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	D5119	A. BUILDING _____ B. WING _____	03/11/2009

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A 000	Initial Comments This is a sixteen bed Assisted Living facility with a census of fifteen on the survey date. The facility's survey result is Red with a final score of 64. There were two complaints investigated during the survey. AL 00012899 was substantiated with deficiencies cited. Refer to citation numbers A301, A404, A510, A517, and A521 for more information. LC # 23-2007 was unsubstantiated with no deficiencies cited. The following are deficiencies cited during this survey and require a plan of correction.	A 000		
A 202	420-5-4-.02 (3) License (3) Licensing. (a) Issuance of License Certificate. The license certificate issued by the State Board of Health shall set forth the name and location of the assisted living facility, the classification of the assisted living facility, and the facility's bed capacity. (b) Separate Licenses. Each assisted living facility shall be separately licensed, regardless of whether it is owned or managed by the same entity as another assisted living facility. (c) Posting of License Certificate. The license certificate shall be posted in a conspicuous place on the licensed premises.	A 202		

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A 202	Continued From page 1 (d) License Not Transferable. A license to operate an assisted living facility shall not be transferable or assignable and shall be granted only for the premises identified in the license application. (e) Expiration of License. Each license to operate an assisted living facility shall expire on December 31 following the date of issuance unless it is timely renewed. This Rule is not met as evidenced by: Based on observation and interview, the Governing Authority failed to ensure the facility maintained a current license to operate an Assisted Living Facility. This deficient practice affected all fifteen residents living in the facility. Findings include: On March 9, 2009, at 9:45 AM, the surveyor observed the facility's Assisted Living Facility (ALF) license, granted by the Alabama Department of Public Health (ADPH), which had expired on December 31, 2008 was posted on the wall . On March 11, 2009, at 12:15 PM, the surveyor asked Employee Identifier (EI) #1, administrator/owner, why she had an expired ALF license posted on the wall. EI #1 told the surveyor that she had been dealing with personal and family illnesses. EI #1 said she had made out the check for the license renewal and had asked EI #2, (administrative designee) to mail the check, however, the check for the license renewal had not been mailed to ADPH in a timely	A 202		

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A 202	Continued From page 2 manner. The surveyor asked EI #1 if she realized she had been running an unlicensed facility since December 31, 2008. EI #1 told the surveyor that she had not thought of that until she had received the notification letter from ADPH which explained that fact. EI #1 went on to explain she had no intention to run an unlicensed facility, she was going through a difficult time and the check wasn't mailed out in a timely manner.	A 202		
A 301	420-5-4-.03 (1)(a)(b) Administration (1) The Assisted Living Facility Governing Authority. (a) An assisted living facility shall have an identified sole proprietorship, corporation, partnership, limited partnership, or other business entity that is its governing authority, or it shall have a designated individual or group of designated individuals who serve as its governing authority. The governing authority shall be responsible for implementing policies for the management and operation of the facility, and for appointing and supervising the administrator who is responsible for overall management and the day-to-day operation of the facility. In family and group assisted living facilities, the governing authority and the administrator may be the same individual. A facility must give complete information to the Department identifying: 1. Each person who has an ownership interest of ten per cent or more of the governing authority; 2. Each person or entity who has an ownership interest of ten per cent or more in the real	A 301		

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A 301	Continued From page 3 property or building used by the assisted living facility to offer its services; 3. Each officer and each director of the corporation if the governing authority is a corporation; and 4. Each partner, including any limited partners, if the governing authority is a partnership. (b) The governing authority shall submit any changes to the information listed above to the Department within 15 days of the change. This Rule is not met as evidenced by: Based on observations, record review, and interview, the Governing Authority failed to ensure the facility was managed and operated in accordance with the Alabama State Board of Health's (SBOH) Rules and Regulations for Assisted Living Facilities (ALF) Chapter 420-5-4 Alabama Administrative Code. Please refer to the following deficiencies for further details and information. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. Findings include: A202 - 420-5-4-.02(3) - The Governing Authority failed to ensure the facility maintained a current license to operate an ALF. This deficient practice affected all fifteen residents living in the facility. A402 - 420-5-4-.04(1) (a) - The facility failed to ensure that EI #6, caregiver, had a physical examination certifying the employee was free of infectious diseases prior to resident contact. This	A 301		

