ALABAMA DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH CARE FACILITIES
ASSISTED LIVING UNIT
STATEMENT OF DEFICIENCIES
FOR
ROSELAND ASSISTED LIVING
55 BURTONWOOD DRIVE
MOBILE, AL 36608
SURVEY DATES: JUNE 13 - JUNE 17, 2005

This facility is licensed for 16 assisted living beds. The census of the facility on the survey dates was 10.

The following are deficiencies cited during the survey and require a plan of correction:

420-5-4-.03(1)(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.

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on observation, record reviews, and interviews with the facility's two owners, the facility's administrator of record, and facility staff, the surveyor determined that the governing authority failed to have all of the required policies for the management and operation of the facility. The surveyor also determined that the governing authority failed to implement policies that it did have in the facility. Finally, the surveyor determined that the governing authority failed to supervise the administrator for the overall management and the day-to-day operation of the facility which resulted in the deficiencies listed in the findings below.

FINDINGS:

On 06/15/05, at 10:45A.M., during an interview with the facility owners who are EI#1 and EI#2, the surveyor asked when they were first aware that a facility had to have a licensed administrator. EI#1 stated that EI#3 told them when they first came to look at the facility and then apply for the facility license. EI#1 stated that EI#3 had agreed to be listed as the administrator as she had an administrator's license and they were leasing the facility from EI#3. The surveyor asked when the license application was made. EI#1 stated that the application was made in March of 2004. The surveyor asked EI#1 and EI#2 if anyone at the facility other than EI#3 was licensed as an assisted living administrator. EI#1 and EI#2 stated no. The surveyor asked EI#1 and EI#2 if they

had any prior experience in working in or operating an assisted living facility prior to March of 2004. EI#1 and EI#2 stated no.

420-5-4-.03(1)(c) - Failed to have a policy for what the facility's responsibility would be if a residents personal belongings were lost.
Failed to state in the fire alarm and sprinkler system policy that each should be inspected on a semiannual basis.

420-5-4-.04(1)(a)1 - Failed to ensure that all facility personnel had a physical examination prior to resident contact.

420-5-4-.04(1)(a)2 - Failed to ensure that all facility personnel had a tuberculosis evaluation prior to resident contact.

420-5-4-.04(2) - Failed to ensure that facility employees did not serve as a representative for any resident.

420-5-4-.04(3)(a)1 - Failed to ensure that the licensed administrator was responsible for the day to day operations of the facility which resulted in deficiencies cited during this survey.

420-5-4-.04(3)(a)2 - Failed to have an individual authorized in writing to act for the administrator during absences.

420-5-4-.04(4)(b) - Failed to ensure that the facility staff members received the initial training.

420-5-4-.05(3)(c) - Failed to ensure that 2 residents had a medical examination record.

420-5-4-.05(3)(d) - Failed to ensure that 2 residents had a written plan of care.

420-5-4-.05(3)(g)4 - Failed to ensure that 1 resident had the right to visit with any person of his or her choice at any reasonable time.

420-5-4-.05(3)(g)10 - Failed to ensure that 9 of 9 residents had the right to health care consistent with established and recognized standards within the community.

420-5-4-.05(3)(g)17 - Failed to post the telephone numbers of the Department of Public Health Toll Free Assisted Living Facilities Complaint Hotline and of the Department of Human Resources Toll Free Elder Abuse Hotline in a conspicuous resident common area.

420-5-4-.06(1) - Failed to ensure that 3 of 8 resident's care was under the direction and supervision of a physician.

420-5-4-.06(2)(h) - Failed to ensure that 3 of 4 resident's had a tuberculosis evaluation prior to admission.

420-5-4-.06(4)(b) - Failed to ensure that 2 unlicensed staff members assisted residents with medications instead of administering medications.

420-5-4-.06(4)(d) - Failed to ensure that unlicensed staff members did not split medications.

420-5-4-.06(4)(e) - Failed to identify a resident who was not cognitively intact and ensure that only licensed staff members administered his/her medications.

420-5-4-.06(4)(j) - Failed to ensure that all medications kept in the facility's control were packaged in the unit dose form.

420-5-4-.06(4)(k) - Failed to have a controlled substance count sheet for a controlled substance in the facility's control.

420-5-4-.07(2)(c)8 - Failed to ensure that frozen foods were thawed under refrigeration.

420-5-4-.07(3)(b) - Failed to post the time schedule of meals with the menu.

420-5-4-.10(1)(a)2 - Failed to ensure that hot water accessible to residents did not exceed 110 degrees Fahrenheit.

420-5-4-.10(1)(d) - Failed to ensure that the facility was free of flies.

420-5-4-.12(3)(m)4 - Failed to ensure that all 4 exterior egress doors accessible to residents did not have delayed or special locking devices on them.

420-5-4-.12(3)(t)3 - Failed to ensure that the fire alarm system and the sprinkler system were inspected on a semiannual basis.

420-5-4-.03(1)(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 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.

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on a review of the facility's records including the policies and procedures, a request for additional policies and procedures, and interviews with the owners, the surveyor determined that the facility failed to have a policy and procedure outlining what the facility's responsibility would be if a resident lost personal belongings in the facility. The surveyor also determined that the facility's policies in place for the sprinkler system and the fire alarm system did not document that an outside licensed agency was required to inspect them on a semiannual basis.

FINDINGS:

On 06/15/05, at 2:40P.M., after reviewing the facility's policies and procedures, the surveyor noted that the policies and procedures were on "Our Southern Home, Inc." policy and procedure forms. The surveyor asked if the facility(Roseland) had adopted the Our Southern Home Inc., policies and procedures. EI#2 stated yes. The surveyor asked if these policies and procedures had been changed to the Roseland policies and procedures. EI#2 stated that the facility did not have anyone to type the word "Roseland" on the policies and procedures so they were adopted by Roseland but remained titled Our Southern Home Inc. The surveyor asked EI#1, EI#2, and EI#4 for the policy which determined what the facility's responsibility was if a resident lost personal belongings. EI#2 showed the surveyor a policy stating that the facility would hold a resident's belongings until they could be picked up if the resident had vacated the premises. The policy also stated that after 30 days the items would be sold or discarded by the facility. The surveyor told EI#2 that a policy was required for what the facility's responsibility would be if a resident lost personal belongings at the facility. The surveyor asked if the facility had a policy addressing the responsibility. EI#2 stated no.

On 06/15/05, at 2:40P.M., after reviewing the facility's policies and procedures and the sprinkler and fire alarm system inspections by outside licensed agency's, the surveyor determined that the facility's policy and procedure for inspection on the sprinkler system documented that a yearly inspection would be done by a licensed and approved sprinkler company. The surveyor references **420-5-4-.12(3)(t)3**: **The sprinkler system shall be inspected by licensed, trained and qualified personnel at least semiannually for compliance with the respective codes.**

The surveyor noted that the policy for the fire alarm system documented, "A monthly check of the alarm system will be performed by the Administrator and/or designated person." The surveyor references **420-5-4-.12(3)(t)3**: **The fire alarm system shall be inspected by licensed, trained and qualified personnel at least semiannually for compliance with the respective codes.**

420-5-4-.04(1)(a)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.

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on a review of the facility's personnel records including physical examinations, a request for the certification that the employee was free of signs and symptoms of infectious skin lesions and diseases prior to resident contact, and an interview with EI#2, the surveyor determined that the facility failed to ensure that 1 of 11 employees had documentation of the physical examination in his/her record prior to resident contact.

FINDINGS:

On 06/15/05, at 2:40P.M., after reviewing the personnel records, the surveyor noted that EI#11 had a hire date of 12/28/04. The surveyor was not able to locate EI#11's medical examination in his/her record. The surveyor asked who had hired EI#11. EI#2 stated that he/she had hired EI#11. The surveyor asked EI#2 to locate the physical examination certifying that EI#11 was free of infectious skin lesions and diseases prior to resident contact. EI#2 stated that EI#11 did not have one.

420-5-4-.04(1)(a)2. Prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis.

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on a review of the facility's personnel records including the evaluations for tuberculosis, a request for the documentation of the evaluation for tuberculosis prior to resident contact, and an interview with EI#2, the surveyor determined that the facility failed to ensure that 1 of 11 employees had the required tuberculosis evaluation prior to resident contact.

FINDINGS:

On 06/14/05, at 7:00A.M., the surveyor met EI#6 who stated that he/she worked the 11-7 shift at the facility and had been there as an employee for about 4 weeks.

On 06/15/05, at 2:40P.M., after reviewing the personnel records, the surveyor noted that EI#6 had a hire date of 05/17/05. The surveyor was not able to locate a tuberculosis evaluation in EI#6's personnel record. The surveyor asked EI#2 to locate the tuberculosis evaluation for EI#6. EI#2 was not able to locate the documentation. The surveyor asked if EI#6 had the tuberculosis evaluation prior to resident contact. EI#2 stated no.

420-5-4-.04(2) No member of the assisted living facility governing authority, and no employee of an assisted living facility, including the administrator, shall serve as legal guardian, as conservator, or as attorney-in-fact for any resident of the facility.

