STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D2810	A. BUILDING _____ B. WING _____	08/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEBS HELPING HANDS	444 MCCORMICK LANE BOAZ, AL 35956

(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 No complaints were investigated during this survey. This is a three bed Family Assisted Living Facility with a census of three on August 7, 2008. The facility's survey result is Red with a final score of 60. The following deficiencies were cited during the survey and require a plan of correction.	A 000		
A 301	420-5-4-.03 (1)(a)(b) Administration (1) 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 ten per cent or more of the governing authority; 2. Each person or entity who has an ownership	A 301		

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A 301	Continued From page 1 interest of ten per cent 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 observation, record reviews and interviews the facility's Governing Authority failed to operate the facility in a manner that met regulatory requirements. The Governing Authority also failed to ensure that deficiencies cited in the last survey dated July 20, 2004, remained corrected. This failure by the Governing Authority resulted in new and repeat deficiencies being cited during this survey. These deficient practices put the three current residents at risk for harm. THIS DEFICIENCY IS REPEATED FROM THE SURVEY OF JULY 20, 2004. Findings: See the following cited deficiency numbers for additional information: 420-5-4-.03(1)c-The facility failed to establish and implement adequate policies. The facility failed to establish procedures for the day to day	A 301		

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A 301	Continued From page 2 operation of the facility. THIS DEFICIENCY IS REPEATED FROM THE SURVEY OF JULY 20, 2004. 420-5-4-.04(1)-The facility did not have a staff member on duty twenty four hours a day, seven days a week. The only night shift staff slept at night. 420-5-4-.04(1)(a)1-All staff members did not have a physical examination. THIS IS A REPEAT DEFICIENCY. 420-5-4-.04(1)(d)-No employee schedule was posted. 420-5-4-.04(4)(b)-Initial training was not provided to the facility staff. THIS IS A REPEAT DEFICIENCY. 420-5-4-.04(4)(c)-The facility was not staffed at all times by at least one person currently certified in cardiopulmonary resuscitation. 420-5-4-.05(3)(d)-The written plan of care did not contain monthly assessments and monthly weights beginning June of 2007 through July of 2008 for three of three current residents. 420-5-4-.05(3)(f)3(i)-The facility failed to report a fracture and resultant emergency room visit to the Assisted Living Facilites Report fax line. 420-5-4-.05(3)(g)-The posted residents' rights were not current. 420-5-4-.05(3)(g)17-The facility failed to have the telephone number and address of the Division of Health Care Facilities, the address of the area Department of Human Resources, and the	A 301		

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A 301	Continued From page 3 telephone numbers of the Department of Public Health toll free Assisted Living Facilities Complaint line and the Department of Human Resources toll free Elder Abuse Hotline posted. THIS IS A REPEAT DEFICIENCY. 420-5-4-.05(3)(g)18-The results and corrective actions resulting from the state inspection of July 20, 2004, were not posted in the facility. 420-5-4-.06(4)(b)2-Three of three current residents were not given the opportunity to utilize the unit dose package system. 420-5-4-.06(4)(k)-All controlled substances in the facility's custody were not secured by a double lock. The facility did not maintain a system for accounting for all controlled substances in its custody. 420-5-4-.06(4)(m)-The facility failed to ensure that all medications were labeled in accordance with the rules of the Alabama State Board of Pharmacy. 420-5-4-.06(4)(n)-The facility failed to destroy, within thirty days, medications that were discontinued or out of date for three of three residents. 420-5-4-.07(1)(b)-The facility failed to have adequate written policies and procedures for the dietary department. 420-5-4-.07(2)(a)2-The facility failed to keep records of each dish sanitization test for three months. THIS IS A REPEAT DEFICIENCY. 420-5-4-.07(2)(c)1-The facility failed to ensure food was not contaminated during preparation	A 301		

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A 301	Continued From page 4 and serving. 420-5-4-.07(2)(f)-The facility failed to ensure hair restraints were worn during preparation and serving of food. 420-5-4-.07(3)(b)-The facility failed to post the meal times. 420-5-4-.07(3)(f)-The facility failed to have on hand a three day supply of potable water. 420-5-4-.10(1)(a)2-The facility failed to ensure hot water temperatures were maintained at 110 degrees Fahrenheit or below. THIS IS A REPEAT DEFICIENCY. 420-5-4-.11(1)(a)-The facility failed to have a current evacuation plan. THIS IS A REPEAT DEFICIENCY. 420-5-4-.11(1)(b)-The facility failed to have documentation of a fire drill for the month of July of 2008. THIS IS A REPEAT DEFICIENCY.	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.	A 302		

