING _____	07/24/2018

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GOLDEN ACRES	6411 HOWELLS FERRY MOBILE, AL 36606

(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 24, 2018, an unannounced licensure survey was completed for this 16 bed Assisted Living Facility with a census of 3. There were no complaints investigated during this survey. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities (ALF). The widespread deficiencies cited pose a significant risk of harm to the residents.	A 000		
A 301	420-5-4-.03 (1)(a)(b) Administration The Assisted Living Facility Governing Authority. (a) An assisted living facility shall have an identified sole proprietorship, corporation, partnership, limited partnership, or other business entity that is its governing authority, or it shall have a designated individual or group of designated individuals who serve as its governing authority. The governing authority shall be responsible for implementing policies for the management and operation of the facility, and for appointing and supervising the administrator who is responsible for overall management and the day-to-day operation of the facility. In family and group assisted living facilities, the governing authority and the administrator may be the same individual. A facility must give complete information to the Department identifying: 1. Each person who has an ownership interest of	A 301		

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A 301	Continued From page 1 ten percent or more of the governing authority; 2. Each person or entity who has an ownership interest of ten percent or more in the real property or building used by the assisted living facility to offer its services; 3. Each officer and each director of the corporation if the governing authority is a corporation; and 4. Each partner, including any limited partners, if the governing authority is a partnership. (b) The governing authority shall submit any changes to the information listed above to the Department within 15 days of the change. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the Governing Authority [Employee Identifier (EI) #1] and the Administrator (EI#2), failed to ensure the facility operated in compliance with the SBOH rules for assisted living facilities (ALF). The administrator failed to adequately perform his duties as administrator to ensure the facility was managed responsibly. This failure resulted in: retention of ineligible residents whose level of care exceeded the facility's capabilities, poorly trained staff, the use of unnecessary physical restraints, the inability to meet residents' care and safety needs, the lack of resident care plans, failure to have resident's care directed by a physician, unsafe medication management, and the failure to maintain a safe environment from poisons and fire which could result in significant harm or death. These widespread failures placed all three (3) residents at significant risk for harm due to the governing	A 301		

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authority and the administrator's widespread failure to apply the rules for the day to day operations of the facility.

Findings:

MISLEADING INFORMATION

On July 10, 2018, EI#1 told the surveyor the facility's fire alarm was struck by lightning "a few days ago." According to the fire alarm contractor the fire alarm was repaired with a new circuit board on June 26, 2018, more than two weeks before the survey.

On July 10, 2018, at 12:12 PM, the surveyor requested a list of current employees, with their titles, and contact information. The surveyor also requested an employee schedule for the current week. EI#1 told the surveyor the schedule was in her computer and that she would print it out. At 5:30 PM, that same day EI#1 agreed to have the previously requested employee list and schedule available the next morning when the surveyor returned. On July 11, 2018, at 10:00 AM, the employee list and schedule were still not available. The surveyor gave EI#1 a final opportunity to provide information by 4:30 PM that same day. EI#1 finally provided a schedule for the current week and a partially completed employee list.

On July 11, 2018, EI#1 and the surveyor reviewed the records for Resident Identifier (RI)#1 and RI#3. EI#1 told the surveyor that the facility had Mercy Life contracts specifically for RI#1 and RI#3. When the surveyor requested a copy of the Mercy Life contract for each resident (RI#1 and RI#3), EI#1 told the surveyor she would get them, but only provided the surveyor with the contract

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between the facility and Mercy Life. The contract was not specific for any particular resident. There were no resident specific contracts provided during the survey.

On July 11, 2018, EI#1 broke the pull station door off of one of the pull stations when she tried to reset the fire alarm. EI#1 contacted the fire alarm contractor to replace the broken fire pull and reset the system. EI#1 told the surveyor that "(the contractor) would probably be out to fix the fire alarm system that day (July 11, 2018) or the next (July 12, 2018)." On July 19, 2018, the surveyor arrived at the facility to find the fire alarm pull station door was still broken, and the fire alarm panel was still in trouble with the same pull stations that had been activated on July 11, 2018.

The following deficiencies were identified as a result of the governing authority's lack of oversight and the administrator's failure to apply the State Board of Health's (SBOH) rules for the day to day operations of the facility.

302 - Administration did not implement and facility staff did not demonstrate adequate knowledge of the facility's policies and procedures.
402 - Employees did not have physical examinations prior to working with residents.
403 - Employees were not screened for a history of abuse with the Nurse Aide Registry.
404 - The facility did not have employee files for all current and previous employees.
406 - The administrator did not perform his duties for the day to day operation of the facility.
408 - Staff did not demonstrate adequate training.
409 - The facility did not schedule a CPR (Cardiopulmonary Resuscitation) certified staff member on each shift.

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A 301	Continued From page 4 410 - All training records did not include attendance signature records. 411 - The administrator did not ensure that staff received all required training. 501 - Staff did not have access to necessary resident records to ensure appropriate care of residents. 502 - Facility records were not maintained in an orderly manner. 506 - Resident records did not contain all required documents. 507 - The facility did not have financial agreements for all residents. 508 - Admission records were not available in all resident records. 509 - The facility did not have complete physician medical examinations within 30 days of admission for each resident. 510 - Resident records did not contain care plans or adequate monthly assessments. 511 - Transfer plans were not documented in the resident records. 512 - Procedures to follow in the event of accident, serious illness, or death were not documented in the resident records. 517 - The facility did not report malfunctions of the fire alarm system to the ADPH within 24 hours of the incidents. 519 - A signed copy of the resident's rights was not filed in each resident's record. 521 - All residents were not provided with a safe and decent environment. 522 - The facility did not honor the Resident's right to be treated with respect and recognition of individuality. 529 - Facility staff did not provide care consistent with established community standards. 542 - The Resident's right to freely come and go was not honored. 601 - Physician orders were not obtained and	A 301		

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A 301	Continued From page 5	A 301		

followed for all resident care and safety.
603 - Residents required care beyond the capabilities of the facility's license.
604 - Unnecessary physical restraints were used for residents.
609 - All residents were not screened for tuberculosis before admission into the facility.
610 - The facility did not have precautionary signs posted for oxygen use and storage.
612 - There were no staff initiated activities observed during the survey.
617 - The facility did not identify residents who could not protect themselves from medication errors.
618 - Unlicensed staff split resident's medications.
619 - The facility allowed unlicensed staff to administer medications to residents who were severely cognitively impaired.
623 - All medications maintained in the facility's custody were not unit dose packaged.
624 - The facility did not have an accurate system in place for monitoring controlled medications kept in the facility's custody.
628 - Poisons and chemicals were not secured or supervised at all times.
629 - The facility admitted and retained a resident who was severely cognitively impaired.
705 - Food and food ingredients were not properly handled to prevent contamination.
710 - Food was not served at proper temperatures to prevent food borne illness.
720 - Menus were not posted or followed.
819 - The kitchen did not have a working range.
1101 - The facility did not have documentation that fire drills were completed for the past year.
1205 - The facility did not provide adequate lighting in the common areas for all residents.
1207 - Emergency lights were not maintained to ensure proper function in the event of an

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A 301	Continued From page 6 emergency. 1213 - Facility staff did not visually check all fire extinguishers each month. 1214 - The facility call light system was not accessible to residents at all times or loud enough to be heard throughout the facility. 1217 - The fire alarm system was not properly maintained to ensure that all components were functioning properly in the event of a fire. The fire alarm and sprinkler systems were not inspected and maintained at least semiannually as required. There were no documented fire alarm or sprinkler inspections available at the time of the survey. 1219 - All EXIT lights were not maintained to ensure proper function in the event of an emergency. 1221 - The smoke barriers were not properly sealed around penetrations by ductwork.	A 301		
A 302	420-5-4-.03 (1)(c)(d) Administration (c) Policies. An assisted living facility shall establish and implement written policies and shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). Policies shall cover the following: 1. How allegations of abuse, neglect, and exploitation will be handled by the facility. 2. Admission and continued stay criteria. 3. Discharge criteria and notification procedures for residents and sponsors. 4. Facility responsibility when a resident's	A 302		

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A 302	Continued From page 7 personal belongings are lost. 5. What services the facility is capable and not capable of providing. 6. Medication assistance. 7. Meal service, timing, menus and food preparation, storage, and handling. 8. Fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness. 9. Staffing and conduct of staff while on duty. (d) Relationship of Staff to Governing Authority. The administrator, medical staff, facility personnel, and all auxiliary organizations shall be directly or indirectly responsible to the governing authority. This Rule is not met as evidenced by: Based on observation, record review, and interview, the governing authority/administration failed to implement and the facility staff failed to demonstrate adequate training regarding the facility's policies and procedures. Findings: During the survey completed on July 24, 2018, the surveyor observed the following policies and procedures were not implemented by administration or demonstrated by facility staff.	A 302		

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A 302	Continued From page 8 Employee files were not developed and maintained for current and previous employees. - deficiency #404 Employees did not have documentation of physical exams prior to resident contact. - deficiency #402 Employees did not receive the required initial training and training documents were not filed in the employee files.- deficiency #408 Employees were not screened on the Nurse Aide Registry Abuse List with documentation filed in the employee file.- deficiency #403 Employee schedules were not posted.- deficiency #404 CPR (cardiopulmonary resuscitation) certified staff were not scheduled on each shift.- deficiency #409 A malfunction of the fire alarm system was not reported to ADPH within 24 hours of the incident.- deficiency #517 Fire extinguishers were not visually checked monthly.- deficiency #1213 Resident records were not developed and updated. - deficiency #506 The fire alarm system was not inspected at least semiannually and maintained as required.- deficiency #1217 The sprinkler system was not inspected/maintained as required at least semiannually.- deficiency #1217 The fire alarm and sprinkler inspections were not maintained onsite.- deficiency #1217 Fire drills were not conducted and documented monthly.- deficiency #1101 Evacuation plans were not posted in each smoke compartment. - deficiency #1101 Emergency lights were not maintained.- deficiency #1207 Residents did not have complete physician medical exams within 30 days of admission to the	A 302		

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A 302	Continued From page 9 facility.- deficiency #509 Residents were not assessed/monitored monthly for weight, falls, elopements, adverse medication reactions, behaviors, or medication awareness. - deficiency #510 Residents' care and safety needs were not identified and staff were not provided with care plans/guidance necessary for the care and safety of all residents - deficiency #510 Physician orders were not obtained and followed.- deficiency #601 Controlled medications were not properly accounted for.- deficiency #624 Medications were not documented, assisted, handled, or stored. - deficiency #617, #618, and #623. Activity calendars were not posted and staff initiated activities were not provided. - deficiency #612 Menus were not posted or followed.- deficiency #720 Food was not handled, cooked, or served, in a manner to prevent food borne illness.- deficiency #705 and #710 Precautionary oxygen signs were not posted.- deficiency #610 Cognitively impaired residents were admitted and retained.- deficiency #629 Unlicensed staff administered medications.- deficiency #619 Residents who could not protect themselves from medication errors were not identified and did not have nurse administered medications until the resident could be trained or discharged.- deficiency #510 and #617 Resident rights were not honored.- deficiency #519, #521, #522, #529, and #542. Please refer to the deficiency numbers above for additional information.	A 302		

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A 402	420-5-4-.04 (1)(a) Personnel and Training Employee Screening. 1. Prior to any resident contact, 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. 2. Prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis. 3. Vaccines. Assisted living facilities shall immunize employees in accordance with current recommended CDC guidelines. Any particular vaccination requirement may be waived or delayed by the State Health Officer in the event of a vaccine shortage. 4. Employees who develop signs or symptoms of infectious skin lesions or diseases that would be capable of transmission to residents through normal staff to resident contact shall not be permitted to have resident contact until free from such signs and symptoms. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that employees had physical examinations prior to working with residents.	A 402		

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A 402	Continued From page 11 Findings: On July 11, 2018, at 11:00 AM, the surveyor requested the current employee files from EI#1. EI#1 told the surveyor there were no paper files, all of the employee files were kept in her computer and stored digitally on "Dropbox". EI#1 was given until 4:30 PM to produce the employee files and other requested documents that were stored in her computer. On July 11, 2018, at 5:00 PM, EI#1 did not provide the surveyor with any employee physical examinations to review for any of the current or past nine (9) employees requested. EI#1 told the surveyor that she did not have enough time to print out all the requested documents.	A 402		
A 403	420-5-4-.04 (1)(b) Personnel and Training 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 review and interview, the facility did not screen all employee's for a history of abuse through the Nurse Aide Registry. Findings:	A 403		

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A 403	Continued From page 12 On July 11, 2018, at 11:00 AM , EI#1 was asked to provide employee files for all the current facility employees. EI#1 provided a few documents on a few of the current employees. EI#1 did not include any documentation from the Nurse Aide Registry showing the current employees were screened for a history of abuse. At 5:00 PM that same day, EI#1 told the surveyor that she did not have enough time to print out everything on all of the employees.	A 403		
A 404	420-5-4-.04 (1)(c)(d) Personnel and Training (c) Personnel Records. An assisted living facility shall maintain a personnel record for each employee. This record shall contain: 1. An application for employment which contains information regarding the employee's education, training, experience, date of hire, and, if applicable, registration and licensure. 2. Record of required physical examinations and vaccinations. 3. Date employment ceased. (d) Employee Schedule. An assisted living facility shall post a schedule of employees indicating names and days and hours scheduled to work. This schedule shall be retained in the facility for three weeks after use.	A 404		

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A 404	Continued From page 13	A 404		

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the facility did not have an employee schedule posted and also failed to have employee files for all current and previous employees.