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on a review of the facility's records, a review of an area hospice agency's records, and interviews with EI#1, EI#2, and EI#4, the surveyor determined that EI#4 was documented as being a power of attorney for RI#3. The surveyor also determined that EI#4 had signed the admission paperwork to an area hospice as being the legal representative for RI#4.

FINDINGS:

On 06/16/05, at 4:00P.M., after the surveyor completed reviewing the facility's resident records, and records from an are hospice agency, the surveyor asked EI#1, EI#2, and EI#4 if any facility staff member was power of attorney for any resident. EI#4, facility manager and unit coordinator, stated that he/she was power of attorney for RI#3 when he/she took RI#3 to the Veteran's Appointments. The surveyor noted that EI#4 had signed Veteran Administration paperwork as being a power of attorney for RI#3. The surveyor asked if EI#4 was a power of attorney for any other resident. EI#4 stated no. The surveyor asked EI#1 and EI#2, the facility owners, if they were aware that EI#4 was a power of attorney for RI#3. EI#1 and EI#2 stated no.

On 06/16/05, at 2:15P.M., while reviewing RI#4's record at a local hospice agency, the surveyor observed the following documents had been signed by EI#4 as representing RI#4: EI#4 had signed as legal representative of RI#4 on the Medicare/Medicaid - Hospice Benefit Election form on 04/22/05. EI#4 had signed as the Patient's Representative on the Medicaid Hospice Election and Physician's Certification form on 04/22/05. EI#4 had signed as the Patient's Representative for RI#4 on the Informed Consent form on 04/22/05. EI#4 had signed as the Patient's Representative for "RI#4 on the hospice Patient's Bill of Rights Alabama form on 04/22/05. EI#4 had signed as the Patient's Representative for RI#4 and as the Primary Caregiver Signature on the Primary Caregiver Consent form on 04/22/05. EI#4 signed as the Patient's Representative for RI#4 on the Revocation of Hospice Care Form, Medicare/Medicaid Patient on 05/11/05.

On 06/17/05, at 1:00P.M., the surveyor asked EI#1, EI#2, and EI#4 to explain why RI#4 had been taken off hospice services. EI#4 stated that RI#4's son/daughter had wanted RI#4 on hospice but then felt that hospice was confusing RI#4 and had RI#4 taken off hospice. The surveyor asked EI#4 who had signed the paperwork admitting RI#4 to hospice and revoking hospice services for RI#4. EI#4 stated, "I did." The surveyor asked why. EI#4 stated that RI#4's son/daughter had wanted EI#4 to sign the papers. The surveyor asked if EI#4 had written permission to sign the hospice documents for RI#4. EI#4 stated no. The surveyor asked EI#1 and EI#2, facility owners, if they were aware that EI#4 had signed the admission and revocation papers for RI#4 to be admitted to hospice. EI#1 and EI#2 stated no.

420-5-4-.04(3)(a)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.

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on a review of the facility's records, interviews with EI#1, EI#2, EI#3, and EI#4, an interview with a representative of the State Board of Examiners, and a conversation with the supervisor of the Assisted Living Facilities division of the Alabama Department of Public

Health, the surveyor determined that the facility failed to ensure that the administrator of record was responsible for the facility operations. The surveyor also determined that the facility failed to ensure that the administrator or any responsible person operated the facility in accordance with the Rules of Alabama State Board of Health, Alabama Department of Public Health, Chapter 420-5-4, Assisted Living Facilities, with Licensure Law.

FINDINGS:

On 06/14/05, at 9:15A.M., the surveyor asked EI#4 who owned the facility. EI#4 stated EI#1 and EI#2. The surveyor asked who was the facility administrator. EI#4 stated EI#3.

On 06/14/05, at 9:30A.M., EI#3 arrived. The surveyor asked EI#3 who was the administrator of the facility. EI#3 stated that he/she was not the administrator and did not manage the home. EI#3 stated that he/she only gave referrals to the facility.

EI#1 stated that EI#3 was the administrator and was listed on the application for the facility license as the administrator. EI#1 stated that EI#3 agreed to be the administrator for the facility until either EI#1 or EI#2 who are both owners were able to be licensed as the administrator. EI#1 stated that EI#3 verbally agreed to have her name on the license application and to act as the facility administrator until someone else was licensed as an administrator.

The surveyor asked EI#3 for documentation that he/she was not the facility's administrator.

On 06/14/05, at 9:50A.M., the surveyor called the Department of Public Health's Assisted Living Unit's Supervisor. The surveyor asked the supervisor to look in the facility's record for the license application. The surveyor asked the supervisor to see who was documented as being the administrator, the date the facility made the application for the license, and the date the application was approved. The supervisor stated that EI#3 was the administrator of the facility, the date the facility made the license application was March 27, 2004, and the date the Department approval the license was March 10, 2005.

On 06/14/05, at 11:30A.M., during an interview with EI#3, the surveyor asked if EI#3 had notified the Department of Public Health that he/she was not the administrator of the facility. EI#3 stated that he/she did not know. EI#3 then stated that he/she did not know that he/she had to notify the Department of not being the administrator for the facility. The surveyor asked if EI#3 had signed the application for the facility name change and license which listed him/her as being the administrator. EI#3 stated that he/she had only signed the forth page of the four page application and was not aware that he/she had been listed as the facility administrator. The surveyor asked EI#3 again if he/she had notified the Department of no longer being the administrator. EI#3 stated, "No. Not in writing." EI#3 stated that they were supposed to take the administrator's examination a year ago and that he/she thought they would also notify the department of the change in administrator. The surveyor asked EI#3 to clarify who "they" were. EI#3 stated EI#1 and EI#2.

The surveyor asked EI#3 if that was his/her signature above the title administrator on RI#3's admission agreement which was dated 01/20/05. EI#3 stated that it was his/her signature but that

he/she had not signed as being the administrator on the agreement. EI#3 stated that he/she was just walking the owners through the process of admitting residents.

The surveyor asked EI#3 what he/she did at the facility. EI#3 stated, "Absolutely Nothing. I come and collect the rent from EI#1 or EI#2." The surveyor asked EI#3 when he/she had last been at the facility prior to 06/14/05. EI#3 stated that he/she thought February or March but just to collect rent. The surveyor asked EI#3 if he/she were aware that any change in Administrator had to be reported to the Department within 15 days. EI#3 stated, "I am now." EI#3 then stated that the application that he/she signed was dated in 2004. The surveyor asked EI#3 if he/she had time since the date of March 27, 2004, when his/her signature was notarized on the application for license listing him/her as the administrator to notify the Department that he/she was not the facility administrator. EI#3 stated, "Yes." The surveyor asked EI#3 if he/she had notified the Department. EI#3 stated, "No." EI#3 then stated that he/she did not know what they did at the facility and that EI#12 usually came to pick up the check. EI#3 stated, "I am not the operator of this facility."

On 06/14/05, at 1:30P.M., the surveyor called the State of Alabama Board of Examiners for Administrators of Assisted Living Facilities. The surveyor asked the representative of the Board if EI#1, EI#2, or EI#4 had an administrator's license for Assisted Living Facilities. The representative stated that none of the three had a license. The representative stated that EI#1 and EI#2 had never taken the training sessions. The representative stated that EI#1's provisional license had expired 01/22/05. The representative stated that EI#2's provisional license had expired 01/22/05. The representative stated that EI#4's provisional license had expired 09/02/04. The surveyor asked the representative who the Board had on record as being the licensed administrator for the facility. The representative stated EI#3.

420-5-4-.04(3)(a)2. There must be an individual authorized in writing to act for the administrator during absences.

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on interviews with EI#1, EI#2, and EI#4, and a request for a written designee to act for the administrator, the surveyor determined that the facility failed to have a written designee to act for the administrator during absences.

FINDINGS:

On 06/14/05, at 9:15A.M., the surveyor asked EI#4 who acted in the facility administrator's absence. EI#4 stated EI#12's first name but stated that he/she did not know EI#12's last name. The surveyor asked EI#4 if this was in writing. EI#4 stated no.

The surveyor asked who was responsible for what occurred in the facility each day. EI#2 stated EI#1 and myself. The surveyor asked if this was in writing. EI#2 stated no.

420-5-4-.04(4)(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.

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 staff records including training records, and interviews with EI#1, EI#2, EI#4, EI#5, and EI#6, the surveyor determined that the facility failed to ensure that the staff members had received the above 9 items of initial training.

FINDINGS:

On 06/14/05, at 4:45P.M., after reviewing the facility's training records for the staff members, the surveyor noted that the initial training had not been completed for the staff members. The surveyor asked EI#1, EI#2, and EI#4 if there were any additional training for the staff members. EI#1, EI#2, and EI#4 stated no.

On 06/15/05, at 7:00A.M., the surveyor asked EI#6 what training he/she had received at the facility. EI#6 stated resident rights. The surveyor asked EI#6 if he/she had received training in state rules. EI#6 stated no.