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A 302	Continued From page 5 3. Discharge criteria and notification procedures for residents and sponsors. 4. Facility responsibility when a resident's 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, a review of the facility's policies and procedures, and interviews with Employee Identifier (EI) #1, the Governing Authority failed to establish and implement adequate written policies and procedures. This failure resulted in new and repeat deficiencies being cited during the survey. The deficiencies resulted in three of three current residents being placed at risk for harm. THIS DEFICIENCY IS REPEATED FROM THE	A 302		

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A 302	Continued From page 6 SURVEY OF JULY 20, 2004. Findings: On August 7, 2008, at 10:50A.M., after reviewing the facilities policies and procedures handbook including the attachments for resident rights and residents agreement, the surveyor interviewed EI#1, Governing Authority, Owner and Administrator. EI#1 stated the items provided to the surveyor for review were the only policies and procedures for the facility. The policies and procedures did not adequately address 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 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 and disaster preparedness. (Note: Family buildings which house three residents or less are not required to have a fire alarm or sprinkler system therefore no policy or procedure is required for a fire alarm or sprinkler system). 9. Staffing and conduct of staff while on duty.	A 302		
A 401	420-5-4-.04 (1) Personnel and Training (1) General. An assisted living facility shall employ sufficient staff and ensure sufficient staff are on duty to meet the care needs of all residents twenty-four hours a day, seven days a week. This means that an assisted living facility must not only have a sufficiently large number of staff members to meet the care needs of all	A 401		

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A 401	Continued From page 7 residents, it must also manage and direct the activities of staff members in a manner that results in adequate care being provided. An assisted living facility shall likewise employ sufficient staff, ensure sufficient staff are on duty, and manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment at all times. This Rule is not met as evidenced by: Based on an interview with EI#1 who is the Governing Authority, Owner, and Administrator, the facility failed to ensure that a staff member was on duty twenty-four hours a day, seven days a week. Findings: On August 6, 2008, at 7:15A.M., the surveyor interviewed EI#1, Owner/Administrator. EI#1 stated the facility had one shift from 7:00A.M. until 3:00P.M. EI#1 stated the only staff member other than herself was EI#2. EI#1 stated EI#2's duties were resident caregiver, housekeeper and cook from about 7:00A.M. until 2:00 or 3:00P.M. on Monday, Tuesday, Thursday and Friday. EI#1 stated EI#2 did not work at night. EI#1 stated that she (EI#1) went to bed in the upstairs portion of the house between 11:00P.M. and 12:00A.M. each night but would get up around 2:00A.M. and 4:00A.M. to go downstairs to the resident portion of the house to make room checks.	A 401		
A 402	420-5-4-.04 (1)(a) Personnel and Training (a) 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	A 402		

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A 402	Continued From page 8 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 a review of facility staff records and an interview with the facility owner, the facility failed to ensure that all staff members who had resident contact had a physical examination certifying the employee was free of signs and symptoms of infectious skin lesions and diseases. THIS DEFICIENCY IS REPEATED FROM THE SURVEY OF JULY 20, 2004. Findings: On August 6, 2008, at 12:30P.M., the surveyor	A 402		

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A 402	Continued From page 9 reviewed EI#4's staff record. The record did not contain the physical examination certifying that EI#4 was free of infectious skin lesions and diseases. The surveyor interviewed EI#1, Owner and Administrator. EI#1 stated EI#4 did not have the physical examination in the staff record. EI#1 stated that EI#4 did have contact with residents from EI#4's hire date of April 29, 2007, through July of 2008. EI#1 stated EI#4 no longer worked at the facility.	A 402		
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. This Rule is not met as evidenced by:	A 404		

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A 404	Continued From page 10 Based on observation and an interview with EI#1, Owner and Administrator, the facility failed to have an employee schedule posted in the facility. Findings: On August 6, 2008, during a tour of the facility, the surveyor did not see an employee schedule posted. On August 6, 2008, at 11:20A.M., the surveyor asked EI#1, Owner and Administrator, if she had a schedule for the facility employees. EI#1 stated the facility did not have an employee schedule as there was only one employee, EI#2, who knew her days and hours to work.	A 404		
A 408	420-5-4-.04 (4)(b) Personnel and Training (b) All staff who have contact with residents, including the administrator, shall have initial training and refresher training, as necessary. The 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.	A 408		

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A 408	Continued From page 11 8. Resident fire and environmental safety. 9. Identifying signs and symptoms of dementia. This Rule is not met as evidenced by: Based on a review of the facility's records including staff and training records and an interview with EI#1, Owner and Administrator, the facility failed to ensure the facility's one staff member had received initial training. THIS DEFICIENCY IS REPEATED FROM THE SURVEY OF JULY 20, 2004. Findings: EI#2, resident caregiver, housekeeper and cook, did not have documentation of initial training in the staff record or the training book for 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. and 9. Identifying signs and symptoms of dementia. On August 6, 2008, at 12:30P.M., the surveyor interviewed EI#1, Owner and Administrator. EI#1 stated she did the staff training herself. EI#1 stated EI#2 had not been trained in the nine areas of training but that EI#2 had participated in a couple of fire drills. EI#1 stated EI#2 had been	A 408		