Findings:

On July 10, 2018, at 12:12 PM, the surveyor requested a list of current employees with their titles and contact information. The surveyor also requested a schedule for the current week. EI#1 told the surveyor that the schedule was in her computer and she would have to print it out. At 5:30 PM, that same day, EI#1 agreed to have the previously requested employee list available the next morning when the surveyor returned.

On July 11, 2018, at 10:00 AM, the employee list and schedule were still not available.

After repeated requests for information, the surveyor told EI#1 that she had until 4:30 PM on July 11, 2018, to provide the information requested by the surveyor or the surveyor would have to cite the facility as not having the information available. EI#1 agreed.

At 4:30 PM, the surveyor received a schedule, an incomplete employee list and some partial employee records for four (4) of the nine (9) current employees (employed as of July 11, 2018).

EI#1 provided the following employee file documents for the surveyor to review:

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A 404	Continued From page 14 EI#5 - a food handler's certificate, tuberculosis (TB) screening, CPR certificate set to expire in October 2018, and a certificate that EI#5 completed nursing assistant training in July 2009. EI#6 - a food handler's certificate, tuberculosis (TB) screening (no date on EI#6's TB Screen), and a CPR certificate set to expire in October 2019. EI#1 told the surveyor that EI#8 and EI#9 no longer worked at the facility. EI#1 showed the surveyor documents printed from the Alabama Board of Nursing website showing that EI#3 and EI#4 were registered nurses (RNs). There was a contract with EI#4 for marketing type duties. There were no other documents for the RNs' employee records. EI#1 showed the surveyor a document printed from the Dietician licensing website showing that the facility dietician was licensed. EI#1 could not provide a contract for the dietician. EI#1 told the surveyor that she could not find the dietician's contract in her email. EI#1 told the surveyor that there were no printed employee files, they were on her computer and she could print them out. However, on July 11, 2018 at 5:00 PM, EI#1 told the surveyor that there were no employee files available for EI#1 (assistant administrator), EI#2 (administrator), EI#4 (registered nurse), EI#7 (caregiver), or EI#8 (caregiver). EI#1 also did not offer to show the surveyor the employee files stored on EI#1's computer.	A 404		

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A 406	Continued From page 15	A 406		
A 406	420-5-4-.04 (3) Personnel and Training The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. Any individual employed as an administrator shall meet all applicable statutory requirements. 2. There must be an individual authorized in writing to act for the administrator during absences. 3. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting. 4. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when needed. 5. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan. 6. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner. (b) The administrator and any individual authorized to act as a substitute shall be at least nineteen years of age.	A 406		

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A 406	Continued From page 16 (c) The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character. This Rule is not met as evidenced by: Based on observation, record review, and interview, the administrator did not perform his duties for the day to day operation of the facility, placing all three residents at risk for significant harm and even death. Findings: On July 10, 11, and 19, of 2018, the surveyor observed that EI#2 was not in the facility during any of the survey days. The surveyor observed that staff were inadequately trained to provide the care and services the residents required. A safe and decent environment was not provided. Infection control practices were not followed. Medications were not safely managed. Residents were physically restrained unnecessarily. Residents rights were not honored. Employee and resident records were poorly developed and not kept up to date. Staff were not provided with care plans and the guidance required to ensure that resident care and safety needs were met. On July 12, 2018, EI#2 told the surveyor that he had not accepted the administrator position with the intention of performing the day to day operations of the facility, those responsibilities had been delegated to EI#1. EI#2 only intended to fill the administrator position to help keep the facility in compliance with the rules, "it was not intended to be a long term situation." EI#2 "tried to get there (to the facility) monthly." EI#2 told the surveyor that he had not been in the facility for	A 406		

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A 406	Continued From page 17 approximately the last 60 days. EI#2 told the surveyor that he spoke with EI#1 on the phone weekly and sometimes more frequently if necessary. EI#2 could not tell the surveyor why or how long the facility fire alarm system had been in trouble, but they paid a contractor to take care of the fire alarm. EI#2 told the surveyor that he looked at employee and resident records for compliance during his visits. EI#2 told the surveyor that the nurse was responsible for determining which residents were admitted to the facility. On July 19, 2018, many of the concerns identified and discussed with EI#1 on July 10 and 11, 2018, had not been addressed. There were still unsecured poisons and chemicals on the porch, in the laundry room, the kitchen, and left hall closet. The fire alarm system was still in trouble with the same two pull stations which had been activated on July 11, 2018, during the fire drill. The foyer pull station was still broken. Later that same morning the fire alarm contractor arrived after receiving a call from the facility. The contractor told the surveyor that he had not planned on coming to the facility until he was notified by the facility, that "the state" was in the building. The contractor told the surveyor that he was there to bypass the broken pull station and reset the fire alarm panel. The contractor told the surveyor that he would return on Tuesday July 24, 2018, to replace the broken fire pull station.	A 406		
A 408	420-5-4-.04 (4)(b) Personnel and Training All staff who have contact with residents, including the administrator, shall have initial training and refresher training, as necessary. The	A 408		

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A 408	Continued From page 18 following subject matter areas shall be covered: 1. State law and rules on assisted living facilities. 2. Identifying and reporting abuse, neglect and exploitation. 3. Special needs of the elderly, mentally ill, and mentally retarded. 4. Basic first aid. 5. Advance Directives. 6. Protecting resident confidentiality. 7. Safety and nutritional needs of the elderly. 8. Resident fire and environmental safety. 9. Identifying signs and symptoms of dementia. This Rule is not met as evidenced by: Based on observations, record review, and interview, the facility staff failed to demonstrate adequate training for resident care and safety. Findings: On July 10, 11, and 19 of 2018, the surveyor observed that the employees required additional training in the following areas: Food handling - the facility did not have a working range; facility staff did not have a food thermometer available to check food cooking/serving temperatures and EI#5 did not know the proper serving temperatures for the resident's food, which placed the residents at	A 408		

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A 408	Continued From page 19 significant risk for food borne illness. Infection control- EI#1 and EI#5 did not change gloves or wash their hands in accordance with community standards when handling resident medications which resulted in contamination of the resident's oral medication. Medication management- staff did not have an accurate system in place for monitoring controlled medications which resulted in missing medications being unaccounted for; all medications were not in unit dose packaging which promoted medication errors by unlicensed staff; oral, topical, nasal, and eye medications were all stored together in the same area of the medication cart which promoted cross contamination; medication administration records were not accurate which would lead to missed medications and medication errors; medications were split without resident direction; medications were administered to cognitively impaired residents by unlicensed staff; residents could not protect themselves from medication errors; and residents were not given the opportunity to protect themselves from medication errors. All of these training deficiencies placed the residents at a significant risk for medication errors, medical health complications, and harm. Employee records were not developed or completed which placed the residents at significant risk for harm from abuse, neglect, or even death. Resident records were not developed or updated which placed the residents at significant risk for harm, neglect, or even death. Fire safety- fire drills were not documented or	A 408		

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A 408	Continued From page 20 completed; evacuation plans were not posted; fire extinguishers were not visually checked monthly; fire alarm and sprinkler inspection reports were not kept onsite; emergency lights were not maintained; fire alarm and sprinkler systems were not inspected and maintained every six months. All of these could result in delayed evacuation of the facility in the event of a fire or emergency and a significant risk for harm and death. Poison control/safety- poisons and chemicals were not supervised or secured at all times which could result in significant harm or death. Activities - no activity calendars were posted, no supplies were observed, and no activities were initiated by staff during the survey, which can lead to resident boredom, signs/symptoms of depression, weight loss and harm. Oxygen safety- precautionary signs were not posted, which could lead to fire, harm, and death. General observation of residents- resident records did not document monthly weights, medication awareness, falls, elopements, adverse medication reactions, and significant changes in health status which could result in neglect, significant harm or death. For additional information please refer to the following deficiencies: #510, #521, #529, #601, #603, #604, #610, #612, #617, #618, #619, #624, #628, #629 #705, #710, #1101, #1207, #1213, #1217, and #1221,	A 408		
A 409	420-5-4-.04 (4)(c) Personnel and Training An assisted living facility shall be staffed at all	A 409		

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A 409	Continued From page 21 times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR). 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 as acceptable for EMS personnel 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. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure there was a CPR (Cardiopulmonary Resuscitation) certified staff member scheduled on each shift. Findings: On July 11, 2018, the employee schedule was reviewed with EI#1, the surveyor noted that there was only one staff member scheduled on each shift. On July 11, 2018, the surveyor requested to review all current employee files. EI#1 told the surveyor the files were stored digitally in her computer. EI#1 told the surveyor later that same	A 409		

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A 409	Continued From page 22 day that she did not have time to print out the files for EI#7 or EI#8. Therefore, EI#1 was not able to provide documented evidence that EI#7 and EI#8, both of whom had worked alone on the 11:00 PM to 7:00 AM shift, were CPR certified.	A 409		
A 410	420-5-4-.04 (4)(d) Personnel and Training Documentation of all staff training to include attendance records shall be maintained. This Rule is not met as evidenced by: Based on record review and interview, the facility did not ensure that all training included attendance records. Findings: On July 11, 2018, EI#1 presented the surveyor with some training documents dated March 2018. EI#1 told the surveyor that the documents were proof that EI#2 had provided training to employees when he visited. There were no attendance records included with the training documents. EI#1 told the surveyor that they didn't require the staff to sign an attendance record. The surveyor explained that the training documents didn't show which employees received the training. EI#1 sat down to her computer, typed up some names, printed out the list, and handed the list of names to the surveyor. EI#1 told the surveyor the list of names were the employees who attended the training session in	A 410		

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A 410	Continued From page 23 March 2018 with EI#2.	A 410		
A 411	420-5-4-.04 (4)(e) Personnel and Training Administrator Accountability. The facility administrator is responsible for ensuring that required training is provided to all members of the facility staff. This Rule is not met as evidenced by: Based on record review and interview, the administrator failed to ensure that staff received all required training. Findings: On July 11, 2018, the surveyor requested to review the employee files for each of the facility's current and previous employees. EI#1 told the surveyor that there were no paper files available for the employees, that she would have to print them out from "Dropbox" (an online digital storage website). The surveyor asked that EI#1 provide the employee files by 4:30 PM. EI#1 was only able to provide "food handler" training records and tuberculosis (TB) screening records for EI#5, and EI#6. The TB screen for EI#6 was not dated. There were no other training records available for any of the other employees, even though EI#1 showed the surveyor a complete training manual which included the testing materials for all the training required by the SBOH.	A 411		

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A 411	Continued From page 24 On July 19, 2018, the surveyor observed a new staff member (EI#10). EI#10 told the surveyor that this was her first day working for the facility. EI#10 said she was a certified medical assistant and worked as a nursing assistant at a local nursing home for about a year and a half. EI#10 agreed the facility staff had just shown her around and told her what to do without any training. EI#6 and EI#7 arrived in the facility before EI#4, RN, left the facility that morning. EI#6 told the surveyor that she was only there for about an hour to help EI#10 and then she would be leaving. EI#6 was still at the facility when the surveyor left at 11:30 AM. EI#6 told the surveyor that EI#7 also came to help EI#10 since it was EI#10's first day. EI#1 and EI#2 were not available in the facility on July 19, 2018. EI#5 told the surveyor that EI#4 was the designee since EI#1 was out of town at a funeral.	A 411		
A 501	420-5-4-.05 (1)(a)(b)(c) Records and Reports (1) General. (a) Responsibility for Records. The administrator shall prepare and file all records, or shall oversee the preparation and filing of records. This duty shall be assigned to other employees in the administrator's absence. (b) Storage and Safety. Provision shall be made for the safe storage of records within the facility. Records shall be stored in a manner to reasonably protect them from water or fire damage. Records shall be safeguarded from unauthorized access.	A 501		