On 06/15/05, at 8:30A.M., the surveyor asked EI#5 what training he/she had received at the facility. EI#5 stated fire drills, resident rights, abuse, food preparation, medications, first aid, CPR, hurricane evacuation and food temperatures. The surveyor asked EI#5 if he/she had received training in state rules for assisted living facilities. EI#5 stated that he/she had read part of the book. The surveyor asked if EI#5 had read all of the book. EI#5 stated no. The surveyor asked if EI#5 had signed any of the training. EI#5 stated he/she had signed the training sheets and that EI#4 had the book with the training sheets.

On 06/15/05, at 8:30A.M., the surveyor asked EI#4 to provide all of the staff training records to the surveyor. EI#4 showed the surveyor the same records of training that the surveyor had reviewed on 06/14/05. The surveyor asked if the only training provided by the facility to some of the staff members was abuse, neglect, exploitation, fire safety, and signs and symptoms of dementia. EI#4 stated yes.

On 06/15/05, at 10:45A.M., the surveyor asked who was responsible for staff training. EI#1 stated EI#2, EI#4, and myself. The surveyor asked why the employees had not received all of the initial training. EI#4 stated that he/she had done the First Aid training. The surveyor asked if the First Aid training was complete. EI#4 showed the surveyor where he/she had taught choking as First aid training. The surveyor asked if there were any additional staff records for initial training. EI#4 stated no.

The surveyor noted that the facility failed to provide initial staff training as follows:

1) 10 of 10 staff members whose records were reviewed did not have the training for State Law and Rules on Assisted Living Facilities: EI#1, EI#2, EI#4, EI#5, EI#6, EI#7, EI#8, EI#9, EI#10, and EI#11.

2) 5 of 10 staff members did not have the training for Identifying and Reporting Abuse, Neglect, and Exploitation: EI#1, EI#2, EI#7, EI#8, and EI#9.

3) 10 of 10 staff members did not have the training for Special Needs of the Elderly, Mentally Ill, and Mentally Retarded: EI#1, EI#2, EI#4, EI#5, EI#6, EI#7, EI#8, EI#9, EI#10, and EI#11.

4) 7 of 10 staff members did not have the training for Basic First Aid: EI#4, EI#5, EI#6, EI#8, EI#9, EI#10, and EI#11.

5) 10 of 10 staff members did not have the training for Advance Directives: EI#1, EI#2, EI#4, EI#5, EI#6, EI#7, EI#8, EI#9, EI#10, and EI#11.

6) 10 of 10 staff members did not have the training for Protecting Resident Confidentiality: EI#1, EI#2, EI#4, EI#5, EI#6, EI#7, EI#8, EI#9, EI#10, and EI#11.

7) 10 of 10 staff members did not have the training for Safety and Nutritional Needs of the Elderly: EI#1, EI#2, EI#4, EI#5, EI#6, EI#7, EI#8, EI#9, EI#10, and EI#11.

8) 6 of 10 staff members did not have the training for Resident Fire and Environmental Safety: EI#1, EI#2, EI#6, EI#7, EI#8, and EI#9.

9) 7 of 10 staff members did not have the training for Identifying Signs and Symptoms of Dementia: EI#1, EI#2, EI#4, EI#6, EI#7, EI#8, and EI#9.

420-5-4-.05(3)(c) 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 a review of the facility's resident records including medical examination records, a request for all medical examination records, and interviews with EI#1, EI#2, and EI#4, the surveyor determined that the facility failed to ensure that 2 of 8 sampled residents had a Medical Examination signed by his/her physician not more than thirty days prior to admission.

FINDINGS:

On 06/14/05, at 4:00P.M., after reviewing resident records, the surveyor noted that RI#1had an admission date to the facility of 01/21/05. The surveyor noted that RI#1 did not have a Medical Examination in his/her record. The surveyor noted that RI#3 had an admission date to the facility of 01/20/05. The surveyor noted that the Medical Examination in RI#3's record was dated 06/14/05.

On 06/15/05, at 9:00A.M., the surveyor asked EI#1, EI#2, and EI#4, to locate the Medical Examinations for RI#1 and RI#3 for admission. EI#2 stated that the Medical Examinations were not in the facility but that RI#1 and RI#3 had been to the doctor.

420-5-4-.05(3)(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 therapeutic diets.

2. A description of the assistance with activities of daily living required by the resident (assistance needed with medications, dressing, bodily hygiene, ambulating, diet, and activities affecting personal safety, for example). As changes in medication and personal

services become necessary, the plan of care shall be promptly updated and all changes shall be documented.

3. 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.

4. 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).

5. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care (HCFA Form 485/487) for each resident receiving care from an outside provider.

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on a review of the facility's resident records, a review of a local hospice agency's records, and interviews with EI#1, EI#2, and EI#4, the surveyor determined that the facility failed to ensure that 2 of the 8 sampled residents had a written plan of care.

FINDINGS:

RI#1

On 06/14/05, at 4:00P.M., the surveyor noted that RI#1 did not have a written plan of care in his/her record. The surveyor noted that RI#1 had an admission date to the facility of 01/21/05.

On 06/15/05, at 9:00A.M., the surveyor asked EI#1, EI#2, and EI#4 if RI#1 had a written plan of care in the facility for admission. EI#2 stated no. The surveyor asked how the staff knew what to do for RI#1 without physician orders and plans of care. EI#4 stated that hospice saw RI#1.

On 06/16/05, at 9:45A.M., the surveyor asked EI#1, EI#2, and EI#4 if RI#1 had a Percutaneous Endoscopic Gastrostomy (PEG) tube when he/she was admitted on 01/21/05. EI#2 stated yes but that it had been removed in January of 2005 at the physician's office. The surveyor asked what was done to the PEG tube site. EI#4 stated that hospice took care of the site. The surveyor asked what the facility did to take care of the site. EI#4 stated that hospice took care of the site. The surveyor asked how the facility knew in May of 2005 that the site was infected. EI#2 showed the surveyor a paper from the physician's office stating, "05/26/05: Complaints: Peg tube site looks infected." EI#4 stated that the hospice nurse told them and that the physician told her when she took RI#1 to the office to have it checked that it was infected. The surveyor asked where the plan of care was located for the PEG tube site care for RI#1. EI#4 stated that hospice put a

cream on the area and that hospice had the plan of care for the site. The surveyor noted that the most recent hospice plan of care for RI#1 was 12/20/04 to 03/19/05 and did not include care for the infected PEG site.

On 06/16/05, at 2:15P.M., while reviewing records at a local hospice agency for RI#1, the surveyor noted that a physician's order dated 06/03/05 documented, "Silver Nitrate twice weekly to affected area (old PEG site)." The surveyor noted that the hospice nurses note dated 06/13/05, documented, "Silver Nitrate applied to PEG site for first time today by CM(case manager). FS(facility staff) taught procedure." The surveyor asked the hospice representative what CM and FS meant. the representative stated CM was Case Manager and that FS was Facility Staff. The Teaching area of the nurses note dated 06/13/05 documented, "Silver Nitrate Bi weekly to PEG site. Staff had prescription filled on 06/03/05 and had not applied when CM made visit today, instructed again on procedure to apply Silver Nitrate. Skin care teaching to staff with Silver Nitrate." The surveyor noted that the facility's staff member, EI#5, had signed the area of the nurses note for the patient's representative. The surveyor made a phone call to the facility and asked EI#5 if he/she had been taught to use the Silver Nitrate on 06/13/05. EI#5 stated, "Well I let EI#4 handle him/her. They showed EI#4 how to care for it not me." The surveyor asked to speak to EI#4. EI#4 stated, "I was just in the room with her(nurse). She did not instruct me." The surveyor asked EI#4 to describe what the hospice nurse had done to the PEG site on 06/13/05. EI#4 stated, "She took the Silver Nitrate and put around it and then a dressing." The surveyor asked EI#4 if the Silver Nitrate was a cream. EI#4 stated, "Yes. On a stick. They did not instruct me. I just watched."

RI#3

On 06/14/05, at 2:30P.M., the surveyor noted that RI#3 had an admission date to the facility of 01/20/05. The surveyor noted that RI#3's written plan of care in his/her record was dated 06/14/05. The surveyor noted that on RI#3's, "Tracking Sheet" in his/her record that the following was documented, "Hospital 05/19/05. Hospital 06/06/05 to 06/10/05. Back to facility from hospital 06/14/05." The surveyor noted a local hospital's discharge instruction sheet in the record which was dated 05/25/05. The surveyor asked if the documentation meant that RI#3 had been in the hospital. EI#4 stated yes. The surveyor asked if RI#3 had a written plan of care for 01/20/05 through 06/14/05. EI#2 stated no.

On 06/15/05, at 9:00A.M., the surveyor asked EI#1, EI#2, and EI#4 if RI#3 had a written plan of care in the facility for admission. EI#2 stated no. The surveyor asked how the staff knew what to do for RI#3 without physician orders and plans of care. EI#4 stated that hospice had seen RI#3 in the past. EI#4 showed the surveyor a plan of care for RI#3 signed by the physician dated 06/14/05. The surveyor had observed that RI#3 returned to the facility from a local hospital at approximately 2:30P.M., on 06/14/05, and the EI#5 took a wheel chair out to the private vehicle to bring RI#3 back into the facility.