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A 408	Continued From page 12 employed as the only other staff member during the last survey of July 20, 2004, where initial staff training had been cited as a deficient practice. EI#1 stated it was difficult to find training in the local area as the reason for not triaining EI#2.	A 408		
A 409	420-5-4-.04 (4)(c) Personnel and Training (c) An assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in 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 of Public Health 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 a review of staff and training records and an interview with EI#1, the facility failed to ensure that it was staffed at all times by one individual currently certified in cardiopulmonary resuscitation. Findings: EI#1, Owner and Administrator, and EI#2, Caregiver, did not have documentation of current cardiopulmonary resuscitation certification in the	A 409		

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A 409	Continued From page 13 facility staff and training records. EI#1's certification had expired January of 2007. EI#2's certification had expired November of 2007. On August 6, 2008, at 12:30P.M., the surveyor interviewed EI#1. EI#1 stated she (EI#1) and EI#2 were the only staff employed by the facility. EI#1 stated that she was not currently certified in cardiopulmonary resuscitation. EI#1 stated EI#2 was not currently certified in cardiopulmonary resuscitation. EI#1 stated that both of the certifications had expired in 2007. EI#1 stated she was not able to locate training courses in cardiopulmonary resuscitation certification in the local area.	A 409		
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 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	A 510		

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A 510	Continued From page 14 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 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.	A 510		

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A 510	Continued From page 15 This Rule is not met as evidenced by: Based on a review of facility resident records and an interview with EI#1, the facility failed to have written plans of care including monthly assessments and weights for three of three sampled residents. Findings: On August 6, 2008, at 8:00A.M., the surveyor interviewed EI#1, Owner and Administrator. EI#1 stated the only monthly assessments and monthly weights that were documented for Resident Identifier (RI) #1, RI#2, and RI#3 were for May of 2007. EI#1 stated that she was aware that monthly assessments and monthly weights were to be written down but that she had not been writing them down since May of 2007. EI#1 stated she just kept track of the assessments and weights in her head. RI#1 had an admission date to the facility of May 12, 2006. RI#1 did not have documention of monthly assessments and monthly weights for June of 2007 through July of 2008. RI#1 had a documented weight of 160 pounds for May of 2007. On August 6, at approximately 1:00P.M., the surveyor observed EI#1 weigh RI#1. RI#1 weighed 168 pounds. RI#2 had an admission date to the facility of March 3, 2006. RI#2 did not have documentation of monthly assessments and monthly weights for June of 2007 through July of 2008. RI#2 had a documented weight of 167 pounds for May of 2007. On August 6, at approximately 1:00P.M., the surveyor observed EI#1 weigh RI#2. RI#2 weighed 170 pounds.	A 510		

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A 510	Continued From page 16 RI#3 had an admission date to the facility of January 2, 2007. RI#3 did not have documentation of monthly assessments and monthly weights for June of 2007 through July of 2008. RI#3 had a documented weight of 138 pounds for May of 2007. On August 6, at approximately 1:00P.M., the surveyor observed EI#1 weigh RI#3. RI#3 was unable to stand without waivering and holding on to her walker. EI#1 stated that RI#3's weight was either 106 or 108 pounds. EI#1 stated the weight was not accurate due to RI#3 waiverng and holding on to her walker.	A 510		
A 517	420-5-4-.05 (3)(f) 3. Records and Reports 3. In addition, the following shall be reported to the Assisted Living Facilities Report Fax line: (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's 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	A 517		

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A 517	Continued From page 17 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 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 a review of facility resident records and an interview with EI#1, the facility failed to report to the Assisted Living Facilities unit a fracture resulting in a visit to the emergency room. Findings:	A 517		

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A 517	Continued From page 18 On August 6, 2008, at 11:20A.M., the surveyor interviewed EI#1. EI#1 stated the only resident who had fallen at the facility was RI#1. EI#1 stated RI#1 was walking in the yard alone about a year ago, stumbled and fell. EI#1 stated RI#1 was taken to an area emergency room the following day when RI#1complained of pain in her elbow. EI#1 stated that RI#1's X-ray showed a hairline fracture of the elbow. EI#1 stated she did not report the fracture to the Alabama Department of Public Health Assisted Living Facility unit. EI#1 stated she was not aware that a fracture resulting in a visit to an emergency room had to be reported. An incident report for RI#1 was dated April 20, 2007. The incident report documented the incident occurred at 11:30A.M., on April 19, 2007. The incident report documented that RI#1was taken to an area emergency room on April 20, 2007, with a diagnosis of a hairline fracture of the elbow.	A 517		
A 519	420-5-4-.05 (3)(g) Records and Reports (g) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate.	A 519		