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A 501	Continued From page 25 (c) Preservation of Records. Those portions of residents' records necessary for staff to provide care, including the care plans and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. Records shall be current from the time of admission to the time of discharge or death and shall be retained in the facility for at least three years after a resident's death or discharge. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to provide staff with necessary and up to date resident records for the appropriate care and safety of all three residents. This deficient practice placed all three residents at significant risk for neglect, harm, and death. Findings: On July 11, 2018, EI#1 agreed that all three resident records were incomplete and did not contain all the necessary information/guidance that staff needed in order to provide adequate care and safety for all three residents. Three (3) different caregivers told the surveyor that the caregivers had not been trained or told about a resident care plan which explained all the residents' care and safety needs. For additional information, please refer to the following deficiencies: #502, #506, #508, #509, #510, #511, #512, #601, and #610.	A 501		

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A 502	Continued From page 26	A 502		
A 502	420-5-4-.05 (1)(d) Records and Reports Maintenance and Filing of Records and Reports. 1. All records and reports required by these rules shall be completed in a timely manner, and shall be maintained and filed in an orderly manner within the assisted living facility premises. 2. All entries on all records and reports shall be made by typewriter or printer or shall otherwise be written legibly using ink. Documents printed on a plain paper electronic facsimile machine shall be deemed to meet this requirement. 3. Adult Protective Services Reports. 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, and shall also be reported to the Department within 24 hours. Such incidents shall be immediately investigated by the facility, and the results of the investigation shall be promptly reported to the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that facility records were maintained in an orderly manner. Findings:	A 502		

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A 502	Continued From page 27 On July 10 and 11 of 2018, every time the surveyor would request a specific document, EI#1 would tell the surveyor, "It should be in the resident's record or it's in my computer, I will have to print it out." However, EI#1 was not able to find the documentation in the record or provide the surveyor with the following requested documentation: Completed employee files for all the current employees, complete resident records, fire drills for a year, fire alarm inspections for one year, sprinkler inspections for one year, or accurate medication administration records for the month of July 2018. EI#1 told the surveyor that she did not ask the fire alarm/sprinkler contractor for copies of the inspection reports because she could just call and get them when she needed them. The reports were not available for review on July 10, or 11, 2018. EI#1 also told the surveyor, "I'm not real computer savvy ... and I'm having trouble finding things in my email." EI#1 told the surveyor on July 11, 2018, at 4:30 PM, that she didn't have enough time to print out all the surveyor requested documents.	A 502		
A 506	420-5-4-.05 (3) Records and Reports Resident Records. For each resident an assisted living facility shall maintain on its premises the seven required documents listed below and any other documents required by the facility's policies and procedures. The seven required documents are the resident's Financial Agreement, the resident's Admission Record, the resident's Medical Examination Record, the resident's Plan of Care, any Incident Report involving the resident, a Statement of Resident Rights signed	A 506		

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A 506	Continued From page 28 by the resident, and the resident's Inventory of Personal Effects. In addition to the above seven documents, the facility shall also maintain on its premises any Advance Directive that has been executed by the resident. NOTE: under no circumstances shall the facility require a resident to execute an advance directive, nor may a facility require a resident to refrain from executing an advance directive. No staff member of the facility may encourage or discourage any resident with respect to the execution of an advance directive or contemplated execution of an advance directive. These records, either typewritten or legibly written in ink, shall be protected from unauthorized disclosure. The resident records shall be retained for a period of not less than three years after the resident is discharged or dies. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that each resident record contained all of the SBOH required documents. Findings: On July 11, 2018, EI#1, EI#3 and the surveyor reviewed the records for RI#1, RI#2 and RI#3. None of the resident records contained all of the following required documents: Financial Agreement, the resident's Admission Record, the resident's Medical Examination Record, the resident's Plan of Care, any Incident Report involving the resident, a Statement of Resident	A 506		

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A 506	Continued From page 29 Rights signed by the resident, and the resident's Inventory of Personal Effects. EI#1 agreed that all three resident records were incomplete in some manner and missing all or some of the above required documents.	A 506		
A 507	420-5-4-.05 (3)(a) Records and Reports Financial Agreement. 1. Prior to, or at the time of admission, the administrator and the resident or the resident's sponsor shall execute a written financial agreement. This agreement shall be prepared and signed in two or more copies with at least one copy given to the resident, or sponsor, if the resident did not sign the agreement, and one copy retained in the assisted living facility. This document shall be made readily accessible to personnel from the State Board of Health during inspections. 2. In addition to any information otherwise required by the facility's policies and procedures this agreement shall contain the following: (i) A complete list of the facility's basic charges (room, board, laundry and personal care and services). (ii) The period covered by the financial agreement. (iii) A list of services not covered under basic charges and for which additional charges will be billed. (iv) The policy and procedures for refunds of any payments made in advance.	A 507		

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A 507	Continued From page 30 (v) The provisions governing termination of the agreement by either party. (vi) The facility's bed-hold policy, procedures, and charges. (vii) Documentation that the resident and sponsor understand that the facility is not staffed and not authorized to perform skilled nursing services nor to care for residents with severe cognitive impairment and that the resident and sponsor agree that if the resident should need skilled nursing services or care for a severe cognitive impairment as a result of a condition that is expected to last for more than ninety days, that the resident will be discharged by the facility after prior written notice. (viii) A reminder to the resident or sponsor that the local ombudsman may be able to provide assistance if the facility and the resident or family member are unable to resolve a dispute about payment of fees or monies owed. (ix) Signatures of both parties or authorized representatives. 3. Prior to execution of the financial agreement the facility shall ensure that the resident or sponsor fully understands its provisions. In the event that a resident is unable to read the agreement due to illiteracy or infirmity, the administrator shall take special steps to assure communication of its contents to the resident (for example, by having the administrator or sponsor read the agreement to a vision-impaired or illiterate applicant).	A 507		

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A 507	Continued From page 31 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to have financial agreements for each resident. Findings: On July 11, 2018, EI#1 and the surveyor reviewed the records for RI#1 and RI#3. There were no financial agreements available for review at this time. EI#1 told the surveyor that RI#1 and RI#3 were different because they had services through Mercy Life so they didn't have financial agreements because the facility had resident specific contracts with Mercy Life. When the surveyor requested a copy of the Mercy Life contract for each resident (RI#1 and RI#3), EI#1 told the surveyor she would get them, but only brought the surveyor the contract between the facility and Mercy Life. The contract was not specific for any particular resident.	A 507		
A 508	420-5-4-.05 (3)(b) Records and Reports Admission Record. A permanent record shall be developed for each resident upon his or her admission to the facility. This record shall be typewritten or legibly written in ink. In addition to any information otherwise required by the facility's policies and procedures, it shall include the resident's name, date of birth, sex, marital status, social security number, and veteran status; the name, address, and telephone number of the resident's sponsor, responsible party, or closest living relative; the name, address, and telephone number of any person or agency providing assistance to the resident; the name and telephone number of the resident's attending	A 508		

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A 508	Continued From page 32 physician; the resident's preferred pharmacy or pharmacist; the resident's date of admission and date of discharge or death, facility, setting, or location to which discharged; cause of death, if known; his or her religious preferences; and information from the resident about insurance policies (funeral arrangements and burial provisions). This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that each resident's record contained an admission record with pertinent demographic information for each resident. Findings: On July 11, 2018, the surveyor and EI#1 reviewed the records for RI#1, RI#2, and RI#3. None of the residents records contained a complete admission record. EI#1 told the surveyor that they had been completed, but she was not able to find the admission records for each resident at the time of the record review on July 11, 2018. On July 19, 2018, RI#2's record had a completed admission record located in the front of RI#2's record.	A 508		
A 509	420-5-4-.05 (3)(c) Records and Reports	A 509		

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A 509	Continued From page 33 Medical Examination Record. Not more than thirty days prior to admission of any resident to an assisted living facility, the resident or prospective resident shall be examined by a physician, who shall report his or her findings in writing to the facility. In addition to any information otherwise required by the facility's policies and procedures, and in addition to any other information the physician believes is pertinent, the medical examination record shall contain the following: 1. All of the physician's diagnoses, and the resident's baseline weight and vital signs. 2. A statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact. 3. Medication presently prescribed (name, dosage, and strength of drug, frequency of administration). 4. A physician order is required for a resident to manage and have custody of his or her own medications. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that each resident had a completed physician's medical examination within 30 days of admission to the facility.	A 509		

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A 509	Continued From page 34 Findings: On July 11, 2018, the surveyor reviewed the records for RI#1 and RI#2 with EI#1. Neither resident had a completed physician's medical examination that addressed all the required areas in the SBOH rules and regulations for ALF. EI#1 told the surveyor that the facility used the documentation they received from the resident's physician or the hospital. None of the documentation for RI#1 or RI#2 contained a physician's statement that the residents were free from signs and symptoms of infectious skin lesions and diseases that were capable of being transmitted to other residents through normal resident to resident contact. There were no physician orders documented in either residents' chart regarding the residents' ability to manage and have custody of their own medications. On July 10 and 11, 2018, the surveyor observed several tubes of prescription ointments in RI#1's room. RI#1 was admitted on March 6, 2018. RI#1's initial physician's documentation was dated January 22, 2018, which was not within 30 days of RI#1's admission to the facility. On July 19, 2018, RI#2's record contained a physician's medical exam dated June 29, 2018, which was not on RI#2's record on July 11, 2018. EI#'s 1, 2, and 4 were not available in the facility at this time for interview.	A 509		
A 510	420-5-4-.05 (3)(d) 1. & 2 Records and Reports (d) Plan of Care. There shall be a written plan of care developed for each resident prior to or at the	A 510		

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A 510	Continued From page 35	A 510		

time of admission. The plan of care shall be based on the medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be developed in cooperation with the resident and, if appropriate, the sponsor. It shall document the personal care and services required from the facility by the resident. This plan shall be kept current, reviewed and updated when there is any significant change in the resident's condition, after each hospitalization, and at other appropriate times. It shall in all cases be reviewed and updated at least annually by the attending physician. In addition to other items that may be required by the facility's own policies and procedures, it shall contain the following:

1. A listing of the resident's needs or problems that require intervention by the facility, such as behavioral symptoms, weight loss, falls, and therapeutic diets. The facility shall assess the appropriateness of interventions required by each resident monthly. The facility shall on a monthly basis weigh and record the weight of each resident. The facility shall assess residents on a monthly basis and more often when necessary to identify significant changes in health status or behavior to include awareness of medication. Significant change is defined as two or more falls in 30 days or less, a significant weight loss, unmanageable or combative or potentially harmful behaviors, any adverse drug interaction or over sedation or any elopement. A significant weight loss is defined as a 5% or greater weight loss in a period of one month or less, or a 7.5% or greater weight loss in a period of three months or less, or a 10% or greater weight loss in a period of six months or less. Any weight loss shall be considered to be unplanned weight loss

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A 510	Continued From page 36 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. Any significant change requires immediate implementation and documentation of interventions or reassessment of existing interventions. 2. A description of the assistance with activities of daily living required by the resident including bathing, dressing, ambulation, feeding, toileting, grooming, medication assistance, diet and risk to personal safety. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the resident records did not contain care plans or monthly assessments which addressed all of the SBOH required assessment areas. Findings: RI#1 On July 11, 2018, the surveyor and EI#1 reviewed records for RI#1, RI#2, and RI#3. RI#1 RI#1 was admitted to the facility on March 6, 2018, and was receiving services from Mercy Life's PACE (Programs of All-Inclusive Care) program. RI#1 had diagnoses which included congestive heart failure, chronic obstructive pulmonary disease, type 2 diabetes, and mental retardation. RI#1 required assistance/supervision with all activities of daily living (ADL), used an	A 510		

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electric scooter for mobility, smoked cigarettes several times a day, and also required oxygen at times for shortness of breath.