On 06/16/05, at 2:15P.M., while reviewing records at a local hospice agency for RI#3, the surveyor noted that RI#3 had a prior admission to the agency with a start of care date of 10/29/04 and a revocation(date of release from hospice) of 02/03/05 with the reason for revocation being aggressive treatment at a local hospital for chest pain. The surveyor noted that RI#3 had a

current record at the hospice agency with the date of admission as 06/15/05 for CHF(Congestive Heart Failure).

420-5-4-.05(3)(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.

1. No resident shall be deprived of any civil or legal rights, benefits or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility.

2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints.

3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy.

4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time.

5. Every resident shall have freedom to participate in and benefit from social, religious and community services and activities and to achieve the highest possible level of independence, autonomy and interaction within the community.

6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the premises, an individual account record for each resident shall be maintained by the administrator and an up-to-date record shall be maintained for all transactions.

7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so.

8. Every resident shall have the right to reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals.

9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident.

10. Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to

receive or reject medical care, dental care, or other health care services except those required to control.

11. Every resident shall have the right to at least 30 days prior written notice of involuntary relocation or termination of residence from the facility unless for medical reasons the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care, or unless the resident engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record.

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

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

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

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

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

(iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time without recourse.

15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges.

16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities.

17. Every resident shall have the right to have the name, telephone number and address of the Division of Health Care Facilities, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll free Assisted Living Facilities Hot Line and the Department of Human Resources toll free Elder Abuse

Hot Line. All of this information shall be posted in a conspicuous location in a resident common area.

18. All state inspection reports and any resulting corrective action plan from the past 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.

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

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

21. Every resident shall have the right to wear his or her own clothes, to keep and use his or her own personal possessions including toilet articles except for personal possessions too large to be stored in the resident's room.

22. Every resident shall have the right to be accorded privacy for sleeping and for storage of personal belongings.

23. Every resident shall have the right to have free access to day rooms, dining and other group living or common areas at reasonable hours and to freely come and go from the home.

24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, advance directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file.

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on observation, interviews with residents, resident's friends/family members, and facility staff, the surveyor determined that the facility violated 1 of 8 residents sampled the right to visit with any person of his or her choice at any reasonable time. The surveyor also determined that the facility failed to ensure that 9 of 9 residents who were observed during medication assistance had the right to health care consistent with established and recognized standards within the community whereby the aide giving assistance did not wash her hands or change gloves between residents during the medication administration process. Finally, the surveyor determined that the facility failed to post the Department of Public Health toll free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll free Elder Abuse Hot Line in a conspicuous location in a resident common area.

FINDINGS:

420-5-4-.05(3)(g)4 - RESIDENT'S RIGHT TO VISIT WITH ANY PERSON OF HIS OR HER CHOICE AT ANY REASONABLE TIME:

On 06/14/05, at 9:15A.M., the surveyor observed facility staff talking with a unidentified resident's sponsor regarding who would be allowed to visit at the facility. The surveyor asked if any other resident had restrictions on visitors. EI#4 stated no.

On 06/14/05, at 4:00P.M., the surveyor interviewed RI#2. The surveyor asked RI#2 if he/she had visitors. RI#2 stated that he/she had visitors in the past but they stopped him/her from coming to the facility. The surveyor asked RI#2 to clarify "they". RI#2 stated EI#1, EI#2, EI#4, and EI#5. The surveyor asked if RI#2 wanted the visitor to be able to come to the facility. RI#2 stated yes.

On 06/14/05, at 5:00P.M., the surveyor interviewed RI#11. The surveyor asked if RI#11 had visitors. RI#11 stated yes. The surveyor asked if any of RI#11's visitors had ever been told that they could not visit the facility. RI#11 stated not mine but someone else's has been told not to come here. The surveyor asked whose visitor had been told to leave. RI#11 stated that either EI#4 or EI#5 had told a visitor of RI#2 to leave and not come back. The surveyor asked how RI#11 knew this. RI#11 stated that he/she witnessed and heard it when it happened.

On 06/14/05, at 9:00P.M., the surveyor interviewed a relative of RI#2's per telephone. The surveyor asked the relative if RI#2 had ever had visitors told by the facility staff that they could not visit. The relative stated that on RI#2's birthday that he/she went to move RI#2 from the facility to the visitor's house. RI#2 had decided not to move. The relative stated that the other visitor was at the facility. He/she stated that the visitor was in a fit as he/she was leaving and that the staff working that day told the visitor to leave and not come back.

On 06/15/05, at 8:45A.M., the surveyor interviewed RI#2 asking if he/she wanted any visitors. RI#2 stated that he/she wanted the visitor that the staff had told to leave and not come back to visit. RI#2 stated that he/she had known the visitor for years and that the visitor would take him/her out to eat, shop and get his/her hair done without charging any fees for the trip.

On 06/15/05, at 2:40P.M., during an interview with EI#1, EI#2, and EI#4, the surveyor asked why RI#2's visitor had been asked to leave the facility. EI#1 stated that the visitor was at the facility on RI#2's birthday along with RI#2's relative. EI#1 stated that RI#2's visitor had started yelling and cursing while in RI#2's room as RI#2 had decided not to move to the visitor's home. EI#1 stated the visitor was asked to leave the building. EI#1 stated that the visitor returned about 2 weeks later on a Sunday. EI#1 stated when the visitor returned that EI#5 called her at her other place of employment and that she(EI#1) told EI#5 to call the police. EI#1 stated that EI#5 called the police and that an officer came out to the facility and made the visitor leave. The surveyor asked EI#1 if she noted the officer's name or knew if a report was filled out by the officer. EI#1 stated that she did not know if the officer filled out a report but that she had spoken to the officer on the telephone but did not recall his name. EI#1 stated that the officer had made the visitor leave as it was private property.

On 06/16/05, at 8:00A.M., the surveyor interviewed EI#5 regarding the visitor. EI#5 stated that on the Sunday when the police officer came to the facility that the visitor brought another female with her to visit RI#2. EI#5 stated that she answered the door and told the visitor that she could

not see RI#2. The surveyor asked why she told the visitor this. EI#5 stated that no one in authority was at the facility at the time and that she asked the visitor to leave and come back later. The surveyor asked why EI#5 had asked the visitor to leave. EI#5 stated that she was just an aide and did not want people walking in off the street to see these people. The surveyor asked EI#5 if anyone at the facility had told her that RI#2 could not have visitors. EI#5 stated no. The surveyor asked EI#5 who had told her not to let the person visit RI#2. EI#5 stated no one had and that she had just asked the visitor to leave and come back later. EI#5 stated that the visitor then started talking loudly so she(EI#5) called EI#1 and EI#4. EI#5 stated they told her to call the police. EI#5 stated that the police told the visitor that if she did not leave that he would arrest her as this was private property so the visitor left. The surveyor asked EI#5 if she knew the officer's name and if he had filled out a report. EI#5 stated the policeman had handed her a card but that she did not know what she had done with it. EI#5 thought that she might have given the card to EI#4 later. EI#5 could not recall the officer's name. EI#5 stated that the visitor had asked the policeman for a report and that he told the visitor to leave or that he would arrest him/her.

On 06/16/05, at 9:00P.M., the surveyor interviewed RI#2's visitor per telephone. RI#2's visitor stated that he/she had to track RI#2 down to locate him/her after RI#2 was moved from another facility during an emergency situation. RI#2's visitor stated that he/she had known RI#2 for years. RI#2's visitor stated that when he/she located RI#2 that he/she was shocked at RI#2's appearance. He/she stated that RI#2 had always kept his/her hair neat but that when he/she first visited at Roseland that RI#2's hair was long and shaggy. The visitor stated that he/she took RI#2 to the barber/beauty shop, to the cemetery and to eat on that first visit. The visitor stated that he/she had visited several times at the facility before RI#2's birthday. The visitor stated that about two weeks before RI#2's birthday that he/she(visitor) had told EI#4 that the resident would be moving. The visitor stated that EI#4 told him/her that RI#2 had been placed in the facility by a county agency and could not be moved unless the county agency moved RI#2. The visitor stated that when he/she and RI#2's family member went to the facility on RI#2's birthday to move him/her out that RI#2 stated that he/she had decided not to move out that date as the facility was having him/her a birthday party. The visitor stated that EI#4 asked the relative if he/she had power of attorney to move RI#2. The visitor stated that the relative stated that no one had power of attorney of RI#2 and that was when RI#2 became upset, started crying and saying that we were upset with him/her. The visitor stated that everyone was talking at once and that he/she was trying to explain to RI#2 that he/she was not upset with RI#2 and trying to calm RI#2 down when EI#4 told him/her to leave the facility and not come back. The visitor stated that he/she told RI#2 that she would leave but would return to visit in a few days. The visitor stated that EI#4 followed him/her to the living area of the facility and told him/her to never return to the facility. The visitor stated that a week or two later he/she returned with another visitor to see RI#2. The visitor stated that EI#5 met him/her at the door stating that he/she had been told that not to let the visitor back in to visit RI#2 and that the visitor would have to leave as it was private property. The visitor stated that he/she could see RI#11 sitting at the table in the dining area and asked him/her to tell RI#2 that he/she had been there to visit but that the workers would not let him/her into the facility. The visitor stated that he/she called 911 on his/her cell phone to get the police out there to see if RI#2 was all right. The visitor stated that after the police officer arrived and talked to EI#5 that the officer told him/her to leave as it was private property or that he/she would be arrested. The visitor stated that he/she asked the officer to do a report and that the officer again told him/her to leave the property or he/she would be arrested. The visitor stated

that all he/she was trying to do was see if RI#2 was all right as EI#5 would not let him/her see RI#2.