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A 519	Continued From page 19 This Rule is not met as evidenced by: Based on observation and an interview with EI#1, the facility failed to ensure that correct residents' rights were posted. Findings: The residents' rights posted behind the door in each residents' room on August 6, 2008, contained twenty three rights instead of the twenty four residents' rights in the regulations. On August 7, 2008, at approximately 10:45A.M., the surveyor interviewed EI#1, Owner and Administrator. EI#1 stated that she was not aware that the residents' rights contained twenty four rights.	A 519		
A 536	420-5-4-.05 (3)(g) 17 Records and Reports 17. Every resident shall have the right to have the name, telephone number and address of the Division of Health Care Facilities, the Local Ombudsman, the Department of Human	A 536		

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A 536	Continued From page 20 Resources, and the telephone numbers of the Department of Public Health toll free Assisted Living Facilities Complaint Fax line and the Department of Human Resources toll free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area. This Rule is not met as evidenced by: Based on observation and an interview with EI#1, the facility failed to have the telephone number and address of the Division of Health Care Facilities, the address of the area Department of Human Resources, and the telephone numbers of the Department of Public Health toll free Assisted Living Facilities Complaint line and the Department of Human Resources toll free Elder Abuse Hotline posted. THIS DEFICIENCY IS REPEATED FROM THE SURVEY OF JULY 20, 2004. Findings: On August 6, 2008, at approximately 10:30A.M., the surveyor observed that the telephone number and address of the Division of Health Care Facilities, the address of the area Department of Human Resources, and the telephone numbers of the Department of Public Health toll free Assisted Living Facilities Complaint line and the Department of Human Resources toll free Elder Abuse Hotline were not posted in the facility. On August 6, 2008, at approximately 10:30A.M., the surveyor interviewed EI#1. EI#1 stated that the telephone number and address of the Division of Health Care Facilities, the address of	A 536		

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A 536	Continued From page 21 the area Department of Human Resources, and the telephone numbers of the Department of Public Health toll free Assisted Living Facilities Complaint line and the Department of Human Resources toll free Elder Abuse Hotline were not posted in the facility. EI#1 stated she was not aware these items had to be posted.	A 536		
A 537	420-5-4-.05 (3)(g) 18 Records and Reports 18. All state inspection reports and any resulting corrective action plan from the past 12 months shall be posted in a prominent location. If there has been no inspection in the past 12 months, then the results of the most recent inspection and any resulting corrective action plan, shall be posted. This Rule is not met as evidenced by: Based on observation and an interview with EI#1, the facility failed to post the results of the most recent inspection and any resulting corrective action plan in a prominent location. Findings: On August 6, 2008, at approximately 10:30A.M., the surveyor observed that the survey results and corrective actions for the July 20, 2004, survey were not posted in a prominent location in the facility. On August 7, 2008, at 10:50A.M., the surveyor asked EI#1 if the survey and corrective actions for July 20, 2004, were posted in the facility. EI#1 stated no as she was not aware that it had to be posted.	A 537		

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A 617	Continued From page 22	A 617		
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 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:	A 617		

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A 617	Continued From page 23 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 and an interview with EI#1 the facility failed to allow three of three residents the opportunity to demonstrate his or her ability to correctly utilize the unit dose package system at every opportunity for medication use and be afforded the opportunity to protect themselves from medication errors. Findings: On August 6, 2008, at approximately 7:15A.M., the surveyor observed two clear plastic	A 617		

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A 617	Continued From page 24 medication cups containing medications on the dining table. One cup contained the name of RI#1. One cup contained the name of RI#2. The surveyor observed one clear plastic medication cup containing medications with RI#3's name on it on a tray on the kitchen counter. The surveyor observed EI#1, Owner and Administraor, place plates of breakfast on the table for RI#1 and RI#2. EI#1 told the surveyor that she (EI#1) prepared the medications in the cups and gave them to the residents to take with their food. EI#1 did not offer the unit dose cards to RI#1 or RI#2 for them to use to identify their medications. EI#1 took a tray containing RI#3's breakfast and cup of medication into RI#3's room where RI#3 preferred to eat. EI#1 did not offer RI#3 her unit dose cards for her to identify her medication. On August 6, 2008, at 11:10A.M., the surveyor interviewed EI#1. EI#1stated she had placed the medications out of the unit dose cards into the plastic cups earlier this morning. EI#1 stated she had not offered the unit dose cards to any of the three residents to use during the medication time with the breakfast meal this morning.	A 617		
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 Alabama 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 system to account for all controlled substances in its possession. All other	A 624		