RI#1's record contained incomplete hospital records for the following hospital stays: March 15-20, 2018 for unknown diagnoses; May 27- 30, 2018, for gastritis and a low hematocrit blood level; and June 1- 5, 2018 for anemia which required a blood transfusion. There was no documentation identifying the problems RI#1 experienced before going to the hospital. There was no indication that RI#1's physician was notified of any symptoms which led up to RI#1 going to the hospital. The only documentation in RI#1's facility "progress notes" was when RI#1 was readmitted to the facility. The nurse documented a skin assessment, that RI#1 was able to make their needs known, and RI#1 was "...non-compliant (with) smoke breaks... non-compliant with food (diabetic diet)...".

There were no monthly assessments which documented monitoring RI#1 for falls, weights, elopements, adverse medication reactions, medication awareness, or significant changes in RI#1's health status.

EI#1 could not find RI#1's Mercy Life care plan or a facility care plan in RI#1's record.

RI#2
RI#2 was admitted to the facility on July 1, 2018, with diagnoses which included senile dementia, vascular dementia, mild protein/calorie malnutrition, and osteoarthritis. RI#2 required assistance with all ADL's, used a wheelchair propelled by staff for mobility, required care for bowel and bladder incontinence, safe transfers with two staff members, and assistance with

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A 510	Continued From page 38	A 510		

feeding at times. EI#5 told the surveyor that RI#2 had mood/behavior issues at times, (probably related to RI#2's dementia diagnoses) which was also not addressed with any care plan interventions.

EI#1 told the surveyor that "the resident agreement for (RI#2), spelled out (RI#2's) care needs." After review of RI#2's resident agreement, the surveyor observed none of RI#2's specific care or safety needs were addressed in RI#2's resident agreement. RI#2's resident agreement was just like the other resident agreements the facility was using, which only defined the services provided by the facility, fees, and other general information.

RI#3

RI#3 was admitted to the facility on July 8, 2018, and was receiving services from Mercy Life's PACE program. RI#3 had diagnoses which included multiple heart related conditions, type 2 diabetes, macular degeneration, chronic pain related to gout and osteoarthritis. RI#3 required chronic pain management and "max" assistance with all ADLs including assistance with safe transfers to a wheelchair for mobility and urinary incontinence care.

On July 19, 2018, RI#3 was observed with long fingernails. RI#3 told the surveyor, "they (nails) need cutting."

EI#1 told the surveyor that RI#3's Mercy Life care plan was what the facility was using to provide care to RI#3. EI#1 said that RI#3 hadn't been in the facility long enough for staff to identify any changes different from the Mercy Life care plan.

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A 510	Continued From page 39 During interviews with caregivers, EI#5, EI#6, and EI#8, all three caregivers told the surveyor they had not received any training about resident care plans.	A 510		
A 511	420-5-4-.05 (3)(d) 3. Records and Reports Written documentation that the facility has devised a plan to transfer the resident to a hospital, nursing home, specialty care assisted living facility, or other appropriate setting if and when the facility becomes unable to meet the resident's needs. The resident's preference, if any, with respect to any particular hospital, nursing home, or specialty care assisted living facility shall be recorded. The facility shall keep written documentation that demonstrates the transfer plan has been thoroughly explained to the resident or sponsor, as appropriate, and that the resident or sponsor understands the transfer plan. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that transfer plans were documented in the resident records. Findings: On July 11, 2018, RI#1, RI#2, and RI#3's records were reviewed with EI#1. EI#1 agreed that the transfer plan documentation for each resident	A 511		

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A 511	Continued From page 40 was incomplete or missing. The missing transfer plans for each resident suggests that the facility did not thoroughly explain the care and service restrictions of an ALF license and could have mislead sponsors to believe the facility could provide services beyond the facility's licensed capability. Please refer to deficiency #603 for additional information related to resident care beyond the facility's licensed capability.	A 511		
A 512	420-5-4-.05 (3)(d) 4. Records and Reports The procedure to follow in case of serious illness, accident or death to the resident (including the name and telephone number of the physician to be called, the names and telephone numbers and addresses of family members or sponsor to be contacted, the resident's or, if appropriate, the sponsor's wishes with respect to disposition of personal effects, and the name and telephone number of the funeral home to be contacted). This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure procedures to follow in the event of accident, serious illness, or death were documented in each resident's record. Findings:	A 512		

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A 512	Continued From page 41 On July 11, 2018, RI#1, RI#2, and RI#3's records were reviewed with EI#1. EI#1 agreed that the emergency plan documentation for each resident was incomplete or missing, which could result in delayed treatment or death for a resident with serious medical problems or complications.	A 512		
A 517	420-5-4-.05 (3)(f) 3. Records and Reports In addition, the following shall be reported to the Departments's Online Incident Reporting System: (i) A fracture or an injury resulting in hospitalization, death, EMS activation or a visit to the emergency room. (ii) A resident who is severely cognitively impaired who is found to be missing from the facility without staff knowledge and immediate and appropriate staff intervention; (iii) Sexual contact or a report of sexual contact between a resident and a staff member of the facility. Sexual contact or report of sexual contact between a resident and a visitor or another resident when the sexual contact is not consensual or when the resident is incapable of consenting to sexual contact. (iv) Physical abuse, verbal abuse, emotional abuse, or a report of such abuse, directed at a resident by a staff member or visitor of the facility and injury such as extensive bruising, pain or injury that is not consistent with actions necessary in providing day to day care to a resident; (v) A fire, earthquake, storm, other act of God or other occurrence (for example, a natural gas leak	A 517		

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A 517	Continued From page 42 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; (vi) Intentional self-inflicted injury, suicide, or suicide attempt by a resident; (vii) An unplanned occurrence that results in media attention; (viii) A medication error, including overdose, that results in a resident being hospitalized; (ix) Ingestion by a resident of a toxic substance that requires medical intervention; (x) A malfunction of the sprinkler system, or fire alarm system. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to report malfunctions of the fire alarm system to the ADPH within 24 hours of the incidents. Findings: On July 10, 2018, the surveyor observed that the facility's fire alarm panel was in "trouble" from the "foyer pull/smoke" (fire pull station or smoke detector in the facility's foyer area). EI#1 told the surveyor the fire alarm panel had been hit by lightning and they were waiting for a part to repair it. EI#1 contacted the certified fire alarm contractor by phone to ask about the repair. EI#1's phone was on speaker mode and the surveyor heard the contractor explain to EI#1 that the circuit board had been replaced, the fire alarm	A 517		

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A 517	Continued From page 43 had already been repaired, and it just needed to be reset. The contractor gave EI#1 step by step instructions on how to reset the fire alarm. After the fire alarm was reset it remained without trouble for the rest of the day. According to the alarm monitoring report for July 2018, the facility's fire alarm had been in trouble since July 1, 2018 (10 days). EI#1 did not have any documentation available during the survey to show the surveyor that the fire alarm had been repaired between July 1, and July 10, 2018. The last work completed on the facility's fire alarm was dated June 26, 2018. On July 24, 2018, the fire alarm contractor told the surveyor that the facility's fire alarm panel required a circuit board to be replaced on June 26, 2018. The fire alarm contractor also told the surveyor that it probably took a couple of days to get the part so the facility did not have a functioning fire alarm from the time of the lightning strike until the repair was completed. According to the facility's fire alarm monitoring report for the month of June 2018, the facility's fire alarm was struck by lightning and went into trouble on June 20, 2018. Therefore, the facility's fire alarm system was not functioning from June 20 through the 26th of 2018, a total of six (6) days. There were no online reports filed by the facility to ADPH which reported the malfunctioning fire alarm system in the month of June or July of 2018.	A 517		
A 519	420-5-4-.05 (3)(g) Records and Reports	A 519		

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A 519	Continued From page 44 Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to file a signed copy of the Resident's Rights in each resident's record.	A 519		

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A 519	Continued From page 45 Findings: On July 11, 2018, the surveyor reviewed RI#1, RI#2, and RI#3's records with EI#1. There were no signed copies of the Resident's Rights in any of the resident's charts. EI#1 agreed that all three resident charts did not have a signed copy of the resident's rights.	A 519		
A 521	420-5-4-.05 (3)(g) 2. Records and Reports 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. This Rule is not met as evidenced by: Based on observations, record review, and interview, the facility failed to provide a safe and decent environment for all residents. This deficiency placed all three residents at significant risk for harm, neglect, and even death. Findings: The three residents living in this facility were not safe due to the significant lack of training for all aspects of the residents' care and safety needs. There were no care plans with guidance on what each resident's actual care and safety needs were. Every aspect of medication management was deficient. Residents' MARs were not accurate or up to date, residents were not given the opportunity to protect themselves from medication errors, controlled medications were	A 521		

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not accounted for, all medications were not in unit dose packaging, residents had medications without physician orders, physician orders without medications, and medications were not properly secured or stored (the medication cart key was left hanging in the medication cart lock and the controlled medication key was stored behind the door.) Poisons and chemicals were not secured or supervised. Resident records were incomplete. Staff were poorly trained on resident rights, fire safety, food safety, infection control, facility policies, and procedures. Employee records did not contain documentation that employees were screened for any history of abuse through the Nurse Aide Registry. There were no documented fire drills, there were no fire alarm or sprinkler system inspections/reports. Fire extinguishers were not visually checked monthly. The fire alarm system was non-functioning for at least six (6) days (between June 20 and 26, 2018) which left the entire facility unprotected in the event of a fire. The facility was not evacuated and there was no documented online report or fire watch implemented during that time which was provided to ADPH.

RI#1

RI#1 was admitted to the facility on March 8, 2018, with diagnoses which included type 2 diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and mental retardation. RI#1 was able to make their needs known and was very much aware of their medications. RI#1 smoked cigarettes daily, used oxygen as needed, required a wheelchair for mobility, and assistance/supervision with ADL. RI#1 did not have precautionary oxygen signs posted on their room door where they used an oxygen concentrator and stored several tanks of

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oxygen. RI#1 was not able to direct others on how to change the regulator on their oxygen tanks therefore, RI#1 was limited to using the oxygen concentrator in their room or go without supplemental oxygen. This placed RI#1 at risk for harm related to complications from COPD and CHF.

According to RI#1's MAR and medication card, RI#1 was not given their Carafate medication four times a day as ordered by their physician, putting them at a significant risk for complications related to gastritis, which they had been hospitalized for in May 2018, June 2018, and again in July 2018. RI#1 required a blood transfusion in June 2018 and was treated in May and July 2018 for gastritis. RI#1's Carafate was filled on May 30, 2018, with 120 tabs or a 30 day supply. On July 18, 2018 the medication was discontinued and there were still 38 tablets left from the 120 tablet/30 day supply. Even with RI#1 being hospitalized for 10 days, there should not have been 38 tablets remaining of the 30 day supply on July 18, 2018. RI#1's Carafate prescription should have been completed/exhausted on approximately July 10, 2018.

The surveyor observed that RI#1 was not given the opportunity to protect themselves from medication errors from unlicensed staff administering medications in the facility.

RI#1 was not provided with the respect or dignity to make their own choices regarding smoking, going outside, or activities. RI#1 was not allowed to smoke more than one cigarette during their four designated smoke times. RI#1 was frequently told they had to wait for smoke breaks even though staff didn't supervise or visit with RI#1 during their smoke breaks. RI#1 was

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observed going to doors frequently to look outside during the survey. RI#1 told the surveyor that they weren't allowed to go outside whenever they wanted to, RI#1 was told they had to do what the staff told RI#1 to. RI#1 wasn't even given time by staff to play dominoes when RI#1 set up the game and asked staff to play. EI#6 laughed and told RI#1, "I don't have time to play dominoes." EI#6 did not even offer to make time later in the shift.

RI#2
RI#2 was admitted to the facility on July 1, 2018, with diagnoses which included dementia. RI#2 required total assistance with all ADL, including care for incontinence of bowel and bladder, used a wheelchair propelled by staff for mobility, and required assistance with feeding at times. RI#2

RI#2 required two staff for safe transfers due to the fact that RI#2 required total assistance. The surveyor observed RI#2 was not able to stand without total support of their weight. RI#2 did not straighten their knees or hips during the transfer. The facility schedule only documented one staff member on each shift. The nurse did not stay for an entire shift and EI#1 and EI#2 were not consistently in the facility.

The surveyor observed EI#7 feed RI#2 bacon with his bare hands which showed EI#7 required additional training to provide proper care for RI#2.