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A 301	Continued From page 4 deficient practice affected one of six sampled employees and all fifteen residents living in the facility. A403 - 420-5-4-.04(1) (b) - The facility failed to ensure each employee was screened for a history of abuse prior to resident contact. This deficient practice affected five of six employees and all fifteen residents living in the facility. A404 - 420-5-4-.04(4) (c) - The facility failed to ensure that there was at least one cardiopulmonary resuscitation (CPR) trained staff member working at all times. This deficient practice affected two of six sampled employees (EI #1 and #6), and all fifteen residents living in the facility. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. A510 - 420-5-4-.05(3) (d) 1. and 2. - The facility failed to develop a written plan of care at the time of admission. The facility also failed to complete monthly assessments of the residents which monitored for significant changes in health status, falls, behaviors, adverse drug reactions and medication awareness. This deficient practice affected four of five sampled residents (Resident Identifier #1, #2, #3, and #4). THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. A515 - 420-5-4-.05(3) (f) 1. - The facility failed to investigate Resident Identifier (RI) #3's fracture of unknown origin. This deficient practice affected one of five sampled residents. A517 - 420-5-4-.05(3) (f) 3. - The facility failed to report required incidents to the Alabama Department of Public Health fax line. This	A 301		

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A 301	Continued From page 5 deficient practice affected two of five sampled residents (RI #3 and #4). THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. A521 - 420-5-4-.05(3) (g) 2. - The facility failed to provide a safe environment for residents at risk for falls. This deficient practice affected two of five sampled residents (RI #3 and #4). Please refer to citation tag numbers A510, A515, and A517, for more detailed information. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. A522 - 420-5-4-.05(3) (g) 3. - The facility failed to treat each resident with respect and dignity. This deficient practice affected one of five sampled residents (RI #1). A602 - 420-5-4-.06(2)(a) - The facility failed to observe for health changes and provide or assist RI #2 to receive necessary assistance with activities of daily living (ADL's), medical attention, and nursing services. The facility failure to provide necessary services resulted in RI #2 developing a pressure sore with cellulitis (infection) on her left heel. This deficient practice affected one of five sampled residents. A703 - 420-5-4-.07(2) (a)2. - The facility failed to ensure that multi -service utensils and dishes were properly washed and sanitized. This deficient practice affected all fifteen residents living in the facility. A708 - 420-5-4-.07(2) (c) 4. - The facility failed to ensure that thermometers were kept in the refrigerators and freezers at all times. This deficient practice affected all fifteen residents living in the facility.	A 301		

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A 301	Continued From page 6 A710 - 420-5-4-.07(2) (c)6. - The facility failed to monitor food temperatures prior to serving. Failure to serve food at appropriate temperatures can result in food borne illness. This deficient practice affected all fifteen residents living in the facility. A715 - 420-5-4-.07(2)(e) - The facility failed to ensure that the trash can in the kitchen had a tight fitting lid and the trash was properly stored until removal. This deficient practice affected all fifteen residents living in the facility. A720 - 420-5-4-.07(3)(c) - The facility failed to ensure that menus were planned and posted at least a week in advance. This deficient practice affected all fifteen residents living in the facility.	A 301		
A 402	420-5-4-.04 (1)(a) Personnel and Training (a) Employee Screening. 1. Prior to any resident contact, newly employed personnel shall have a physical examination certifying that the employee is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to residents through normal staff to resident contact. 2. Prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis. 3. Vaccines. Assisted living facilities shall immunize employees in accordance with current recommended CDC guidelines. Any particular vaccination requirement may be waived or delayed by the State Health Officer in the event of a vaccine shortage.	A 402		