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A 624	Continued From page 25 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 and an interview with EI#1 the facility failed to ensure that all controlled substances in it's custody were stored using a double lock system. The facility additionally failed to maintain a system to account for all controlled substances in its possession. Findings: 1. On August 6, 2008, at approximately 8:00A.M., EI#1, Owner and Administrator, removed all three resident's current medication boxes from a closet with a single lock on the door. The medication boxes contained the following medications for RI#1 and RI#2 that were controlled substances. RI#1 had Alprazolam 0.25 milligrams and Darvocet N-100 tablets in the current medication box that was secured by a single lock. RI#2 had Zolpidem Tartrate 10 milligrams in the current medication box that was secured by a single lock.	A 624		

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A 624	Continued From page 26 On August 6, 2008, at 9:40A.M., EI#1 showed the surveyor the locked box in the closet that contained RI#3's Fentanyl 25 microgram patches. EI#1 stated this was the only controlled substance in the facility. On August 6, 2008, at 3:30P.M., the surveyor accompanied EI#1 to the locked closet. EI#1 removed three boxes stating they contained discontinued and as needed medications for the three residents. The boxes were secured by the single locking closet door. RI#1 had Percocet 5 milligrams in the discontinued or as needed box. RI#3 had Hydrocodone 5 milligrams with acetaminophen 325 milligrams in the discontinued or as needed box. 2. On August 6, 2008, at approximately 10:30A.M., the surveyor interviewed EI#1. EI#1 stated she did not have any system to show when controlled substance medications were received, the amount of medication received, when the medications were taken by the residents or if any had been destroyed. EI#1 stated there was not a daily count of controlled substance medications to determine if they were all accounted for in the facility.	A 624		
A 626	420-5-4-.06(4)(m) Care of Residents (m) Labeling of Drugs and Medicines. All containers of medicines and drugs shall be labeled in accordance with the rules of the Alabama State Board of Pharmacy and shall include appropriate cautionary labels, such as, "Shake Well," or "For External Use Only."	A 626		

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A 626	Continued From page 27 Medications maintained as stock must contain the manufacturer's label and shall be properly labeled in accordance with accepted professional standards. This Rule is not met as evidenced by: Based on observation and an interview with EI#1 the facility failed to ensure that all medications were labeled in accordance with the rules of the Alabama State Board of Pharmacy. Findings: On August 6, 2008, at approximately 8:00A.M., the surveyor observed in RI#3's current medication box two professional sample packages of Aricept. There was not a label on either sample package with the resident's name, prescription number, prescribing physician, and directions on how to take the medication. On August 6, 2008, at approximately 2:00P.M., the surveyor interviewed EI#1, Owner and Administrator. EI#1 stated the two Aricept professional sample packages in RI#3's current medication box were given to RI#3 at the physician's office. EI#1 stated that RI#3's family had not reordered the medication from a mail order company before the medication had run out. EI#1 stated the physician had given the sample packages to give to the resident until the medication arrived.	A 626		
A 627	420-5-4-.06(4)(n) Care of Residents (n) Disposal of Medications. 1. Controlled substances and legend drugs dispensed to residents, that are unused because	A 627		

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A 627	Continued From page 28 the medication is discontinued or because the resident dies, shall be destroyed within 30 days, except unused legend drugs may be donated to a charitable clinic pursuant to Alabama Administrative Code, Chapter 420-11-11 et. seq. 2. Medications of residents who are discharged or transferred to another facility shall be returned to the residents. The responsible party will sign a statement that these medications have been received. The statement shall list the pharmacy, prescription number, date, resident's name and strength of the medication and the amount. This statement shall be maintained in a file for at least two years. Discontinued medications shall not be stored or housed in the facility. 3. When medication is destroyed on the premises of the assisted living facility, a record shall be made and filed for at least two years. This record shall include: the name of the assisted living facility, the method of disposal, the pharmacy, the prescription number, the name of the resident, the name, strength, and dosage of the medication, and the amount and the reason for the disposal. This record shall be signed and dated by the individual performing the destruction and by at least one witness. This Rule is not met as evidenced by: Based on observation and an interview with EI#1 the facility failed to destroy within thirty days medications that were discontinued or out of date for three of three residents. Findings: On August 6, 2008, at 3:30P.M., EI#1, Owner and	A 627		