On 06/17/05, at 9:40A.M., the surveyor interviewed EI#5. The surveyor asked EI#5 to tell what occurred the Sunday that the visitor returned to the facility. EI#5 stated that two other people were at the facility with her. EI#5 stated that the visitor and another female walked in the door. The surveyor asked how they walked in the door since the door had a magnetic locking system. EI#5 stated that a book was propping the door open. EI#5 stated that she asked the visitor what she needed. EI#5 stated the visitor stated that they were there to see RI#2. EI#5 stated that she asked them to wait until she called someone in authority to see if it was OK if they visited RI#2. EI#5 stated that the visitor then started yelling and talking very loud saying that she was going to see RI#2. EI#5 stated that she asked the visitor to step outside but that the visitor refused. The surveyor asked EI#5 if when the visitor first arrived if the visitor was loud and verbally abusive. EI#5 stated no that it was when she told the visitor that she had to make the call that she became loud and verbally abusive. The surveyor asked EI#5 if she went and asked RI#2 if he/she wanted to see the visitors that day. EI#5 stated, "No. I did not. She came in slinging around and saying in a nasty voice she was here to see RI#2. I told her to wait and let me call someone in authority. I called EI#4 and EI#2, no EI#1 and EI#1 said call police." The surveyor asked what EI#5 meant by slinging around. EI#5 stated that he/she slung the door back when he/she was told that he/she had to leave. The surveyor asked EI#5 what time of day this occurred. EI#5 stated around 3:00P.M. The surveyor asked if visitors were allowed at that time of day. EI#5 stated yes that visitors were allowed all day.

On 06/16/05, at 8:45A.M., the surveyor asked EI#4 if she had the officer's card or name. EI#4 stated that she did not remember a card or the name. The surveyor asked if she could remember the date this happened on the Sunday. EI#4 stated she thought it was on a Sunday but could not identify a date.

On 06/16/05, at 11:00A.M., the surveyor interviewed RI#2. The surveyor asked RI#2 if the visitor had made him/her cry on his/her birthday. RI#2 stated no that it was not the visitor who upset him/her. The surveyor asked RI#2 who had upset him/her. RI#2 stated all of them. The surveyor asked RI#2 to clarify who all of them were. RI#2 stated the EI#4, EI#5, the visitor and a relative were in his/her room talking and upset him/her. The surveyor asked if any facility staff told the visitor to leave. RI#2 stated yes. The surveyor asked what facility staff told the visitor to leave. RI#2 stated EI#4 and EI#5. The surveyor asked if the staff members had told the visitor that day not to come back. RI#2 stated yes but that the visitor told him/her that she would return in a few days. RI#2 stated that the visitor did return in a few days but that EI#5 made the visitor leave without seeing him/her. The surveyor asked if the staff had asked RI#2 on his/her birthday if he/she wanted to see the visitor. RI#2 stated that EI#4 and EI#5 had asked. The surveyor asked RI#2 what he/she told EI#4 and EI#5. RI#2 stated that he/she told them yes. The surveyor asked RI#2 if he/she had told the staff that he/she wanted the visitor to return as long as the visitor did not upset him/her. RI#2 stated, "No. I told them that I wanted her to visit. She did not upset me. They all upset me on my birthday." The surveyor asked RI#2 if he/she wanted the visitor to visit the facility or stay away from the facility. RI#2 stated that he/she wanted the visitor to come visit him/her at the facility.

On 06/17/05, at 9:40A.M., the surveyor asked EI#1, EI#2, EI#4, and EI#5, if any facility staff had called the visitor to see if arrangements could be worked out for her to visit RI#2. EI#4 stated that she had tried calling and that the visitor never answered the phone. The surveyor asked if anyone from the facility had called the visitor and told her that she could visit but that she could not be yelling, talking loudly, or swinging door shut while at the facility. EI#1 stated no. The surveyor asked if anyone from the facility had called the visitor to see if alternate arrangements for visits with RI#2 could be made. RI#2 stated no. The surveyor asked if anyone from the facility had asked RI#2 if he/she wanted the person to visit. EI#5 stated yes that EI#4 had asked RI#2 on his/her birthday after they had made the visitor leave. EI#5 stated that RI#2 stated that if the visitor did not upset him/her that he/she wanted the visitor to visit. The surveyor asked if any staff had told the visitor not to come back. EI#1, EI#2, EI#4, and EI#5 all stated no. The surveyor asked if any facility staff had told the visitor not to call the facility. EI#1, EI#2, EI#4, and EI#5 all stated no. EI#5 then stated that on the day she had called the police that the visitor had threatened to close the facility down and move RI#2, RI#5, and RI#11 to her house.

420-5-4-.05(3)(g)10 - RESIDENTS DID NOT HAVE THE RIGHT TO HEALTH CARE CONSISTENT WITH ESTABLISHED AND RECOGNIZED STANDARDS WITHIN THE COMMUNITY AS THE AIDES DID NOT WASH THEIR HANDS OR CHANGE GLOVES BETWEEN RESIDENTS WHEN ADMINISTERING MEDICATIONS.

On 06/14/05, at 8:15A.M., the surveyor observed EI#4 prepare medications for RI#5 by opening the slot on the unit dose cassette, pour the medication from the slot into her bare hand, then place the medication into a white paper soufflé cup. The surveyor accompanied EI#4 who took the cup to RI#5. The surveyor accompanied EI#4 who returned to the medication cart, removed cassettes for RI#2, opened the slots, poured the medication into her bare hand, then placed the medication into a white paper soufflé cup and take to RI#2. The surveyor observed that EI#4 did not wash her hands or use sanitizer between residents. The surveyor observed that EI#4 placed the medications for both residents into her bare hands before placing them into the soufflé cup.

On 06/15/05, at 7:15A.M., the surveyor observed EI#5 prepare medications for RI#1, RI#3, RI#4, RI#5, RI#7, RI#8, RI#9, and RI#12. The surveyor accompanied EI#5 and observed that EI#5 wore the same pair of gloves for the entire time that she was preparing and giving medications. The surveyor observed EI#5 open the slots on the medication cassettes, pour the medication into her gloved hand, then place the medication into a white paper soufflé cup, take the cup and a container of water to the resident, and then return to the medication cart and repeat the procedure for each of the 8 residents without changing gloves at any time.

420-5-4-.05(3)(g)17 - FAILURE TO POST THE TELEPHONE NUMBERS OF THE DEPARTMENT OF PUBLIC HEALTH TOLL FREE ASSISTED LIVING FACILITIES COMPLAINT HOTLINE AND THE DEPARTMENT OF HUMAN RESOURCES TOLL FREE ELDER ABUSE HOTLINE:

On 06/14/05, at 7:00A.M., during a tour of the facility, the surveyor observed that the number for the Department of Public Health's Elder Care Hotline number was posted. The surveyor observed that the same number was also posted as being the Department of Human Resources Toll Free Elder Abuse Hotline number. The surveyor observed that the facility had not posted

the Assisted Living Facililties Complaint Hotline number. The surveyor observed that the facility had not posted the Department of Human Resources Toll Free Elder Abuse Hotline number.

420-5-4-.06(1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician.

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on observation, a review of the facility's resident records, and interviews with facility staff, the surveyor determined that the facility failed to ensure that 2 of 8 residents sampled had their medical care directed and supervised by a physician as the facility did not have physician orders for RI#1, and RI#3. The surveyor also determined that the facility failed to ensure that all medications in the facility's custody and control were ordered in a manner to prevent missed medications which resulted in physician orders not being followed for 3 of 8 sampled residents:

FINDINGS:

NO PHYSICIAN ORDERS

RI#1

On 06/14/05, at 4:00P.M., after reviewing resident records, the surveyor noted that RI#1 had an admission date to the facility of 01/21/05. The surveyor could not locate a medical examination or any physician orders in RI#1's record.

On 06/15/05, at 9:00A.M., the surveyor asked EI#1, EI#2, and EI#4 to locate the medical examination or physician orders for RI#1. EI#2 stated that the medical examination was not in the record but that RI#1 had been to the doctor. The surveyor asked if RI#1 had any signed physician orders in the facility. EI#2 stated no.

On 06/15/05, at 9:15A.M., the surveyor observed that RI#1 had the following medications in the facility's medication cart: Terazosin 1mg(milligram) - one each day; Hydrochlorothiazide 25mg - one each day; Cloinidine 0.1mg - one each day; Metaprolol Tartrate 25mg - one half tablet twice daily; Aricept 10mg - one each day; and Isosorbide Dinitrate 10mg - one each day.

RI#3

On 06/14/05, at 4:00P.M., after reviewing resident records, the surveyor noted that RI#3 had an admission date to the facility of 01/20/05. The surveyor could not locate a medical examination or any physician orders in RI#3's record.