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A 402	Continued From page 7 4. Employees who develop signs or symptoms of infectious skin lesions or diseases that would be capable of transmission to residents through normal staff to resident contact shall not be permitted to have resident contact until free from such signs and symptoms. This Rule is not met as evidenced by: Based on employee file review and interview, the facility failed to ensure that EI #6, caregiver, had a physical examination certifying the employee was free of infectious diseases prior to resident contact. This deficient practice affected one of six sampled employees and all fifteen residents living in the facility. Findings include: The surveyor reviewed EI #6's employee file. EI #6's hire date was documented as March 1, 2009, there was no documented evidence of a physical examination completed prior to resident contact on February 27, 2009, when EI #6 began training with another staff member. On March 11, 2009, at 10:00 AM, the surveyor verified during an interview with EI #1, administrator/owner, that EI #6 did not have a physical examination documented in her employee file prior to resident contact on February 27, 2009.	A 402		
A 403	420-5-4-.04 (1)(b) Personnel and Training (b) An assisted living facility shall not hire an	A 403		

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A 403	Continued From page 8 individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry. This Rule is not met as evidenced by: Based on employee file review and interview the facility failed to ensure each employee was screened for a history of abuse prior to resident contact. This deficient practice affected five of six employees and all fifteen residents living in the facility. Findings include: The surveyor reviewed the following employee files and found no documented evidence of abuse screening from the ADPH Nurse Aide Registry: EI #2, Licensed Practical Nurse (LPN), was hired on July 23, 2001. EI #3, Activity Director, was hired on June 23, 2007. EI #4, Cook/Caregiver, was hired on February 2, 2007. EI #5, Certified Nurse Aide (CNA), was hired on January 21, 2009. EI #6, Caregiver, was hired on March 01, 2009. On March 11, 2009, at 10:00 AM, the surveyor discussed the missing abuse registry documentation for each of the employee files with	A 403		

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A 403	Continued From page 9 EI #1,administrator/owner. EI #1 said she was not aware of how to get documentation when she called the nurse aide abuse registry.	A 403		
A 404	420-5-4-.04 (1)(c)(d) Personnel and Training (c) Personnel Records. An assisted living facility shall maintain a personnel record for each employee. This record shall contain: 1. An application for employment which contains information regarding the employee's education, training, experience, date of hire, and, if applicable, registration and licensure. 2. Record of required physical examinations and vaccinations. 3. Date employment ceased. (d) Employee Schedule. An assisted living facility shall post a schedule of employees indicating names and days and hours scheduled to work. This schedule shall be retained in the facility for three weeks after use. This Rule is not met as evidenced by: Based on employee file review and interview, the facility failed to ensure that there was at least one CPR trained staff member working at all times. This deficient practice affected two of six sampled employees (EI #1 and EI #6) and all fifteen residents living in the facility.	A 404		

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A 404	Continued From page 10 THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. Findings include: During review of the employee files for EI #1, administrator/owner, and EI #6, caregiver, the surveyor did not see any documented evidence of current CPR training for these two employees. The staff schedule documented that EI #1 worked shifts as needed for the schedule dated February 22 through March 7, 2009. The staff schedule documented that EI #6 worked alone during the 11:00 PM through 7:00 AM shift on March 4, 7, 9, and 10, 2009. On March 11, 2009 at 10:10 AM, EI #1 could not find documented evidence of current CPR training for EI #1 and #6. EI #1 also agreed that EI #6 worked the above documented shifts alone. EI #1 said she had no way to show documentation for the shifts that she had worked, but she had worked alone.	A 404		
A 510	420-5-4-.05 (3)(d) 1. & 2 Records and Reports (d) Plan of Care. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall be based on the medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be developed in cooperation with the resident and, if appropriate, the sponsor. It shall document the personal care and services required from the facility by the resident. This plan shall be kept current, reviewed and updated when there is any significant change in the resident's condition, after each	A 510		