RI#2 was observed in a hospital bed with full bed rails in the up position on both sides of RI#2's bed. RI#2's call light was on the wall at the head of the bed and clearly out of RI#2's reach. RI#2 was able to make some needs known, but required staff to anticipate most of their care and safety needs. The staff were not properly trained

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A 521	Continued From page 49 and had no care plan for guidance on how to safely care for RI#2. RI#2 told the surveyor that they did not take any medication, but the surveyor observed RI#2 was administered their medications by unlicensed staff. RI#2 's MAR was not accurate based on a hospital/emergency room discharge form dated July 9, 2018 and physician orders dated July 14, 2018. The hospital discharge form implied that RI#2 had a history of taking the following medications and to "ask your primary provider about these medications": Calcium 600 + D daily, Albuterol inhaler every 4 hours as needed, Donepezil 10 mg at bedtime, Lasix 40 mg daily, Megace 40 mg daily, Namenda 5 mg at bedtime, Potassium Chloride 10 milliequivalents daily, and Prilosec 40 mg (daily). The facility did not follow-up with RI#2's physician about the additional medications that weren't documented on RI#2's MAR until July 14, 2018 (after the facility's first onsite survey). RI#2's physician ordered the following medications on July 14, 2018: Calcium 600 + D daily, Albuterol inhaler every 4 hours as needed, Donepezil 10 mg, Lasix 40 mg daily, Megace 40 mg daily, Namenda 5 mg at bedtime, Potassium Chloride 10 milliequivalents daily, and Prilosec 40 mg (daily). So RI#2 was placed at significant risk for medical complications including fluid overload due to not receiving their medications between July 1 and 14, 2018. EI#5 told the surveyor that when RI#2 first arrived at the facility, the staff gave RI#2's Haldol 0.5 mg and Ativan 0.5 mg medications wrong. The staff gave RI#2's Haldol and Ativan medications at scheduled times during the day, instead of giving both medications PRN (as needed) as ordered by RI#2's physician. EI#5 showed the surveyor the	A 521		

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times written on RI#2's medication cards in black marker and told the surveyor they were the times the staff were giving RI#2's medications when RI#2 first arrived in the facility. The staff gave RI#2's Haldol and Ativan medications on schedule even though the pharmacy labels were clearly marked to give RI#2 the Haldol and Ativan medications only as needed.

RI#2 was unsafe and at significant risk for harm and neglect because of the facility's use of unnecessary physical restraints, poorly managed medications, inability to protect themselves from medication errors and the fact that RI#2's care and safety needs exceeded the facility's licensed capabilities due to RI#2's severe cognitive impairment.

RI#3

RI#3 was admitted to the facility on July 8, 2018, with diagnoses which included: type 2 diabetes, congestive heart failure, pacemaker, macular degeneration, chronic pain, gout, and osteoarthritis. RI#3 required assistance with all ADL, including urinary incontinence. RI#3 required assistance with safe transfers due to swelling of their feet and macular degeneration.

RI#3 told the surveyor that they could not read their medication cards without glasses and RI#3 did not have any glasses in the facility. The surveyor stopped EI#5 from making a medication error with RI#3's medications on Tuesday, July 10, 2018. EI#5 was going to give RI#3 Lasix 80 mg which was only supposed to be given to RI#3 on Monday, Wednesday, and Friday.

RI#3 could not protect themselves from medication errors which placed RI#3 at significant

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A 521	Continued From page 51 risk for harm and medical complications related to medication errors and unlicensed staff administering RI#3's medications. These are just a few examples of the unsafe environment provided by the facility, it is not an all inclusive list of deficient practices. Please refer to deficiency #301 for the complete list of unsafe practices identified.	A 521		
A 522	420-5-4-.05 (3)(g) 3. Records and Reports Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy. This Rule is not met as evidenced by: Based on observation and interview, the facility did not honor the resident's right to be treated with respect and recognition of individuality. Findings: CIGARETTES The surveyor observed during all three (3) days of the survey that RI#1 was told by at least three (3) different facility staff (EI#1, EI#5, and EI#6) that RI#1 was restricted on the number of cigarettes RI#1 was allowed to have and when RI#1 was allowed to smoke. RI#1 didn't even have custody of their own cigarettes, the facility staff kept RI#1's cigarettes in the office or in the facility's	A 522		

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A 522	Continued From page 52 medication cart. On July 10, 2018, EI#1 told the surveyor that RI#1 used to smoke two (2) packs of cigarettes a day and RI#1's (family member) cut RI#1 back to just four (4)cigarettes a day. The surveyor reviewed RI#1's record which did not have a documented physician's order restricting the number of cigarettes RI#1 was allowed to have or the number of times per day that RI#1 was allowed to smoke. The surveyor observed that RI#1 was very able to make their needs known and requested cigarettes more frequently than RI#1 received them. RI#1 told the surveyor that RI#1 was not allowed to smoke whenever they wanted to, RI#1 had to do what they (facility staff) said RI#1 was allowed to do. DIET On July 10, 2018, the surveyor observed EI#1 asking RI#2 what kind of ice cream they liked. EI#1 then told RI#1, "... you can't have ice cream." On June 11, 2018, RI#1's record was reviewed with EI#1. On June 5, 2018, RI#1's discharge summary contained a physician's order for a, "Consistent carbohydrate/Diabetes diet". Throughout RI#1's nurse progress notes, the nurse documented, RI#1 was "non-compliant" with diet/food and smoke times. There was no care plan regarding RI#1's care needs.	A 522		

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A 522	Continued From page 53 The facility did not have a regular menu posted until the second day of the survey (July 11, 2018). RI#1 was observed to receive the same food/snacks as the other resident's living in the facility, only slightly larger portions at times or a second serving if requested. There was no diabetic menu posted in the kitchen or common areas. There were no sugar free desserts documented on the menu.	A 522		
A 529	420-5-4-.05 (3)(g) 10. Records and Reports 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. This Rule is not met as evidenced by: Based on observation, the facility staff did not provide care consistent with established community standards regarding glove use and handwashing. Findings: On July 10, 2018, the surveyor observed EI#5 wear a single pair of gloves and touch the medication cart drawer handles, papers, pen, medication cards, and RI#3's oral medication. Wearing the same gloves, EI#5 put an eye drop in each of RI#3's eyes, dabbed RI#3's cheeks	A 529		

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A 529	Continued From page 54 with tissue, put the soiled tissues on the dining room table, got scissors from a drawer in the kitchen, applied RI#3's Lidocaine patch, then gathered up the trash along with RI#3's eye drop box. Still wearing the same gloves, EI#5 put RI#3's eye drop box in the medication cart, gathered RI#3's medication cards from the counter in the office, put RI#3's medication cards in the medication cart, then removed the soiled gloves and used hand sanitizer. On July 11, 2018, the surveyor observed EI#1 wear the same pair of gloves to touch the medication cart keys, all of the medication cart drawers, the pill splitter, and then finally the resident's oral medication.	A 529		
A 542	420-5-4-.05 (3)(g) 23. Records and Reports 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. This Rule is not met as evidenced by: Based on observation and interview, the facility did not honor the resident's right to freely come and go from the facility. Findings: On March 6, 2018, RI#1 was admitted to the facility with diagnoses which included: congestive heart failure, mental retardation, type II diabetes, and chronic obstructive pulmonary disease.	A 542		

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A 542	Continued From page 55 On July 10, 2018, the surveyor observed RI#1 talking with EI#1 about going outside. EI#1 told RI#1, "No, there are fox out there that will attack you." EI#1 and RI#1 went back and forth about why RI#1 shouldn't go outside because of the fox, how RI#1 wasn't afraid of the fox, and what RI#1 would do if a fox tried to attack RI#1, until RI#1 finally gave up the discussion of going outside and went to their room. During the three days of the survey, the surveyor observed that RI#1 was allowed to go outside to smoke a cigarette and then had to come right back inside. RI#1 was frequently observed during the survey looking outside, but was only observed to go out to smoke a total of two or three times during the three days the surveyor was onsite, even though smoking times were posted as: 7:30 AM to 8:00 AM, 10:30 AM to 11:00 AM, 12:30 PM to 1:00 PM, and 5:30 PM to 6:00 PM. On July 19, 2018, RI#1 told the surveyor that they did not get to go outside anytime they wanted because, "I (RI#1) have to do what they say."	A 542		
A 601	420-5-4-.06(1) Care of Residents 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	A 601		

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A 601	Continued From page 56 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 Emergency Medical Services system (911 or an other emergency call). (b) Back-up Physician Support. Each assisted living facility shall have an agreement with one or more duly licensed physicians to serve in those instances when a resident's own attending physician cannot be reached, and to provide temporary medical attention to any resident whose attending physician is temporarily not available. (c) The use of the word "physician" in these rules shall not be deemed to preclude a properly licensed nurse practitioner or a physician assistant from performing any function in an assisted living facility that otherwise would be required to be performed by a physician so long as that function is within the nurse practitioner's or physician assistant's scope of practice. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that all resident care was under the direction of a physician, the facility also failed to follow physician orders for all resident care. Findings:	A 601		

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A 601	Continued From page 57 RI#1 On July 11, 2018, RI#1's record was reviewed with EI#1. On June 5, 2018, RI#1 was readmitted to the facility from a five (5) day hospital stay for low blood pressure, nausea, vomiting, cough, and shortness of breath. RI#1's discharge orders dated June 5, 2018, did not include physician orders for the following: oxygen, any medications to be kept at the bedside, or smoking restrictions. On July 10, 2018, the surveyor accompanied by EI#1 observed several oxygen tanks and an oxygen concentrator in RI#1's room. RI#1 also had several tubes of Lotrisone cream in their room. During all three (3) days that the surveyor was onsite at the facility, RI#1 was told by at least three (3) different facility staff that RI#1 was restricted on the number of cigarettes that RI#1 was allowed to have and when RI#1 was allowed to smoke. The facility staff kept RI#1's cigarettes in the office or in the medication cart. According to RI#1's MAR's and medication card, RI#1 was not given their Carafate medication four times a day as ordered by their physician, putting them at a significant risk for complications related to gastritis, which they had been hospitalized for in May 2018, June 2018, and again in July 2018. RI#1 required a blood transfusion in June 2018 after treatment in May 2018 for gastritis. RI#1's Carafate was filled on May 30, 2018, with 120 tabs or a 30 day supply. On July 18, 2018 the medication was discontinued and there were still 38 tablets left from the 120 tablet/30 day supply. Even with RI#1 being hospitalized for 10 days, there should not have been 38 tablets remaining	A 601		

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A 601	Continued From page 58 of the 30 day supply on July 18, 2018. RI#1's Carafate prescription should have been completed/exhausted on approximately July 10, 2018. RI#2 On July 11, 2018, RI#2's record was reviewed with EI#1 and EI#2. RI#2 was admitted to the facility on July 1, 2018, without any physician orders for care. On July 7, 2018, RI#2 went to the local emergency room for diagnoses of infective urethritis and senile dementia without behavioral disturbance. The only medication ordered at that time was Bactrim DS 800-160 milligrams (mg) one tablet by mouth two (2) times a day for seven (7) days. The hospital discharge form also implied that RI#2 had a history of taking the following medications and to "ask your primary provider about these medications": Calcium 600 + D daily, Albuterol inhaler every 4 hours as needed, Donepezil 10 mg at bedtime, Lasix 40 mg daily, Megace 40 mg daily, Namenda 5 mg at bedtime, Potassium Chloride 10 milliequivalents daily, and Prilosec 40 mg (daily). There was no MAR for RI#2 for July 7 and 8, 2018. There was no documentation in RI#2's record that the facility followed up on the additional medications that were listed on RI#2's hospital discharge form until July 14, 2018 (see details below). On July 9, 2018, RI#2's MAR documented the following: "Aricept 10 mg take 1 by mouth every day - scheduled for 0800; Plavix 75 mg take 1 by mouth every day - scheduled for 0800; Quetiapine Fumarate 25 mg Take 1 by mouth twice daily (hold for sedation) - scheduled for	A 601		

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A 601	Continued From page 59	A 601		

0800 and 1400; Haloperidol 0.5 mg take 1 by mouth three times daily as needed; Lorazepam 0.5 mg take by mouth three times daily as needed." The Bactrim antibiotic ordered on July 7, 2018, was not listed on RI#2's MAR.

On July 10, 2018, EI#1 told the surveyor that RI#2's MAR had not been updated with the new physician orders (from July 7, 2018) yet, she was "working on it."