On 06/15/05, at 9:00A.M., the surveyor asked EI#1, EI#2, and EI#4 to locate the medical examination or physician orders for RI#3. EI#4 provided the surveyor with a medical examination dated 06/14/05. The surveyor asked for any medical examination or physician orders prior to 06/14/05. EI#2 stated that RI#3 did not have a medical examination in the record prior to 06/14/05 but that she knew that RI#3 had been to the doctor. The surveyor asked if the facility had any signed physician orders prior to 06/14/05. EI#2 stated no.

The surveyor reviewed the medical examination dated 06/14/05 and noted that the diagnoses were Aphasia; Stroke with right hemiparesis; Congestive Heart Failure; Past Myocardial Infarction; Coronary Artery Disease; Chronic Renal Insufficiency; Acute Dyspnea. The surveyor noted the diet order was a 2 gram sodium pureed diet. The surveyor noted the medications were Aspirin 325mg - one each day, Coreg 25mg - one twice daily; Dilantin 300mg - each night at bed time; Ferrous Sulfate 325mg - one twice daily; Hydralazine 50mg - one three times daily and hold if systolic blood pressure below 90; Isordil 20mg - one three times daily; Lasix 80mg - one each day; Potassium 10meq - one each day; Milk of Magnesia - 30cc(cubic centimeters) - as needed.

On 06/15/05, at 9:15A.M., the surveyor observed that RI#3 had the following medications in the facility's medication cart and in an envelope in the facility's possession: Albuterol 90mcg(micrograms) Oral Inhaler - 2 puffs every 4 hours as needed; NTG(Nitroglycerin) 0.4mg patch - one each day, hold from midnight to 6:00A.M.; Ferrous Sulfate 324mg EC - one every 12 hours; Phenytoin Sodium 100mg - 3 capsules at bed time; KCL 20meq(milliequavalents) - one every 24 hours; Omeprazole 20mg SA - one each morning.

FAILURE TO ORDER MEDICATIONS WHICH RESULTED IN THE PHYSICIAN ORDERS NOT BEING FOLLOWED BY THE FACILITY:

RI#4

RI#4 had an admission date to the facility of 03/21/05. RI#4's medical examination dated 03/16/05 had the following medications ordered by the physician: Reminyl 8mg - one twice daily, Namenda 10mg - one twice daily, Flomax 0.4mg - one each evening, Timolol 0.5% one drip in each eye each morning, and Combivent 2 puffs four times daily.

On 06/15/05, at 8:15A.M., while accompanying EI#5 on the medication pass for the morning, the surveyor observed that RI#4 received the following medications from EI#5: Reminyl 4mg - two tablets, Vitamin E 400 International Units, and Namenda 10mg. The surveyor observed that RI#4 did not receive Timolol eye drops or the Combivent inhaler.

On 06/15/05, at 9:15A.M., the surveyor observed the medications in RI#4's medication drawer located in the facility's medication cart. The surveyor observed that the eye drops and inhaler were not in the drawer. The surveyor asked EI#1, EI#2, and EI#4 where the eye drops and inhaler were for RI#4. EI#4 stated that she ordered them on 06/08/04 from the VA pharmacy and that she gave the last doses on Monday morning (06/14/05). The surveyor asked how long it took for RI#4's medications to arrive. EI#4 stated from 5-7 days usually but sometimes longer. The surveyor asked if RI#4 would miss the physician ordered eye drops and inhaler until it arrived from the VA pharmacy. EI#4 stated yes. The surveyor asked if RI#4 had an emergency pharmacy that could be used. EI#4 stated that they ordered RI#4's medications from the VA pharmacy and that a local pharmacy repackaged in unit dose form. EI#4 stated that they did not order medications for RI#4 from a pharmacy other than the VA.

RI#7

RI#7 had an admission date to the facility of 01/10/05. RI#7's medical examination had the following medications ordered by the physician: Aspirin 81mg - one each day, Dilantin 100mg - one each day, Zyprexa 5mg - one each day, Ativan 0.5mg - one each day, and Tylenol 325mg - 2 tabs every 6 hours as needed. The physician ordered that RI#7's medications be administered by the facility nursing staff.

On 06/15/05, at 7:15A.M., the surveyor accompanied EI#5, an aide at the facility, as she prepared and gave the following medication to RI#7: Aspirin 81 mg. EI#5 stated that RI#7 was out of his/her other medications so she could not give them. The surveyor asked how long RI#7 had been out of the other medications. EI#5 stated that the last time the medications had been given to RI#7 was Monday morning, June 13, 2005. EI#5 stated that the facility was waiting for the family member to bring the medications to the facility. The surveyor observed that RI#7 did not receive the Dilantin 100mg as ordered by the physician. The surveyor noted that EI#5 was not a nurse.

On 06/15/05, at 9:15A.M., the surveyor reviewed RI#7's medications which were in the control and custody of the facility. The surveyor observed that the Multi-dose bottle of Dilantin 100mg did not contain any capsules of Dilantin. The surveyor observed that the prescription label on the Dilantin bottle directed the medication to be given twice daily.

RI#8

RI#8 had an admission date to the facility of 04/28/05. RI#8's medical examination had the following medications ordered by the physician: Flonase Nasal Spray - one spray each day, Klonopin 0.5mg - one at bed time, Ocean Nasal Spray - 4 times daily, Seroquel 25mg - one each morning and one at bed time each night (on 05/11/05, the Seroquel was changed by the physician's prescription to one each morning), Sinemet 25/100mg - one at bed time each night, Synthroid 88mcg - one each day, and Zoloft 50mg - one each day.

On 06/15/05, at 7:15A.M., the surveyor accompanied EI#5 as she prepared and gave the following medications to RI#8: Seroquel 25mg, and Levothyroid 88mcg. EI#5 stated that RI#8 was out of Zoloft and had taken the last tablet yesterday. The surveyor observed that RI#8 did not receive Zoloft 50mg as ordered by the physician.

On 06/15/05, at 9:15A.M., the surveyor reviewed RI#8's medications which were in the control and custody of the facility. The surveyor observed that RI#8's medications were packaged in unit dose form by a local pharmacy. The surveyor asked about the Zoloft not being in the medications. EI#4 stated that she gave the last Zoloft 50mg yesterday morning and had faxed the refill request to the pharmacy last night.

420-5-4-.06(2)(h) Prior to admission, residents shall be evaluated for tuberculosis.

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on a review of the facility's resident records, a request for tuberculosis evaluations, and an interview with facility owners and staff, the surveyor determined that the facility failed to ensure

that 3 of 4 residents who were admitted to the facility had the required tuberculosis screening prior to admission.

FINDINGS:

RI#6

On 06/14/05, at 4:00P.M., after reviewing resident records, the surveyor noted that RI#6 had an admission date to the facility of 12/02/04. RI#6's medical examination was not dated and did not list a tuberculosis evaluation or results on the form. The surveyor was not able to locate any other tuberculosis evaluation in RI#6's record.

On 06/15/05, at 10:45A.M., the surveyor asked EI#1, EI#2, and EI#4 to provide the tuberculosis evaluation on RI#6.

On 06/16/05, at 4:00P.M., the surveyor asked if the tuberculosis evaluation had been found for RI#6. EI#2 stated no.

RI#7

On 06/14/05, at 4:00P.M., the surveyor noted that RI#7 had an admission date to the facility of 01/10/05. RI#7's medical examination was dated 01/10/05 but did not list a tuberculosis evaluation or results on the form. The surveyor was not able to locate any other tuberculosis evaluation in RI#7's record.

On 06/15/05, at 10:45A.M., the surveyor asked EI#1, EI#2, and EI#4 to provide the tuberculosis evaluation on RI#7.

On 06/16/05, at 4:00P.M., the surveyor asked if the tuberculosis evaluation had been found for RI#7. EI#2 stated no.

RI#8

On 06/14/05, at 4:00P.M., the surveyor noted that RI#8 had an admission date to the facility of 04/28/05. RI#8's medical examination was dated 04/28/05 but did not list a tuberculosis evaluation or results on the form. The surveyor was not able to locate any other tuberculosis evaluation in RI#8's record.

On 06/15/05, at 10:45A.M., the surveyor asked EI#1, EI#2, and EI#4 to provide the tuberculosis evaluation on RI#8.

On 06/16/05, at 4:00P.M., the surveyor asked if the tuberculosis evaluation had been found for RI#8. EI#2 stated no.

420-5-4-.06(4)(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.

420-5-4-.06(4)(c) 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, and interviews with facility staff, the surveyor determined that 2 of 2 unlicensed facility staff members were administering not assisting residents with medications.

FINDINGS:

On 06/14/05, at 8:15A.M., the surveyor asked EI#4 if she was a licensed nurse. EI#4 stated no.

On 06/15/05, at 7:15A.M., the surveyor asked EI#5 if she was a licensed nurse. EI#5 stated no.

RI#1

On 06/14/05, at 4:00P.M., after reviewing RI#1's record, the surveyor noted that RI#1 did not have a medical examination or physician's orders in his/her record.