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A 510	Continued From page 11 hospitalization, and at other appropriate times. It shall in all cases be reviewed and updated at least annually by the attending physician. In addition to other items that may be required by the facility's own policies and procedures, it shall contain the following: 1. A listing of the resident's needs or problems that require intervention by the facility, such as behavioral symptoms, weight loss, falls, and therapeutic diets. The facility shall assess the appropriateness of interventions required by each resident monthly. The facility shall on a monthly basis weigh and record the weight of each resident. The facility shall assess residents on a monthly basis and more often when necessary to identify significant changes in health status or behavior to include awareness of medication. Significant change is defined as two or more falls in 30 days or less, a significant weight loss, unmanageable or combative or potentially harmful behaviors, any adverse drug interaction or over sedation or any elopement. A significant weight loss is defined as a 5% or greater weight loss in a period of one month or less, or a 7.5% or greater weight loss in a period of three months or less, or a 10% or greater weight loss in a period of six months or less. Any weight loss shall be considered to be unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician. Any significant change requires immediate implementation and documentation of interventions or reassessment of existing interventions. 2. A description of the assistance with activities of daily living required by the resident including	A 510		

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A 510	Continued From page 12 bathing, dressing, ambulation, feeding, toileting, grooming, medication assistance, diet and risk to personal safety. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to develop a written plan of care at the time of admission. The facility also failed to complete monthly assessments of the residents which monitored for significant changes in health status, falls, behaviors, adverse drug reactions, and medication awareness. This deficient practice affected four of five sampled residents (RI #1, #2, #3, and #4). THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. Findings include: RI #1 RI #1's record was reviewed and documented that RI #1 was admitted to the facility on August 19, 2004, with diagnoses which included: osteoporosis, hypertension, abnormal gait, hypertension, and right breast cancer. On March 9, 2009, at 8:45 AM, the surveyor observed RI #1 sitting in her wheelchair in the living room.	A 510		

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A 510	Continued From page 13 On March 10, 2009, at 10:35 AM, the surveyor interviewed RI #1's attending physician. The physician said that RI #1 had a visual impairment, was able to make her needs known, and had symptoms of mild to moderate dementia. There were no monthly assessments which monitored RI #1's medication awareness, behaviors, significant changes or falls. The resident record had no written care plan which addressed RI #1's care needs. RI #2 RI #2's record was reviewed and documented that RI #2 was admitted to the facility on January 08, 2008 with diagnoses which included: cerebrovascular accident with left side hemiparesis, cervical osteoarthritis and osteoporosis with a history of a left hip fracture. RI #2 currently receives hospice services for congestive heart failure. On March 9, 2009, at 9:45 AM, the surveyor asked EI #5, which residents required the most care. EI #5 told the surveyor that RI #2 was bed bound and required total assistance with all ADL's, including feeding and incontinence care. On March 10, 2009, at 10:35 AM, the surveyor interviewed RI #2's attending physician. The physician said that RI #2 was slowly declining, bed bound related to back pain, and her wounds (coccyx, heel and ankle) were healed now. There were no monthly assessments which monitored RI #2's medication awareness, wounds, weights, behaviors, falls or significant changes. RI #2's record had no written care plan	A 510		