On July 9, 2018, RI#2's physician documented the following orders/"Care Plan: 1) Bactrim DS, one (tablet) PO (by mouth) BID (two times a day) x 7 d (for seven days). 2) Prilosec one tab PO BID x 7 days. 3) Ice Cream PRN (as needed). ...". RI#2's physician listed the following as RI#2's "Current Medications: Ativan 0.5 mg; Haldol 0.5 mg; Seroquel 25 mg.". There were no other specific medication orders documented in RI#2's record at the time of the survey.

EI#5 told the surveyor that when RI#2 first arrived at the facility the staff were giving RI#2's medication wrong. The staff were giving RI#2 Haldol 0.5 mg three times a day on schedule and Ativan 0.5 mg three times a day instead of giving both medications only as needed. EI#5 showed the surveyor the times written on RI#2's medication cards in black marker and told the surveyor they were the times the staff were administering RI#2's medications when they first arrived until they found out the medications (Ativan and Haldol) were only supposed to be given as needed. RI#2's medications were given wrong by staff even though RI#2's medication cards were clearly marked with directions to give "as needed".

On July 19, 2018, the following medications had

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A 601	Continued From page 60 been added to RI#2's MAR dated July 17 through 22, 2018, based on physician orders dated July 14, 2018 - Calcicarb 600 with (Vitamin) D take one by mouth every day: Lasix 40 mg 1 tablet by mouth each day; Macrobid 100 mg give 100 mg by mouth twice a day for 7 days 1 capsule; Megace 40 mg give 1 tablet by mouth each day; Namenda 5 mg give 1 tablet by mouth every PM; Potassium (Chloride Extended Release) 10 milliequivalents (MEQ) give 1 tablet by mouth each day; Albuterol 90 Micrograms (MCG) give 1 to 2 puffs by mouth every 4 hours as needed. These were medications that RI#2 should have been taking since admission to the facility. RI#2 did not go to the physician, EI#4 just clarified medication orders that were listed on documentation (hospital discharge form dated July 7, 2018) that the facility already had in RI#2's record. RI#3 RI#3 was admitted to the facility from a skilled nursing facility on July 8, 2018. RI#3 had diagnoses including: congestive heart failure, chronic pain, atrial fibrillation, type 2 diabetes, peripheral edema, pacemaker, and macular degeneration. RI#3 had signed physician orders dated July 3, 2018, for the following medications that were not listed on RI#3's July 9, 2018, MAR: "Tylenol 325 mg take 2 tablets by mouth every 6 hours as needed for mild pain and fever; amiodarone 200 mg take 1 tablet by mouth once a day for the heart; aspirin 81 mg delayed release take 1 tablet by mouth once a day for circulation; Bisacodyl 5 mg delayed release take 1 tablet by mouth once a day as needed for constipation; Gabapentin 300 mg take 1 capsule by mouth once daily at	A 601		

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A 601	Continued From page 61 bedtime for nerve pain; Potassium Chloride 20 mEq take 1 tablet by mouth every morning for potassium supplement; Tamsulosin 0.4 mg take 1 capsule my mouth daily for prostate; Tramadol 50 mg take 1 tablet by mouth 3 times daily as needed for pain. RI#3's July 9, 2018, MAR had the following medications listed without physician orders documented in RI#3's record: Tylenol 325 mg 1 tablet by mouth daily; and Artificial Tears 1.4% drops instill 1 to 2 drops in the affected eye as needed. RI#3's Nitrostat order from the physician was improperly transcribed onto RI#3's July 9, 2018, MAR. RI#3's MAR documented that RI#3's Nitrostat 0.4 mg was every 5 minutes as needed for chest pain, but RI#3's physician's order documented, "Nitrostat 0.4 mg 1 tablet under the tongue at onset of chest pain as needed. ...may repeat every 5 minutes x 3 total doses as directed." On July 10, 2018, EI#1 told the surveyor that the facility had just switched over to the electronic MAR (EMAR), and the staff were still in training. EI#1 was observed putting medication orders into the EMAR program using the directions from the medication cards' pharmacy labels, instead of the written orders from the physicians.	A 601		
A 603	420-5-4-.06(2)(b) Care of Residents Services Beyond Capability of Assisted Living Facility. Whenever a resident requires hospitalization, medical, nursing, or other care beyond the capabilities and facilities of the assisted living facility, arrangements shall be	A 603		

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A 603	Continued From page 62 made to discharge the resident to an appropriate setting, or to transfer the resident promptly to a hospital or other health care facility able to provide the appropriate level of care. This Rule is not met as evidenced by: Based on observation and interview, the facility admitted a resident who required care beyond the capabilities of the facility's license. Findings: On July 11, 2018, the surveyor reviewed RI#2's record with EI#1. RI#2 was admitted to the facility on July 1, 2018. RI#2 had diagnoses which included, senile dementia and vascular dementia with behavioral disturbance, and mild protein-calorie malnutrition. RI#2 required assistance with all ADL. RI#2 required care with bowel and bladder incontinence. RI#2 was observed to require assistance with feeding at times and required two caregivers for assistance with safe transfers. RI#2's physician note dated July 9, 2018, documented, "...appears to be losing weight..slightly dry mucosa (dehydration indicator)... weakness (both legs)... needs MAX assist with ADL's... ice cream PRN (as needed)...". On July 10, 2018, at 4:00 PM, EI#1 asked RI#2 what kind of ice cream they liked. RI#2 said,	A 603		

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A 603	Continued From page 63 "Vanilla". EI#1 said, "Your doctor wants you to have some ice cream." The surveyor observed there was no ice cream in the facility freezer or offered at any snack times during any days of the survey. The only snacks or desserts given to RI#2 were fruit (grapes and mandarin oranges) and peanut butter crackers (RI#2 ate one of six cracker sandwiches). On July 10, 2018, the surveyor observed EI#7 feed RI#2 bacon with his bare hands. On July 11, 2018, the surveyor observed EI#4 and EI#6 transfer RI#2 from the wheelchair to the bed. RI#2 did not straighten their knees or hips, and did not bear any of their weight on their legs. RI#2 had some contractures of their right hand and fingers, making it difficult to grab a cup or glass without a handle. RI#2 rarely spoke unless they were spoken to first. On July 11, 2018, RI#2 told the surveyor that they did not take any medication when in fact they had multiple medications they took at least twice a day including: Seroquel (controls mood) , Namenda (helps with dementia symptoms), Aricept (helps with dementia symptoms), Potassium (supplement), Lasix (reduces fluid in system), and Clopidogrel (slows blood clotting time). RI#2 had severe cognitive impairment and was unable to identify their own name on their own medication card. RI#2 told the surveyor that they could read the names but they didn't see their name on any of the medication cards.	A 603		
A 604	420-5-4-.06(2)(c) Care of Residents	A 604		

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A 604	Continued From page 64 Mechanical Restraint and Seclusion. No form of restraint or seclusion shall be applied to residents of an assisted living facility except in extreme emergency situations when the resident presents a danger of harm to himself or herself or to other residents. In such an event, the facility shall immediately notify the resident's physician and sponsor, and appropriate treatment, transfer to an appropriate health care facility, or both shall be provided without any avoidable delay. In no event shall emergency behavioral symptoms of residents be treated with sedative medications, anti-psychotic medications, anti-anxiety medications, or other psychoactive medications in an assisted living facility. This Rule is not met as evidenced by: Based on observation and interview, the facility used unnecessary physical restraints for residents. Findings: On July 10, 2018, the surveyor accompanied by EI#1 observed RI#2 in a hospital type bed with full side rails, placed in the middle of the bed, in the up position. RI#2 was not able to remove the rails due to limited physical mobility and general weakness. EI#1 told the surveyor that RI#2 used the side rails to help pull themselves up in the bed. EI#5 told the surveyor that RI#2 could hold onto staff for transfers.	A 604		

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A 609	Continued From page 65	A 609		
A 609	420-5-4-.06(2)(h)(i) Care of Residents (h) Prior to admission, residents shall be evaluated for tuberculosis. (i) Vaccines. Assisted living facilities shall immunize residents in accordance with current recommended CDC guidelines. Any particular vaccination requirement may be waived or delayed by the State Health Officer in the event of a vaccine shortage. This Rule is not met as evidenced by: Based on observation and record review, the facility failed to ensure that all residents were screened for tuberculosis before admission into the facility. Findings: On July 11, 2018, RI#2's record was reviewed with EI#1. RI#2 was admitted to the facility on July 1, 2018, for a "respite" stay (less than 30 days). RI#2's record did not contain a chest x-ray or tuberculosis screening documentation. After looking through RI#2's record, EI#1 told the surveyor, "I can't find it."	A 609		
A 610	420-5-4-.06(2)(j) Care of Residents Oxygen Therapy. If a resident receives oxygen therapy in a facility: 1. All oxygen equipment, such as tubing, masks, and nasal cannulae shall be maintained in a safe and sanitary condition.	A 610		

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A 610	Continued From page 66 2. All oxygen tanks shall be safely maintained and stored. 3. The facility shall require safe use of oxygen therapy. No smoking and appropriate precautionary signs shall be posted. 4. The facility shall ensure that each resident using oxygen therapy maintains an adequate supply of oxygen. 5. The facility shall have written policies and procedures governing oxygen administration and storage. 6. The facility shall ensure that all staff members are trained in safe handling of oxygen, in safety practices to be observed during oxygen administration, and in the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to have precautionary signs posted for oxygen in use and storage. Findings: On July 10, 2018, the surveyor accompanied by EI#5 observed RI#1 had eight oxygen tanks and an oxygen concentrator in their room. There was no precautionary sign on RI#1's door to alert staff and visitors of the oxygen stored in RI#1's room. RI#1 was also a smoker. EI#1 agreed there was no sign on RI#1's door	A 610		

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A 610	Continued From page 67 regarding the use and storage of oxygen in RI#1's room.	A 610		
A 612	420-5-4-.06(3)(a) Care of Residents Personal Care and Services. (a) The facility shall offer appropriate activity programs to each resident, maintaining supplies and equipment as necessary to implement the activity programs. This Rule is not met as evidenced by: Based on observations and interviews, there were no staff initiated activities observed during the survey. Findings: During all three days of the survey, there were no staff initiated activities observed. There was no resident activity calendar posted in the common areas. EI#1 told the surveyor that the activity calendar was in EI#1's computer. On July 10, 2018, the surveyor observed a conversation between RI#1 and EI#1 on why RI#1 shouldn't go outside because RI#1 would get attacked by a fox. RI#2 and RI#3 were observed throughout the survey to either sleep in their wheelchairs in front of the television in the dining room or sit/sleep in their beds.	A 612		

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A 612	Continued From page 68 On July 19, 2018, RI#1 got a new unopened box of dominoes out of a drawer in the sitting room next to the dining room. RI#1 opened the box of dominoes, removed the plastic, set up the game, and asked EI#6 to play dominoes. EI#6 laughed and told RI#1, "You know I don't have time to play dominoes." RI#1 just sat there waiting, then put the dominoes away and went back to their room.	A 612		
A 617	420-5-4-.06(4)(b)(c)(d) Care of Residents (b) For purposes of this section, "aware of his or her medications" shall mean either of the following: 1. The resident can maintain possession and control of his or her medications, and self-administer medications, without creating an unreasonable risk to health and safety; or 2. The resident has a reasonable lay person's understanding of the unit dose packaging system in use by the facility such that the resident could likely protect himself or herself from medication errors if unit dose packages are brought to the resident by facility staff. 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. (c) A resident who is not aware of his or her medications is deemed to be severely cognitively impaired. Severely cognitively impaired is defined as a resident being incapable of recognizing his or her name, or if he or she does not understand and cannot be trained to understand the unit dose medication system in use by the facility, or if the resident likely cannot protect himself or herself from medication errors	A 617		

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A 617	Continued From page 69 by the facility staff. (d) An assisted living facility resident who is aware of his or her medications as defined above may be assisted with the self-administration of medication by any assisted living facility staff, including staff members who hold no professional licensure. Assistance with self-administration of medication includes the following practices: 1. Reminding a resident who is aware of his or her medications as defined above 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. 2. Physically assisting a resident who is aware of his or her medications as defined above by opening or helping to open a container holding oral medications. 3. Offering liquids to a resident who is aware of his or her medications as defined above to assist that resident in ingesting oral medications. 4. Physically bringing a container of oral medications to a resident who is aware of his or her medications as defined above. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility did not identify residents who could not protect themselves from medication errors and failed to allow residents the opportunity to identify their medications as their own. Findings:	A 617		