On 06/15/05, at 7:15A.M., the surveyor observed EI#5 take unit dose cassettes out of the medication cart in the kitchen, open the slots on the cassettes, and place Isosorbide Dinitrate 10mg, Aricept 10mg, Metoprolol Tartrate 25mg (one half tablet), Clonidine 0.1mg, Terazosin HCL 1mg, and Hydrochlorazide 25mg into a white paper soufflé cup. EI#5 took the cup to RI#1 who took the medication. EI#5 did not take the cassettes to RI#1 for him/her to identify the unit dose package and medication within it as being his/hers.

RI#3

On 06/15/05, at 7:15A.M., the surveyor observed EI#5 take a unit dose cassette out of the medication cart in the kitchen, open the slot on the cassette, and place Ferrous Sulfate 324mg into a white paper soufflé cup. EI#5 took the cup to RI#3 who took the medication. EI#5 did not take the cassette to RI#3 for him/her to identify the unit dose package and medication within it as being his/hers.

On 06/15/05, at 9:00A.M., the surveyor reviewed RI#3's medical examination dated 06/14/05. Documentation on this exam was that the resident could not self administer medications.

RI#4

On 06/14/05, at 4:00P.M., after reviewing RI#4's record, the surveyor noted that RI#4's medical examination record dated 03/28/05 documented that RI#4 needed medication management.

On 06/15/05, at 7:15A.M., the surveyor observed EI#5 take cassettes out of the medication cart in the kitchen, open the slots on the cassettes, and place Reminyl 4mg (two tablets), Vitamin E 400 international units, and Namenda 10mg in a white paper soufflé cup. EI#5 took the cup to RI#4 who took the medication. EI#5 did not take the cassettes to RI#4 for him/her to identify the unit dose package and medication within it as being his/hers.

RI#5

On 06/14/05, at 8:15A.M., the surveyor observed EI#4 during medication assistance. EI#4 took the unit dose cassettes out of the medication cart in the kitchen. EI#4 opened the slots on the cassettes and placed Risperdal 0.25mg, KCL Gluconate 545, and Exelon 3mg in a white paper soufflé cup. EI#4 then took the cup to RI#5 who took the medication. EI#4 did not take the cassettes to RI#5 for him/her to identify the unit dose package and medication within it as being his/hers.

On 06/14/05, at 4:00P.M., after reviewing resident records, the surveyor noted that RI#5 did not have a physician's order to self-medicate.

On 06/15/05, at 7:15A.M., the surveyor observed EI#5 during medication assistance. EI#5 took the unit dose cassettes out of the medication cart in the kitchen. EI#5 opened the slots on the cassettes and placed Risperdal 0.25mg, KCL Gluconate 545, and Exelon 3mg in a white paper soufflé cup. EI#5 then took the cup to RI#5 who took the medication. EI#5 did not take the cassettes to RI#5 for him/her to identify the unit dose package and medication within it as being his/hers.

RI#7

On 06/14/05, at 4:00P.M., after reviewing resident records, the surveyor noted that RI#7's medical examination dated 01/10/05, had the question, "What Medication Assistance if any is Needed?" The documented answer was, "Administration per nursing staff."

On 06/15/05, at 7:15A.M., the surveyor observed EI#5 during medication assistance. The surveyor observed that EI#5 took one multi dose bottle out of RI#7's drawer in the medication cart in the kitchen, opened the top on the bottle and placed Aspirin 81mg in a white paper

soufflé cup for RI#7. EI#5 told the surveyor that RI#7 had taken the last Dilantin yesterday and they were waiting for the family member to bring more medication to the facility. The surveyor observed that EI#5 took the soufflé cup to RI#7 but did not take the multi dose bottle for RI#7 to identify the bottle and medication within it as being his/hers.

RI#8

On 06/14/05, at 4:00P.M., after reviewing RI#8's record, the surveyor noted that the medical examination dated 04/28/05 documented that RI#8 could not self medicate.

On 06/15/05, at 7:15A.M., the surveyor observed EI#5 take unit dose cassettes out of the medication cart in the kitchen, open the slots on the cassettes, and place Seroquel 25mg, and Levothyroid 88mcg in a white paper soufflé cup. EI#5 stated that RI#8's Zoloft was not there as the resident had taken the last one on 06/14/05, and it had been ordered from the pharmacy. EI#5 took the cup to RI#8 who took the medication. EI#5 did not take the cassettes to RI#8 for him/her to identify the unit dose package and medication within it as being his/hers.

420-5-4-.06(4)(d) Assistance with self-administration of medications shall under no circumstances include any of the following practices:

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.

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on observation, a review of the facility's resident records, and interviews with facility staff, the surveyor determined that the facility failed to ensure that medications were not split by an unlicensed staff member.

FINDINGS:

On 06/14/05, at 4:00P.M., after reviewing resident records, the surveyor noted that RI#7's medical examination dated 01/10/05, had the question, "What Medication Assistance if any is Needed?" The documented answer was, "Administration per nursing staff."

On 06/15/05, at 9:15A.M., the surveyor observed that RI#7 had the following multi dose medication in the facility's medication cart: Simvastatin 80mg, take one half tablet at bed time, quantity filled 15. The surveyor observed that the Simvastatin bottle contained 3 whole oblong pink caplets and one half of a caplet.

On 06/15/05, at 9:15A.M., the surveyor asked EI#4 who split the caplets of Simvastatin where a half caplet could be given as ordered. EI#4 stated that RI#7's son/daughter did it before bringing the medication to the facility. The surveyor questioned the 3 whole caplets in the bottle. EI#4 stated that no one at the facility split the caplets.

On 06/15/05, at 2:40P.M., the surveyor asked EI#11 if she gave medications to the residents at night. EI#11 stated yes. The surveyor asked EI#11 if she split any medications. EI#11 stated the ones that needed it. The surveyor asked whose medications were split. EI#11 stated RI#7's.

420-5-4-.05(6)(4)(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.

420-5-4-.06(4)(e) A resident of an assisted living facility who is not aware of his or her medications 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").

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on a review of the facility's resident records, observation of unlicensed staff members giving medications, and interviews with facility staff and RI#4, the surveyor determined that RI#4 who could not protect him/her self from medication errors was being administered medications by unlicensed facility staff.

FINDINGS:

On 06/14/05, at 4:00 P.M., after reviewing RI#4's record, the surveyor noted that RI#4 had an admission date to the facility of 03/28/05. The surveyor noted that RI#4's medical examination dated 03/28/05 documented the diagnoses as being Prostate Cancer and Dementia. The physician documented on the medical examination dated 03/28/05 that RI#4 needed medication management.

On 06/15/05, at 7:15A.M., the surveyor observed EI#5 take cassettes out of the medication cart in the kitchen, open the slots on the cassettes, and place Reminyl 4mg (two tablets), Vitamin E 400 international units, and Namenda 10mg in a white paper soufflé cup. EI#5 took the cup to RI#4 who took the medication. EI#5 did not take the cassettes to RI#4 for him/her to identify the unit dose package and medication within it as being his/hers.

On 06/16/05, at 8:30A.M., the surveyor was in the dining room of the facility interviewing EI#1, EI#2, and EI#4. RI#4 walked up to the surveyor and asked the surveyor, "Why am I here?" The

surveyor told the resident that she did not know why he/she was here. The surveyor asked RI#4 how long he/she had lived at the facility. RI#4 stated that he/she did not know. The surveyor asked RI#4 how he/she was treated at the facility. RI#4 stated the place was okay for anyone who needed to be there but that he/she did not need to be there and was going to leave. RI#4 again asked the surveyor, "Why am I here?" The surveyor told RI#4 that she did not know why he/she was living at the facility. The surveyor asked RI#4 how he/she came to the facility. RI#4 stated that he/she did not know but was trying to find out how he/she got here. The surveyor asked RI#4 if he/she took medications. RI#4 stated that he/she did not know. The surveyor asked EI#5 if she had already given RI#4 his/her medications this date. EI#5 stated yes. The surveyor asked EI#5 if she had given RI#4 his/her Vitamin E already this morning. EI#5 stated yes. The surveyor showed the Vitamin E cassette to RI#4. RI#4 was able to read his/her name on the medication label. The surveyor asked RI#4 if he/she had already taken this medication this morning. RI#4 stated that he/she did not know. RI#4 looked at EI#1, EI#2, and EI#4 and asked if he/she had already taken the medicine that morning. The surveyor asked RI#4 if EI#4 told him/her now that it was time to take the medication would he/she take it now. RI#4 stated that he/she would. The surveyor then asked RI#4 if he/she had already taken the medication this morning. RI#4 stated that he/she did not know. RI#4 then asked the surveyor again, "Why am I here?" EI#4 told RI#4 that his/her son/daughter brought him/her here as he/she could not remember to take his/her medications and could not remember to turn the stove eyes off after he/she had finished cooking.

420-5-4-.06(4)(j) 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 provider when these are detected.

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on observation, a review of the facility's records, and interviews with facility staff, the surveyor determined that the facility failed to ensure that all medications kept in it's control or custody were packaged in unit dose packaging. The surveyor also determined that the facility did not have pharmacy reviews for possible adverse drug interactions.