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A 510	Continued From page 14 which addressed RI #2's care needs. RI #3 RI #3's record was reviewed and documented that RI #3 was admitted to the facility on August 4, 2004, with diagnoses which included: anemia, abnormal gait/falls and Alzheimer's dementia. A physician's progress note dated January 21, 2009, documented increased right ankle pain affecting walking, and ordered a MRI (magnetic resonance imaging) scan to be completed, to rule out an acute fracture. The MRI dated January 30, 2009, documented that RI #3 had a fractured right ankle. Incident reports documented that RI #3 had two falls on February 15, 2009, at 12:00 AM and 9:30 PM. On March 9, 2009, at 8:45 AM, the surveyor observed RI #3 sitting in a wheelchair with a cast on her right lower leg that covered the area from the middle of her calf to the base of her toes. On March 10, 2009, at 10:35 AM, the surveyor interviewed RI #3's attending physician. The physician said that RI #3 had a stress fracture of her right ankle and had mild to moderate dementia. On March 10, 2009, at 3:15 PM, the surveyor observed RI #3 transfer herself from her wheelchair to a rocking chair in the living room. A staff member observed RI #3 from across the living room. The staff member did not discourage RI #3 from transferring herself nor attempt to assist RI #3 to transfer safely.	A 510		

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A 510	Continued From page 15 There were no monthly assessments which monitored RI #3's medication awareness, behaviors, significant changes or falls. RI #3's record had no written care plan which addressed RI #3's care needs. RI #4 RI #4's record was reviewed and documented that RI #4 was admitted to the facility on August 9, 2007, with diagnoses which included: acute/chronic renal failure, osteoporosis, osteoarthritis, abnormal gait, anxiety, depression, weight loss, insomnia, and psychosis. RI #4's record documented, "an apparent fall" on December 10, 2008, which resulted in multiple large bruises on the right shoulder, neck, upper cheek and right eye. On January 25, 2009, RI #4 had a fall with scalp laceration and a fractured right shoulder which was later identified by a bone scan dated February 11, 2009. RI #4 had two more fall incidents dated February 12 and 22, 2009. There were no monthly assessments which monitored RI #4's medication awareness, behaviors, significant changes or falls. RI #4's record had no written care plan which addressed RI #4's care needs. On March 10, 2009, at 10:20 AM, the surveyor asked EI #2, LPN, where the monthly assessments were documented. EI #2 said the monthly assessments were in the nurses notes. The surveyor asked EI #2 what she documented in her monthly assessment. EI #2 told the surveyor that she monitored ADL's; how new	A 510		

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A 510	Continued From page 16 residents were adapting to the facility, and vital signs. Then EI #2 asked the surveyor if the monthly assessments were required (by the SBOH rules and regulations). The surveyor asked if EI #2 was assessing the residents for medication awareness. EI #2 said she didn't know she was supposed to. On March 10, 2009, at 10:55 AM, the surveyor asked EI #5, CNA, if there was any kind of documentation for the caregivers to find out what the residents care needs were. EI #5 said she had not seen anything since she started in January, 2009. EI #5 said she learned the residents care needs through verbal communication with other staff and the residents. On March 10, 2009, at 3:45 PM, the surveyor asked EI #1, administrator/owner, where the care plan documentation was kept in the facility. EI #1 said the facility didn't really have care plan documentation, and they were not aware that they needed to be doing care plans.	A 510		
A 515	420-5-4-.05 (3)(f) 1. Records and Reports (f) Incident Investigation. 1. When an incident, as defined below, occurs in an assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct an investigation, and appropriate interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 24 hours of the incident. The report shall be given immediately upon completion to the administrator for review. The entire investigative file shall be made available for inspection and copying by representatives of the Alabama Department of Public Health upon	A 515		

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A 515	Continued From page 17 request. The entire investigative file means the incident report itself and all records and documents created or reviewed in connection with the investigation. Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff. In addition to other items required by the facility's policies and procedures, the incident report shall contain the following: (i) Circumstances under which the incident occurred. (ii) When the incident occurred (date and time). (iii) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (iv) Immediate treatment rendered. (v) Names, telephone numbers, and addresses of witnesses. (vi) Date and time relatives or sponsor were notified. (vii) Out-of-facility treatment. (viii) Symptoms of pain and injury discussed with the physician, and the date and time the physician was notified. (ix) The extent of injury, if any, to the affected resident or residents. (x) Follow-up care and outcome resolution. (xi) The action taken by the facility to prevent the occurrence of similar incidents in the future.	A 515		

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A 515	Continued From page 18	A 515		

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to investigate RI #3's fracture of unknown origin. This deficient practice affected one of five sampled residents.