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A 617	Continued From page 70 On Tuesday, July 10, 2018, the surveyor observed EI#5 prepare RI#3's medication. EI#5 put an 80 milligram Lasix pill in the cup of medications she was preparing for RI#3. The medication label and the medication administration record both documented that RI#3 was only supposed to take the Lasix medication on Monday, Wednesday, and Friday. Just before EI#5 left the office to administer RI#3's medications, the surveyor stopped EI#5 and told her she was about to make a medication error. EI#1 was in the office at this time and witnessed the interaction. EI#5 and EI#1 identified the Lasix medication by the markings on the other Lasix pills, and removed the Lasix medication from RI#3's medication cup. EI#5 proceeded to give RI#3 a cup full of pills without giving RI#3 the opportunity to protect themselves from medication errors by looking at the medication cards before putting the medications into a cup. On July 11, 2018, the surveyor accompanied by EI#1, asked RI#3 to look at three (3) cards of medication and identify the medication card with RI#3's name on it. RI#3 told the surveyor "I can't read anything without my glasses." The surveyor asked if RI#3 had any glasses in the facility. RI#3 responded, "No I left without them." The surveyor asked RI#3 if they could try to read the names on the medication cards. RI#3 responded, "I can't. Not without my glasses."	A 617		
A 618	420-5-4-.06(4)(e) Care of Residents Assistance with self-administration of medications shall under no circumstances include any of the following practices:	A 618		

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A 618	Continued From page 71 1. Giving a resident injections of any kind. 2. Administering eye drops, eardrops, nose drops, inhalers, suppositories, or enemas. 3. Telling or reminding a resident that it is time to take a PRN, or as needed medication. 4. Crushing or splitting medications. 5. Placing medications in a feeding tube. 6. Mixing medications with food or liquids. Provided, that a resident who is capable of maintaining possession and control of his or her own medications, who does maintain possession and control of his or her medications, 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, or nose drops by unlicensed facility staff so long as the assistance provided is under the total control and direction of the resident. This Rule is not met as evidenced by: Based on observation and interview, the facility allowed unlicensed staff to split medications for a resident. Findings: On July 10, 2018, the surveyor observed EI#5 put all of RI#3's medications into a cup. EI#5 split RI#3's potassium pill in half using a pill cutter before putting the potassium in RI#3's cup of medication. EI#5 verified that she split the potassium pill in half.	A 618		

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A 619	Continued From page 72	A 619		
A 619	420-5-4-.06 (4)(f) Care of Residents A resident of an assisted living facility who is severely cognitively impaired shall have medications administered only by an individual who is currently licensed to practice medicine or osteopathy by the Medical Licensure Commission of Alabama, or by an individual who is currently licensed by the Alabama State Board of Nursing as a Registered Professional Nurse ("RN") or Licensed Practical Nurse ("LPN"). Residents with a chronic condition that cause him or her to be severely cognitively impaired shall be appropriately discharged. This Rule is not met as evidenced by: Based on observation and interview the facility allowed unlicensed staff to administer medications to residents who were severely cognitively impaired. Findings: On July 10, 2018 the surveyor observed EI#5 give a cup of medication to RI#2. On July 11, 2018, RI#2's record was reviewed with EI#1. RI#2 was admitted to the facility on July 1, 2018 with diagnoses which included senile dementia. On July 11, 2018, the surveyor accompanied by EI#1 observed RI#2 tell the surveyor that RI#2 didn't take any medication at the facility or at home. The surveyor handed RI#2 three cards of	A 619		

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A 619	Continued From page 73 medication and asked if RI#2's name was on any of the cards of medication. RI#2 did not identify their name on the card of medication that belonged to them. The surveyor asked RI#2 if they had any trouble seeing the names written on the cards. RI#2 told the surveyor, "No I can see it, not my name." The surveyor requested an immediate plan of action for RI#2 to have a licensed nurse to administer RI#2's medications until RI#2 was discharged from the facility. EI#1 agreed to have a nurse administer RI#2's medications until RI#2 was discharged.	A 619		
A 623	420-5-4-.06(4)(j) Care of Residents 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. 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 not self-managing medications must use a single pharmacy, but 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 or 30 days prior to the policy taking effect. 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 adverse drug interactions and to advise the facility and the prescribing health care	A 623		

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A 623	Continued From page 74 provider when these are detected. This Rule is not met as evidenced by: The facility failed to ensure that all medications maintained in the facility's custody were in unit dose packaging. Findings: On July 10, 2018 the surveyor accompanied by EI#1 observed several of the residents' medications in multi-dose bottles. While holding a multi- dose bottle of medication for RI#1, EI#1 said, "I hate these bottles, they are so hard to use." The surveyor explained that the facility wasn't supposed to have multi-dose bottles of medications, only unit dose packaged medications. EI#1 requested that the surveyor show her in the SBOH rules for ALF where the facility wasn't supposed to have multi-dose bottles so she could tell the pharmacy.	A 623		
A 624	420-5-4-.06(4)(k) Care of Residents (k) 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 law, federal law, 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, and the facility shall maintain	A 624		

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A 624	Continued From page 75 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. This shall include medications stored in a resident's room when the staff and not the resident have access to the medications. Medications may be kept in the custody of an individual resident who is aware of his or her medications and 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 in the resident's living quarters, if the room is single occupancy and has a locking entrance. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility did not have an accurate system in place for monitoring controlled medications in the facility's custody. Findings: On July 10, 2018, the surveyor accompanied by EI#1 and EI#5 observed the controlled medications locked in the facility's medication cart. RI#2 had a card of Lorazepam/Ativan 0.5 milligrams (mg) with 7 tablets - the only count sheet for RI#2's Ativan documented there were 25 tablets available. There were 18 tablets that were not accounted for. RI#3 had a card of Tramadol 50 mg with 22 tablets - the only count sheet for RI#3's Tramadol documented there were 28 tablets available. There were 6 tablets that were unaccounted for.	A 624		

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A 624	Continued From page 76 EI#5 told the surveyor the staff only counted the controlled medications when they gave one, to make sure they were signed out.	A 624		
A 628	420-5-4-.06(5) Care of Residents Storage of Medical Supplies and Poisons. (a) First Aid Supplies. First aid supplies shall be maintained in a place readily accessible to persons providing personal care and services in the assisted living facility. These supplies shall be inspected at least annually to ensure their usability. (b) Poisonous or External Use Substances. Cleaning supplies and poisons shall be attended at all times or shall be kept in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all poisons and chemicals were secured or supervised at all times. Findings: On July 10, 11, and 19, 2018, the surveyor observed multiple containers of poisons and chemicals including ant poison, bathroom cleaner, drain cleaner, and wasp poison. The chemical and cleaners were in various forms, sprays, liquids and granules. The poisons and chemicals were stored in unlocked areas	A 628		

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A 628	Continued From page 77 including the laundry room, a hall closet, the kitchen, and the back porch. Even after the surveyor explained to EI#1 that the poisons and cleaners were required to be supervised or secured, the surveyor found the same chemicals and poisons unsecured and unsupervised.	A 628		
A 629	420-5-4-.06(6) (a) Care of Residents Admission and Retention of Residents. (a) An assisted living facility shall not admit or retain a resident who is severely cognitively impaired as defined in section (4)(c). This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility admitted a resident who was severely cognitively impaired. Findings: On July 11, 2018, the surveyor reviewed RI#2's record with EI#1. RI#2 was admitted to the facility on July 1, 2018. RI#2's diagnoses included senile dementia. EI#1 told the surveyor that RI#2 was admitted for "respite" care, which meant that RI#2 was only supposed to stay for 30	A 629		

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A 629	Continued From page 78 days or less. EI#1 told the surveyor the requirements were the same for RI#2 as for any other resident living in the facility. On July 11, 2018, the surveyor accompanied by EI#1 observed that RI#2 did not recognize their name on their medication card and in fact, RI#2 told the surveyor that they (RI#2) did not take any medications. RI#2 had multiple medications ordered and the surveyor observed EI#5 give RI#2 medication on July 10, 2018.	A 629		
A 705	420-5-4-.07 (2)(c) 1. Food Service 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. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure that food and food ingredients were properly stored and handled to prevent contamination and food borne illness. Findings: On July 10, 2018, the surveyor observed EI#7, break off several pieces of bacon with his bare hands and fed them to RI#2. This observation	A 705		

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A 705	Continued From page 79 was shared with EI#1 who responded by wrinkling her nose, closing her eyes, shaking her head, and sighing out loud, "Oh".	A 705		
A 710	420-5-4-.07 (2)(c) 6. Food Service 6. Potentially hazardous hot foods shall be at a minimum temperature of 135 degrees Fahrenheit and cold foods at a maximum temperature of 41 degrees Fahrenheit. Frozen food must be maintained at a temperature where it is kept frozen solid. This Rule is not met as evidenced by: Based on observations and interview, the facility did not ensure that potentially hazardous food was served at proper temperatures to prevent food borne illness. Findings: On July 10, 2018, the surveyor observed EI#5 prepare lunch plates for each resident. EI#5 told the surveyor the rotisserie chicken was precooked and she warmed up the sliced chicken in the microwave for five minutes. EI#5 said, "It (chicken) was too hot for me (EI#5) to touch". EI#5 told the surveyor that she did not have a "tester" to check the actual temperatures of the residents food she was preparing.	A 710		
A 720	420-5-4-.07 (3) (c) Food Service Menu. The menu shall be planned and written at least one week in advance. The current week's	A 720		

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A 720	Continued From page 80 menu shall be posted in the food service area and shall be kept on file for the following two weeks. For any resident with a physician's order for a therapeutic diet, the facility shall have a copy of the diet and the facility shall document the adjustment of its menu to accommodate the resident's needs. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to post the menu in the dining room and also failed to follow the menu. Findings: On July 10, 2018, the surveyor accompanied by EI#1 observed that there was no menu posted in the dining room area. EI#1 told the surveyor she had to print them from her computer. On July 10 and 11, 2018, the surveyor observed the following meals and noted the menu was not followed. July 10, 2018- breakfast - french toast and bacon were served- waffles, sausage, and fruit cocktail were documented on the menu; lunch - iceberg salad with tomatoes, a slice of rotisserie chicken, baked beans, wheat toast, and mandarin oranges were served- vegetable salad, spaghetti, french bread, peas, and orange slices were on the menu; dinner - pizza and iceberg salad (no tomatoes) were served- turkey patty, baked beans, carrot sticks, celery sticks and tapioca pudding were on the menu.	A 720		

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A 720	Continued From page 81 On July 11, 2018, - lunch - smothered chicken and rice, broccoli, and grapes were served- carrot salad, chicken over rice, and fresh squash were on the menu. By not following the menu, residents were served chicken at least two days in a row, grapes were served for snacks and desserts. Iceberg salad was served as the main vegetable for two consecutive meals.	A 720		
A 819	420-5-4-.08 (4)(o) Physical Facilities (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. 2. Refrigerator. A Family or a 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, 5 pound type BC for residential hoods and K type for commercial hoods. 4. A three-compartment sink with a booster heater or chemical sanitizing system for the third compartment shall be provided in Congregate assisted living facilities. 5. Garbage cans with cover.	A 819		

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A 819	Continued From page 82 6. 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. This Rule is not met as evidenced by: Based on observation and interview, the facility did not have a working range in the kitchen. Findings: On July 11, 2018, the surveyor observed EI#5 cooking food for lunch using a three burner hotplate. EI#5 told the surveyor that the four burner gas stove "don't work" then she said, "it works, it's not hooked up." EI#5 showed the surveyor the hot plates and electric grill the staff used for cooking all the residents meals. EI#5 also told the surveyor the ice maker was not being used either. Then she said, "but there's only 3 people."	A 819		
A1101	420-5-4-.11 Fire Safety General. (a) Evacuation Plan. All assisted living facilities shall maintain a current written fire control and	A1101		

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A1101	Continued From page 83 evacuation plan. In facilities, which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. Fire control and evacuation plans shall be kept current. Written observations of the effectiveness of the fire drill plan shall be filed and kept for at least three years. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days, 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 Code. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9:00 PM and 6:00 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. This Rule is not met as evidenced by: Based on observation, record review and interview the facility did not have documentation that fire drills were completed as required.	A1101		