FINDINGS:

On 06/14/05, at 8:15A.M., the surveyor observed that the facility's medication cart was located in the facility kitchen. The surveyor observed that the facility staff had a key to unlock the cart.

The surveyor observed that a half door between the kitchen and the living area was closed and locked from inside if no staff were in the kitchen area.

On 06/15/05, at 9:15A.M., the surveyor observed the following medications for RI#7 in the medication cart that were not in unit dose form: Multi dose bottles of Aspirin 81mg, quantity filled 90; Dilantin 100mg SA, quantity filled 60, the surveyor observed that the bottle did not contain any capsules; Olanzapine 5mg, quantity filled 30, and Simvastatin 80mg, take one half tablet at bed time, quantity filled 15.

On 06/15/05, at 2:40P.M., after reviewing the facility's records, the surveyor noted that there was not any documentation regarding pharmacy reviews for possible adverse drug interactions in the information provided to the surveyor.

On 06/16/05, at 4:00P.M., the surveyor asked if the facility had pharmacy reviews for the residents where the pharmacy reviewed the medications for possible adverse drug interactions. EI#2 stated no.

420-5-4-.06(4)(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 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 interviews with facility staff, the surveyor determined that the facility failed to ensure that controlled substances in the facility's custody were accounted for at all times.

FINDINGS:

On 06/15/05, at 9:00A.M., the surveyor asked EI#1, EI#2, and EI#4 how the facility accounted for controlled substances. EI#2 stated with a controlled substance count sheet. The surveyor asked if the facility had any controlled substances in it's custody. EI#2 stated no. The surveyor asked if the facility had any controlled substance count sheets currently in use. EI#2 stated no. EI#4 opened the double locked box in the medication cart and the surveyor observed that it did not contain any medications.

On 06/15/05, at 9:15A.M., the surveyor reviewed RI#8's medications which were in the facility's custody. The surveyor observed that RI#8 had Clonazepam 0.5mg, a Schedule IV Controlled Substance in his/her drawer in the medication cart.

420-5-4-.07(2)(c)8. Frozen food items (raw and cooked) shall be thawed under refrigeration prior to preparation. Raw meats shall be stored below and away from vegetables, fruits and other foods to prevent contamination (meat juices dripping on other foods).

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on observation and an interview with EI#5, the surveyor determined that the facility failed to ensure that frozen food items were thawed under refrigeration prior to preparation.

FINDINGS:

On 06/15/05, at 8:30A.M., the surveyor observed frozen chicken parts in a bag in a pan of water in the sink in the kitchen.

On 06/15/05, at 8:45A.M., the surveyor observed that the frozen chicken parts remained in the pan of water in the kitchen sink.

On 06/15/05, at 9:00A.M., the surveyor observed that the frozen chicken parts remained in the pan of water. The surveyor observed that the pan of water was now located on the counter top to the right of the kitchen sink. The surveyor showed EI#1 and EI#2 the chicken parts in the water and asked why the chicken was in the pan of water. EI#1 and EI#2 stated that they did not know but that it should be thawed in the refrigerator. The surveyor asked EI#5 why the chicken was in the pan of water. EI#5 stated that she was thawing the chicken for the noon meal.

420-5-4-.07(3)(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#4, the surveyor determined that the facility failed post the meal times with the menu.

FINDINGS:

On 06/14/05, at 7:00A.M., the surveyor observed that the menu was posted in the living area of the facility. The surveyor observed the living area and the dining area but was not able to locate the times that the meals were served.

On 06/14/05, at 8:15A.M., during an interview with EI#4, the surveyor asked where the meal times were posted. EI#4 stated that they were not posted. The surveyor asked why. EI#4 stated that she was not aware that the meal times had to be posted.

420-5-4-.10(1)(a)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 surveyor determined that the facility failed to ensure that the water accessible to the residents was maintained at or below 110 degrees Fahrenheit.

FINDINGS:

On 06/14/05, at 4:30P.M., the surveyor measured the temperature of the hot water in the following residents bathrooms which exceeded 110 degrees Fahrenheit:

Bathroom by room 5 - the thermometer measured 124 degrees Fahrenheit.

Bathroom on the lower part of the building near the parking area - the thermometer measured 118 degrees Fahrenheit.

420-5-4-.10(1)(d) Control of Insects, Rodents and Other Pests. Each facility shall be kept free of ants, flies, roaches, rodents, and other pests. Proper and lawful methods for their eradication or control shall be used. Droppings shall be evidence of infestation by pests.

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on observation and interviews with facility staff and residents, the surveyor determined that the facility was not kept free of flies.

FINDINGS:

On 06/14/05, at 7:00A.M., the surveyor observed that the front door would not open. The surveyor knocked on the door. EI#5 let the surveyor in the door. The surveyor observed that maglocks were engaged on the door. The surveyor observed that EI#5 pressed a button beside the door in the den area which set off a buzzer. The surveyor observed that the maglock on the door would not release until the buzzer quit.

On 06/14/05, at 9:15A.M., the surveyor asked EI#4 how the residents got out of the exterior doors. EI#4 stated they pressed the buttons at the doors and waited for the locks to release. The surveyor asked how the residents came into the building. EI#4 stated they either knocked or propped the doors open where they could come back in.

On 06/14/05, at 9:30A.M., the surveyor observed that the exterior door near the deck was propped open with a brick and that two residents were on the deck. The residents stated that the door was propped open so they could get back into the building to their rooms. The surveyor observed that all 4 exterior egress doors that the residents had access to contained a maglock system that was activated on each door.

On 06/14/05, at 3:00P.M., the surveyor heard RI#7 complain that there were flies in the building. The surveyor observed two flies in the dining and den area of the building.

On 06/16/05, at 8:00A.M., RI#7 complained of flies being in the building. The surveyor observed that the front door was propped open by a book.

420-5-4-.12(3)(m)4. Exterior egress doors shall not prevent free and unhindered egress from the facility. Delayed egress or other special locking arrangements are permitted only in specialty care assisted living facilities.

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on observation, and an interview with facility staff and residents, the surveyor determined that the facility had delayed egress with special locking arrangements on all exterior egress doors which are not permitted in assisted living facilities.

FINDINGS:

On 06/14/05, at 7:00A.M., the surveyor observed that the front door would not open. The surveyor knocked on the door. EI#5 let the surveyor in the door. The surveyor observed that maglocks were engaged on the door. The surveyor observed that EI#5 pressed a button beside the door in the den area which set off a buzzer. The surveyor observed that the maglock on the door would not release until the buzzer quit.

On 06/14/05, at 9:15A.M., the surveyor asked EI#4 how the residents got out of the exterior doors. EI#4 stated they pressed the buttons at the doors and waited for the locks to release. The surveyor asked how the residents came into the building. EI#4 stated they either knocked or propped the doors open where they could come back in.

On 06/14/05, at 9:30A.M., the surveyor timed the delay on each of the 4 exterior egress doors that were accessible to the residents. The time delay before the lock released on the lower wing back door opening into the fenced in area adjacent to the parking lot was 30 seconds. The time delay before the lock released on the door located near Dickens Ferry Road was 15 seconds. The time delay before the lock released on the door which faced Burtonwood Drive was 15 seconds. The time delay before the lock released on the back door leading to the deck in the fenced area was 15 seconds.

On 06/15/05, at 10:45A.M., the surveyor asked EI#1 and EI#2 if assisted living facilities were allowed to have maglocks (special locking system) on exterior egress doors. EI#1 stated she thought they could have maglocks as long as the resident was able to press the button to get out. EI#1 stated the maglocks were on the doors when they leased the facility. The surveyor asked why the doors were being propped open. EI#1 stated the residents did it in order to be able to get back into the building. The surveyor asked if they had read the Assisted Living Rules. EI#1 stated yes but not the part about the doors.

420-5-4-.12(3)(t)3. The fire alarm system and the sprinkler system shall be inspected by licensed, trained and qualified personnel at least semiannually for compliance with the respective codes. Inspection reports shall be maintained in the facility.

THIS RULE IS NOT MET AS EVIDENCED BY:

Based on a review of the facility's fire alarm and sprinkler system inspection records, and a request to EI#1, EI#2, and EI#4 for any additional records regarding these inspections, the surveyor determined that the facility failed to ensure that the fire alarm system and the sprinkler system were inspected by licensed, trained and qualified personnel at least semiannually.

FINDINGS:

On 06/14/05, at 11:30A.M., while reviewing facility information, the surveyor noted that EI#1 and EI#2 leased the facility on March 23, 2004.

On 06/15/05, at 2:40P.M., after reviewing inspection records for the fire alarm and sprinkler systems, the surveyor noted that the fire alarm system did not have any inspection records for 2004 or 2005. The surveyor noted that the sprinkler system had inspection records dated 03/12/04 and 03/03/05. The surveyor noted that this was not semiannually. The surveyor asked if the facility had any other inspection records or if the facility could obtain from the inspection company any other inspection records of the fire alarm and sprinkler systems. EI#2 stated that the ones dated 03/12/04 and 03/03/05 for the sprinkler system was all that the facility had.

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