Findings include:

RI #3's record documented that RI #3 was admitted to the facility on August 4, 2004, with diagnoses which included: abnormal gait/falls, and Alzheimer's Dementia.

RI #3's nurses notes dated January 7, 2009, documented that the 11:00 PM-7:00 AM shift CNA reported swelling and discoloration of RI #3's right ankle. RI #3 was unable to stand on both feet, complained of pain to her right foot and could not give details of how the injury occurred. An X-ray report dated January 7, 2009, documented there was no fracture of the right ankle.

A physician's progress note dated January 21, 2009, documented increased right ankle pain affecting walking, and ordered for a MRI to be completed to rule out an acute fracture.

The MRI dated January 30, 2009, documented that RI #3 had a fractured right ankle.

On March 9, 2009, at 8:45 AM, the surveyor observed RI #3 sitting in a wheelchair with a cast on her right lower leg that covered the area from the middle of her calf to the base of her toes. The surveyor asked RI #3 how she hurt her leg. RI #3 said she stepped wrong and fell, but it was okay now. During the interview with RI #3 she was looking at and showing the surveyor her left

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A 515	Continued From page 19 foot and leg (not the right leg with the cast). On March 10, 2009, at 3:45 PM, the surveyor asked EI #1, administrator/owner, for the investigation regarding RI #3's right ankle fracture. EI #1 said she did not do an investigation.	A 515		
A 517	420-5-4-.05 (3)(f) 3. Records and Reports 3. In addition, the following shall be reported to the Assisted Living Facilities Report Fax line: (i) A fracture or an injury resulting in hospitalization, death, EMS activation or a visit to the emergency room. (ii) A resident who is severely cognitively impaired who is found to be missing from the facility without staff knowledge and immediate and appropriate staff intervention; (iii) Sexual contact or a report of sexual contact between a resident and a staff member of the facility. Sexual contact or report of sexual contact between a resident and a visitor or another resident when the sexual contact is not consensual or when the resident's is incapable of consenting to sexual contact. (iv) Physical abuse, verbal abuse, emotional abuse, or a report of such abuse, directed at a resident by a staff member or visitor of the facility and injury such as extensive bruising, pain or injury that is not consistent with actions necessary in providing day to day care to a resident; (v) A fire, earthquake, storm, other act of God or other occurrence (for example, a natural gas leak	A 517		

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A 517	Continued From page 20 or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility; (vi) Intentional self-inflicted injury, suicide, or suicide attempt by a resident; (vii) An unplanned occurrence that results in media attention; (viii) A medication error, including overdose, that results in a resident being hospitalized; (ix) Ingestion by a resident of a toxic substance that requires medical intervention; (x) A malfunction of the sprinkler system, or fire alarm system. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report required incidents to the ADPH fax line. This deficient practice affected two of five sampled residents (RI #3 and #4). THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. Findings include: RI #3 RI #3's record documented that RI #3 was admitted to the facility on August 4, 2004, with	A 517		

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A 517	Continued From page 21 diagnoses which included: abnormal gait/falls, and Alzheimer's Dementia. RI #3's nurses notes dated January 7, 2009, documented that the 11:00 PM-7:00 AM shift CNA reported swelling and discoloration of RI #3's right ankle; RI #3 was unable to stand on both feet, complained of pain to her right foot and could not give details of how the injury occurred. The MRI dated January 30, 2009 documented that RI #3 had a fractured right ankle. On March 10, 2009, at 3:45 PM, the surveyor asked EI #1, administrator/owner, if she had reported RI #3's right ankle fracture to ADPH. EI #1 said she did not report the incident to ADPH. RI #4 RI #4's record documented that RI #4 was admitted to the facility on August 9, 2007, with diagnoses which included: acute/chronic renal failure, osteoporosis, osteoarthritis, abnormal gait, anxiety, depression, weight loss, insomnia, and psychosis. RI #4's record documented that RI #4 had a fall with scalp laceration on January 25, 2009 and a fractured right shoulder which was identified by a bone scan on February 11, 2009. On March 10, 2009, at 3:45 PM, the surveyor asked EI #1, administrator, if she had reported RI #4's fall with scalp laceration and fractured right shoulder to ADPH. EI #1 said she did not report the incident to ADPH.	A 517		
A 521	420-5-4-.05 (3)(g) 2 Records and Reports	A 521		