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A 627	Continued From page 29 Administrator, removed three containers from the facility's medication closet that she identified as being the three resident's discontinued medications. EI#1 stated the boxes contained medications that had been discontinued and also medications that were used as needed for the three residents. EI#1 identified the following medications as being discontinued over thirty days ago. RI#1 had Clonidine 0.1 milligrams, Celexa 40 milligrams, Effexor XR 75 milligrams, Enablex 7.5 milligrams, Mirtazapine 15 milligrams, Namenda 5 milligrams, Seroquel 25 milligrams, Depakote 125 milligrams, Depakote 250 milligrams, Wellbutrin XL 150 milligrams, Percocet 5/325 milligrams, Aricept 10 milligrams, and Sertraline HCL 100 milligrams. The surveyor asked EI#1 if all of these medications for RI#1 had been discontinued thirty days ago or longer. EI#1 stated yes. EI#1 stated she was not aware that discontinued medications had to be destroyed after thirty days. RI#2 had Ferrous Sulfate 325 milligrams, Vytorin 10/20 milligrams, Klor-Con 10 milliequavalents and Avalide 300/25 milligrams. The Klor Con prescription label documented discard after May 24, 2007. The Avalide prescription label documented discard after December 4, 2007. EI#1 stated the medications had been discontinued thirty days ago or longer for RI#2. EI#1 verified the discard dates on the labels as being correct dates. RI#3 had Prednisone 5 milligrams, Risperdal 0.5 milligrams, Synthroid 112 micrograms, Sanctura 20 milligrams, and Macrobid 100 milligrams. The Risperdal prescription label documented discard	A 627		

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A 627	Continued From page 30 after December 27, 2007. The Sanctura prescription label documented discard after June 4, 2008. The Macrobid prescription label documented discard after April 2, 2008. EI#1 stated the medications had been discontinued thirty days ago or longer for RI#3. EI#1 verified the discard dates on the labels as being correct dates. RI#3 had as needed medications in this box. The as needed medications had expired. The facility had not discarded the as needed medications of APAP/Hydrocodone 500/5 milligrams with the prescription label documentation to discard after March 13, 2008, Acetaminophen 325 milligrams with the prescription label documentation to discard after December 6, 2007, Phenergan 25 milligrams with the prescription label documentation to discard after April 10, 2008, and Diphenhydramine HCL 25 milligrams with the prescription label documentation to discard after April 16, 2008. EI#1 verified the discard dates on the labels as being correct dates.	A 627		
A 702	420-5-4-.07 (1)(b) Food Service (b) Written Policies and Procedures. The dietitian, with the approval of the administrator, shall develop written policies and procedures for the guidance of all personnel handling food as outlined by the most current Food and Drug Administration Food Code published by the U.S. Department of Health and Human Services. The facility shall develop and implement dietary policies and procedures to meet the needs of the residents in the facility. In addition to other matters deemed necessary by the facility, dietary policies shall address: 1. Sanitation of dishes, utensils, and services	A 702		

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A 702	Continued From page 31 equipment, and sanitary food preparation and handling. 2. The attire and cleanliness of staff members who prepare, handle or serve food. 3. A schedule of meals, which shall include between-meal nourishment or snacks, and fluids. 4. Food substitutions or alternatives. 5. Method to ensure adequate dietary plan is implemented for any resident with a therapeutic diet or special dietary needs. 6. Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food. 7. Provision of necessary services to any resident requiring adaptive devices to eat. 8. Procedure for food service in the event of a disaster. Disaster menus shall be developed. The policy shall address how food will be obtained and maintained at safe temperatures if electricity is not available. 9. Procedure for the handling of potentially hazardous foods such as meat, milk, ice, and eggs. 10. Storage of food. This Rule is not met as evidenced by: Based on observation and an interview with EI#1 the facility failed to have written policies and procedures for the dietary department.	A 702		

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A 702	Continued From page 32 Findings: On August 7, 2008, at 10:50A.M., after reviewing the facility's policy and procedure book, the surveyor asked EI#1, Owner and Administrator, if the facility had any other policies and procedures for the dietary department. EI#1 stated no. EI#1 stated the facility did not have disaster menus written down. The following written policies and procedures were not addressed in the one paragraph "Meal Service and Preparation" policy provided by EI#1: 1. Sanitation of dishes, utensils, and services equipment, and sanitary food preparation and handling. 2. The attire and cleanliness of staff members who prepare, handle or serve food. 3. A schedule of meals, which shall include between-meal nourishment or snacks, and fluids. 4. Food substitutions or alternatives. 5. Method to ensure adequate dietary plan is implemented for any resident with a therapeutic diet or special dietary needs. 6. Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food. 7. Provision of necessary services to any resident requiring adaptive devices to eat. 8. Procedure for food service in the event of a disaster. Disaster menus shall be developed. The policy shall address how food will be obtained and maintained at safe temperatures if electricity is not available. 9. Procedure for the handling of potentially hazardous foods such as meat, milk, ice, and eggs. 10. Storage of food.	A 702		
A 703	420-5-4-.07 (2)(a) Food Service (a) Dish and Utensils Washing, Disinfection and Storage.	A 703		