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A1101	Continued From page 84 Findings: FIRE DRILLS The surveyor asked EI#1 for the documented fire drills for the past year. EI#1 told the surveyor they were in her computer and she would have to print them out. On July 11, 2018, the surveyor asked for the fire drill documentation for the past year. EI#1 told the surveyor she would have to print them from her computer. The surveyor gave EI#1 until 4:30 PM on July 11, 2018 to provide the surveyor with all requested documentation. The fire drills were not provided to the surveyor during the onsite survey completed July 11, 2018.	A1101		
A1205	420-5-4-.12 (3)(c) Physical Plant Lighting. Each resident's room shall have artificial light adequate for reading and other uses as needed. All entrances, hallways, stairways, inclines, ramps, cellars, attics, storerooms, kitchens, laundries, and service units shall have sufficient artificial lighting to prevent accidents and promote efficiency of service. Night lights shall be provided in all hallways, stairways, and bathrooms. This Rule is not met as evidenced by: Based on observation and interview, the facility did not provide adequate lighting in the common areas for all residents.	A1205		

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A1205	Continued From page 85 Findings: On July 10, 2018, the surveyor accompanied by EI#1 observed that 8 of the 16 lights in the dining room were not lit and that only one half of the dining room was illuminated. The residents were using three of the four tables in the dining room. EI#1 told the surveyor, "We don't need all these lights on." The surveyor explained that RI#3 did not have adequate light over the table where RI#3 was eating. EI#1, stated, "Yeah, I'll have to get someone to turn on that light, it's turned off at the string." The light string/chain was approximately two (2) inches long and could not be reached by a person of average height without a step stool or ladder. On July 11 and 19, 2018, the surveyor observed that RI#3 was still eating without any lights on over their table.	A1205		
A1207	420-5-4-.12 (3)(e) Physical Plant Emergency Lighting. All assisted living facilities shall provide emergency lighting to adequately illuminate halls, corridors, kitchens, dining areas, and stairwells in case of electrical power failure. As a minimum, dry cell battery-operated lighting shall be provided to light such spaces. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that emergency lights were maintained to ensure proper function in the event of an emergency.	A1207		

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A1207	Continued From page 86 Findings: On July 10, 2018, the surveyor accompanied by EI#1 observed two emergency lights that did not function properly when tested. One non-functioning emergency light was located in the sitting room by the main dining room and the second light was located in the conference room across from the staff restroom. EI#1 agreed that the two emergency lights did not function when tested and agreed to get them fixed.	A1207		
A1213	420-5-4-.12 (3)(o) Physical Plant Fire Extinguishers. Fire extinguishers shall be provided for each hall, kitchen and laundry, of type and capacity appropriate to the need. 1. Each fire extinguisher shall receive an annual inspection with maintenance, and recharging when necessary, by a fire equipment servicing representative. An annual servicing tag shall be attached to the extinguisher reflecting the name of the servicing company, representative, day, month and year of maintenance. 2. A visual inspection of each fire extinguisher shall be conducted monthly by designated staff of the facility and documented on the attached extinguisher tag by the designated staff person.	A1213		

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A1213	Continued From page 87 This Rule is not met as evidenced by: Based on observation and interview, the facility staff failed to visually check all fire extinguishers each month. Findings: On July 10, 2018, the surveyor accompanied by EI#1 observed that five (5) of five (5) fire extinguishers in the facility had not been visually checked by staff since the annual inspection was completed in December of 2017. EI#1 told the surveyor that she did not know that needed to be done.	A1213		
A1214	420-5-4-.12 (3)(p) Physical Plant Call System. Except in Family facilities, a central electric or electronic call system shall be conveniently provided for each resident, usable in bedrooms and bathrooms. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure the facility call light system was accessible and loud enough to be heard throughout the facility. Findings: On July 10, 2018, the surveyor observed RI#2 in bed with full side rails in the up position. RI#2's call light pendent was in the holder on the wall and out of reach of RI#2. EI#1 agreed that RI#2	A1214		

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A1214	Continued From page 88 could not press the pendent that was hanging out of reach on the wall. EI#1 removed the pendent from the holder and attached the call light to RI#2's side rail. On July 10, 2018, at 12:40 PM, the surveyor was in RI#3's rooms and activated RI#3's call light pendent hanging on the wall by RI#3's bed. The surveyor could not hear the call light sounding from RI#3's room. RI#3's room was located approximately 25 to 30 feet from the office. The office is where the call light box was located and call light alarms could be heard. On July 10, 2018, at 12:46 PM, the surveyor activated the call light system in RI#3's room. The call light alarm could not be heard in the dining room with the television playing at a normal volume. The call light alarm could not be heard unless the staff were in the office or just outside the office where the alarm box was located.	A1214		
A1217	420-5-4-.12 (3)(t) Physical Plant Fire Alarm and Sprinkler System. 1. 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. 2. The fire alarm system and the sprinkler system	A1217		

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A1217	Continued From page 89 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 2 years. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure that fire alarm outages were reported to ADPH and that the facility was evacuated or a fire watch was initiated until repairs were completed. The facility also failed to have the semi-annual fire alarm and sprinkler system inspections and the inspection reports available onsite for the past year. Findings: On July 10, 2018, the surveyor observed that the facility's fire alarm panel was in trouble from the "foyer pull/smoke". EI#1 told the surveyor that the fire alarm panel had been hit by lightning and they were waiting for a part to repair it. EI#1 contacted the certified fire alarm contractor by phone to ask about the repair. EI#1's phone was on speaker mode and the surveyor heard the contractor explain to EI#1 that the circuit board had been replaced and the fire alarm had already been repaired, it just needed to be reset. The contractor gave EI#1 step by step instructions on how to reset the fire alarm. After the fire alarm was reset, it remained without trouble for the remainder of the day. According to the alarm monitoring report, the	A1217		

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A1217	Continued From page 90 facility's fire alarm had been in trouble since July 1, 2018 (10 days). On July 11, 2018, the surveyor asked EI#1 if she was able to activate the fire alarm and reset it. EI#1 told the surveyor, "Yes, that is what I pay (fire alarm contractor) for." After the fire alarm was activated, EI#1 broke the pull station door off of one of the pull stations when trying to reset the fire alarm. During the fire drill, two pull stations (the left hall pull and the foyer pull) were activated to ensure the system would go into trouble even with a trouble signal already showing on the alarm panel. EI#1 contacted the fire alarm contractor to replace the broken fire pull and reset the system. EI#1 told the surveyor that "(the contractor) would probably be out to fix the fire alarm system that day (July 11, 2018) or the next (July 12, 2018)." On July 10, 2018, the surveyor requested the fire alarm and sprinkler inspections for the past year. EI#1 asked the surveyor if the reports were received in the ADPH central office in Montgomery. The surveyor explained there had been no reports received and that two years of inspections were required to be available on site for review. EI#1 told the surveyor that she did not get copies of the inspection reports, because she could call the company and get them whenever she needed them. There were no documented fire alarm or sprinkler inspections available for review at the time of the survey. On July 18, 2018, the facility submitted fire alarm inspections for June 14, 2017, December 13, 2017, and June 20, 2018. There were no sprinkler inspections provided. On July 19, 2018, the surveyor observed that the	A1217		

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A1217	Continued From page 91 facility fire alarm system was still in trouble and had not been repaired or reset since July 11, 2018. There were two (2) active trouble alarms showing on the facility fire alarm panel, one for the "left hall pull" and one for the "foyer pull". Later that same day the fire alarm contractor arrived at the facility to bypass the broken pull station in the foyer and reset the fire alarm system. The fire alarm contractor told the surveyor that the new pull station would be in on Monday (July 23, 2018), and he would be at the facility on Tuesday (July 24, 2018) to replace it. On July 24, 2018, upon further investigation and interview with the fire alarm contractor, the surveyor was told that the facility's fire alarm system had actually been repaired on June 26, 2018, "a couple days" after the fire alarm panel was hit by lightning. The contractor also told the surveyor that the facility did not have a functioning fire alarm system from the time of the lightning strike until the circuit board was replaced. According to the facility's alarm monitoring report for June 2018, the facility's fire alarm system was struck by lightning on June 20, 2018, and the facility was without a functioning fire alarm system between June 20, 2018 and June 26, 2018. This fire alarm outage was not reported to ADPH, the facility was not evacuated and there was no documentation submitted to ADPH for a fire watch.	A1217		
A1219	420-5-4-.12 (3)(v) (x) Physical Plant (v) Exit Marking. In Group and Congregate facilities, a sign bearing the word "EXIT" in plain legible block letters shall be placed at each exit. Additional signs shall be placed in corridors and passageways wherever necessary to indicate the	A1219		

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A1219	Continued From page 92 direction of exit. Letters of signs shall be at least four inches high. All exit and directional signs shall be kept clearly legible by continuous internal electric illumination and have battery back-up or emergency power. (x) Heating, Lighting, and other Service Equipment. 1. Central or individual room gas heating systems shall be of the enclosed flame type equipped with automatic flame shut-off control and shall be vented directly to the outside. Heating units of any type shall be located to avoid direct contact with any combustible material and shall be maintained in accordance with manufacturer's recommendation. 2. Open flame and portable heaters are prohibited in assisted living facilities. This does not apply to a fire place with gas logs protected as noted elsewhere in these rules. 3. Lighting shall be restricted to electricity. Electric wiring, motors, and other electrical equipment in all assisted living facilities shall be in accordance with local electrical codes and the NFPA National Electrical Code. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all EXIT lights were maintained to ensure proper function in the event of an emergency. Findings: On July 10, 2018, the surveyor accompanied by	A1219		

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A1219	Continued From page 93 EI#1 observed that an EXIT sign in the left hall was not illuminated as required. EI#1 agreed the EXIT light was not functioning properly and agreed to get it fixed.	A1219		
A1221	420-5-4-.12 (5) Physical Plant Building Requirements - Group Assisted Living Facilities. (a) General. Group assisted living facilities licensed, constructed or renovated after December 25, 1991 shall be limited to one story buildings and shall comply with the currently adopted building code and National Fire Protection Association, Life Safety Code. Facilities, or portions of facilities, built under the currently adopted codes shall comply with the Life Safety Code chapter for New Residential Board and Care Occupancies, Impractical Evacuation Capability (excluding NFPA 101A Alternative Approaches to Life Safety). Facilities, or portions of facilities, built under previously adopted editions of the codes shall comply with the currently adopted Life Safety Code chapter for Existing Residential Board and Care Occupancies, Impractical Evacuation Capability (excluding NFPA 101A Alternative Approaches to Life Safety). (b) Required Fire Exits. 1. At least two exits, remote from each other and so located that there will be no dead-end corridors in excess of twenty feet, shall be provided. 2. Exits shall be so located that the distance of travel from the corridor door of any occupied	A1221		

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A1221	Continued From page 94 room to an exit shall not exceed 100 feet. 3. Each bedroom or suite shall have at least one doorway opening directly to the outside, or to an exit corridor leading directly to the outside. 4. Exit doors shall swing to the exterior. 5. Panic hardware shall be installed on all exit doors of facilities submitted for plan review on or after October 5, 2001. As a minimum, single action hardware is required on all exit doors of existing facilities. (c) Corridors and Passageways. Corridors and passageways used as a means of exit, or part of a means of exit, shall be at least 36 inches wide, shall be unobstructed, and shall not lead through any room or space used for a purpose that may obstruct free passage. (d) Smoke Barrier Separations. 1. Buildings exceeding 3,000 square feet in area shall be divided into separate areas by smoke barriers so located as to provide ample space on each side for approximately one-half the beds. Smoke barriers shall have a fire-resistive rating of not less than one hour or minimum one half hour for existing sprinkled facilities. 2. Doors provided in smoke barriers shall be smoke-resistive, so installed that they may normally be kept in the open position, but will close automatically upon fire alarm activation. 3. Duct penetrations in smoke barriers shall be properly protected with smoke dampers.	A1221		

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A1221	Continued From page 95 4. Penetrations of smoke barriers with wiring, conduits, pipes, etc., shall be sealed to maintain the fire and smoke rating. This Rule is not met as evidenced by: Based on observation and interview the facility failed to seal penetrations of smoke barriers. Findings: On July 10, 2018, the surveyor accompanied by EI#1 observed heating and air conditioning ductwork, in a right hall closet, which passed through a smoke wall, that was not properly sealed. TONYA AVENATTI, REGISTERED NURSE	A1221		