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A 703	Continued From page 33 1. Wash water shall be changed with sufficient frequency to avoid gross contamination, and final rinse water shall be kept clean and clear. 2. Hand washed repeated service and multi-service utensils and dishes, after washing and rinsing, shall be sanitized by either of the following methods: (A) Utensils and dishes shall be completely immersed for a period of not less than 30 seconds in water that is at least 171 degrees Fahrenheit (pouring scalding water over utensils and dishes does not meet this requirement); or (B) A cold water sanitizer. A sanitizing solution shall be used in accordance with manufacturer's instructions. Utensils and dishes shall be completely immersed for a period of not less than 10 seconds in a clean solution containing not less than 50 ppm, and not more than 200 ppm, of available chlorine bleach, or 30 seconds in 12.5 ppm of iodine or the amount of time set by the manufacturer in a 200 ppm quaternary ammonium solution. Water temperature must be at least 75 degrees Fahrenheit. Water temperatures and chemical concentrations shall be monitored and documented prior to dish washing. A record of each test shall be maintained for at least three months. 3. Dishes and utensils shall be allowed to air dry. 4. After washing, rinsing, sanitizing, and air-drying, all repeated use serviceware (utensils and dishes) shall be stored in a clean, dry place that is protected from pests, dust, splash, and other contaminants. Utensils shall be handled in such a way as to prevent contamination from hands and clothing. 5. The results from the use of dish washing	A 703		

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A 703	Continued From page 34 machines shall be equivalent to those obtained from the method outlined above, as documented in material provided from the manufacturer and kept on file at the facility. This Rule is not met as evidenced by: Based on a review of facility records and an interview with EI#1 the facility failed to keep a record of each sanitizing test for at least three months. THIS DEFICIENCY IS REPEATED FROM THE SURVEY OF JULY 20, 2004. Findings: On August 6, 2008, at 10:00A.M., the surveyor interviewed EI#1, Owner and Administrator. EI#1 stated she used chlorine bleach in the final rinse cycle of the dishwasher to sanitize the dishes. EI#1 stated she washed and sanitized the dishes in the dishwasher at least once a day if not more often. The "Dishwashing Testing Log" provided to the surveyor by EI#1 documented, "May 11 through June 20 one half cup of bleach, purple, okay. June 21 through July 11 one half cup bleach in rinse okay. July 12 through August 4 purple." EI#1 stated this log did not contain each individual sanitizing test for at least three months.	A 703		
A 705	420-5-4-.07 (2)(c) 1. Food Service (c) Protection of Food from Contamination. 1. Food and food ingredients shall be stored,	A 705		

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A 705	Continued From page 35 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 an interview with EI#5 the facility failed to handle and serve food as to keep it procted from any type contamination. Findings: On August 6, 2008, at 11:20A.M., the surveyor observed EI#1, Owner and Administrator, and EI#5, Trainee, who had a hire date of July 25, 2008, prepare the lunch meal. EI#5 broke two eggs into a bowl to make cornbread. EI#5 got raw egg on her fingers while breaking the egg shells. EI#5 did not wash her hands but wiped them on a cloth dish towel in the kitchen. EI#5 mixed the cornbread, peeled and sliced raw tomatos, stirred vegetables cooking in pots on the cooktop, and set plates and cups out for serving the residents lunch meal without washing her hands at any time. On August 6, 2008, at approximately 11:50A.M., the surveyor interviewed EI#5 in EI#1's presence. EI#5 stated she had gotten raw egg on her hands while cracking egg shells and had not washed her hands. EI#5 stated she had continued to prepare the lunch meal and set plates and cups out for the residents after having her hands contaminated with raw egg.	A 705		

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A 716	Continued From page 36	A 716		
A 716	420-5-4-.07 (2)(f) Food Service (f) Employees' Cleanliness. 1. Employees engaged in the handling, preparation, and serving of food shall wear clean clothing at all times. Employees shall wear hair restraints, for example, hair nets, headbands, caps, or other adequate means to prevent contamination of food from hair. Employees whose duties include contact with residents shall change clothing or wear a clean covering over clothing before handling, preparing, or serving food. 2. Employees handling food shall wash their hands thoroughly before starting work each day, immediately after contact with any soiled matter, and before returning to work after each visit to the rest room. 3. Street clothing not worn by the employee shall be stored in lockers, dressing rooms or closets designated for staff use. This Rule is not met as evidenced by: Based on observation the facility did not ensure that hair restraints were used while handling, preparing and serving food. Findings: On August 6, 2008, at 7:15A.M., the surveyor observed EI#1, Owner and Administrator, prepare and serve the breakfast meal for the	A 716		

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A 716	Continued From page 37 three residents. EI#1 did not wear a hair restraint of any type. On August 6, 2008, at 11:20A.M., the surveyor observed EI#1 and EI#5, Trainee, prepare the lunch meal for the three residents. EI#1 and EI#5 did not wear hair restraints of any type during the meal preparation.	A 716		
A 719	420-5-4-.07 (3) (b) Food Service (b) Timing of Meals. A time schedule for serving meals to residents and personnel shall be established. Meals shall be served approximately five hours apart with no more than fourteen hours between the evening meal and breakfast. The time schedule of meals shall be posted with the menu. The facility shall make evening snacks available after service of the evening meal. The facility shall provide fluids throughout the day and shall make between-meal nourishment (snacks) available. This Rule is not met as evidenced by: Based on observation and an interview with EI#1 the facility failed to have written times for meals posted with the menu. Findings: On August 6, 2008, at 11:20A.M., the surveyor asked EI#1, Owner and Administrator, where the menu and meal times were posted. EI#1 stated the menu was in the laundry room. EI#1 stated if meal times were written they should be on the menu. The surveyor observed the menu in the	A 719		

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A 719	Continued From page 38 laundry room. No meal times were written on the menu. The surveyor asked EI#1 if the residents used the menu in the laundry room. EI#1 stated no. EI#1 stated she and the residents talked about the menu but the residents did not go in the laundry room to look at it.	A 719		
A 723	420-5-4-.07 (3) (f) Food Service (f) The amount of food on hand shall be sufficient to serve three meals per day to all residents for three days. Nonperishable food and potable water shall be maintained in the facility in sufficient quantity to serve three meals per day to all residents for three days. This Rule is not met as evidenced by: Based on observation and an interview with EI#1 the facility failed to have potable water in the facility. Findings: On August 6, 2008, during the tour of the facility, the surveyor did not observe any stored emergency potable water in the facility. On August 6, 2008, at approximately 3:00P.M., the surveyor asked EI#1, Owner and Administrator, if there was any stored emergency potable water in the building. EI#1 stated no.	A 723		
A1001	420-5-4-.10 (1)(a) Sanitation and Housekeeping (1) Sanitation. (a) Water Supply.	A1001		

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A1001	Continued From page 39 1. If at all possible, all water shall be obtained from a public water supply. If it is impossible to connect to a public water system, the private water supply shall meet the approval of the local County Health Department. 2. Water under pressure of not less than fifteen pounds per square inch shall be piped within the building to all sinks, toilets, lavatories, tubs, showers and other fixtures requiring water. Tubs, showers, sinks, lavatories, and other fixtures used by residents shall have hot water supplied. Hot water accessible to residents shall in no case exceed 110 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation the facility failed to ensure that hot water assessable to residents did not exceed 110 degrees Fahrenheit. THIS DEFICIENCY IS REPEATED FROM THE SURVEY OF JULY 20, 2004. Findings: On August 6, 2008, at approximately 10:45A.M., the surveyor accompanied EI#1, Owner and Administrator and measured the hot water temperature in the kitchen as 118 degrees Fahrenheit on the surveyor's thermometer and 120 degrees Fahrenheit on EI#1's thermometer. The hot water temperature in RI#3's bathroom was 118 degrees Fahrenheit on the surveyor's thermometer and 120 degrees on EI#1's thermometer. EI#1 stated these two areas were the closest ones to the facility's one hot water	A1001		

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A1001	Continued From page 40 heater. The surveyor instructed EI#1 the water temperature had to be 110 degrees Fahrenheit or less. On August 6, 2008, at approximately 11:20A.M., EI#1 stated that she had not kept a log of the hot water temperature to show the temperature had remained 110 degrees or below since being cited as measuring above 110 degrees Fahrenheit in the survey of July 20, 2004. EI#1 stated that the water temperature was usually measured as being between 110 and 115 degrees Fahrenheit. The surveyor asked EI#1 when the hot water temperature had been taken by a facility staff member before today. EI#1 stated she did not know when it had last been taken.	A1001		
A1101	420-5-4-.11 Fire Safety (1) General. (a) Evacuation Plan. All assisted living facilities shall maintain a current written fire control and 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, quarterly on each shift. 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.	A1101		

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A1101	Continued From page 41 (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 and an interview with EI#1 the facility failed to have a current evacuation plan posted. The facility also failed to have a fire drill documented for the month of July of 2008. THIS DEFICIENCY IS REPEATED FROM THE SURVEY OF JULY 20, 2004. Findings: On August 6, 2008, at 7:15A.M., the surveyor asked EI#1, Owner and Administrator, how many residents lived in the facility. EI#1 stated three and that each resident had their own room. On August 6, 2008, at approximately 10:30A.M., EI#1 showed the surveyor the facility's posted evacuation plan. All of the areas on the evacuation plan were not identified. RI#3's bedroom was not on the plan. EI#1 stated the same evacuation plan was posted in each resident's room. EI#1 stated the evacuation plan had not been updated and was not labeled to show each area of the facility. On August 6, 2008, after reviewing the fire drill documentation in the facility, the surveyor	A1101		

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A1101	Continued From page 42 interviewed EI#1 at 10:00A.M. EI#1 stated she had done a fire drill in July of 2008 but she had not documented it. EI#1 stated she was aware it was to be written down but she had not as she had been busy working on getting another building ready.	A1101		