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A 521	Continued From page 22 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. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide a safe environment for residents at risk for falls. This deficient practice affected two of five sampled residents (RI #3 and #4). Please refer to citation tag numbers A510, A515, and A517, for more detailed information. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. Findings include: RI #3 RI #3's record was reviewed and documented that RI #3 was admitted to the facility on August 4, 2004, with diagnoses which included: anemia, abnormal gait/falls and Alzheimer's dementia. Incident reports documented that RI #3 had two falls on February 15, 2009, at 12:00 AM and 9:30 PM. On March 9, 2009, at 8:45 AM, the surveyor observed RI #3 sitting in a wheelchair with a cast on her right lower leg that covered the area from the middle of her calf to the base of her toes. The surveyor asked RI #3 how she hurt her leg. RI #3 said she stepped wrong and fell, but it was okay now. During the interview with RI #3 she was looking at and showing the surveyor her left foot and leg (not the right leg with the cast).	A 521		

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A 521	Continued From page 23 On March 10, 2009, at 10:35 AM, the surveyor interviewed RI #3's attending physician. The physician said that RI #3 had a stress fracture of her right ankle, and had mild to moderate dementia. On March 10, 2009, at 3:15 PM, the surveyor observed RI #3 transfer herself from her wheelchair to a rocking chair in the living room. A staff member observed RI #3 from across the living room. The staff member did not discourage RI #3 from transferring herself nor attempt to assist RI #3 to transfer safely. There were no monthly assessments which monitored RI #3 for significant changes. There was no investigation by the facility regarding how RI #3 had fractured her right ankle. RI #3's record had no written care plan which addressed RI #3's fall risk or her current care needs. RI #4 RI #4's record was reviewed and documented that RI #4 was admitted to the facility on August 9, 2007, with diagnoses which included: osteoporosis, osteoarthritis, abnormal gait, anxiety, insomnia, and psychosis. On December 10, 2008, RI #4's record documented, "an apparent fall" which resulted in multiple large bruises on the right shoulder, neck, upper cheek and right eye. On January 25, 2009, RI #4 had a fall with scalp laceration and a fractured right shoulder which was later identified by a bone scan dated February 11, 2009.	A 521		

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A 521	Continued From page 24 Incident reports documented that RI #4 had two more fall incidents dated February 12 and 22, 2009. There were no monthly assessments which monitored RI #4's significant changes. RI #4's record had no written care plan which addressed RI #4's fall risk or her current care needs. On March 10, 2009, at 3:45 PM, the surveyor asked EI #1, administrator/owner, what the facility had done for RI #3 and RI #4 in regards to their falls. EI #1, said there was no documentation for the interventions that had been verbally communicated.	A 521		
A 522	420-5-4-.05 (3)(g) 3 Records and Reports 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. This Rule is not met as evidenced by: Based on observation and interview the facility failed to treat each resident with respect and dignity. This deficient practice affected one of five sampled residents (RI #1). Findings include: RI #1's record was reviewed and documented that RI #1 was admitted to the facility on August 19, 2004, with diagnoses which included: osteoporosis, hypertension, abnormal gait, hypertension, and right breast cancer. On March 09, 2009, from 10:40 AM through	A 522		

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A 522	Continued From page 25 11:25 AM, the surveyor completed continuous observations of the following interaction between RI #1 and EI #3, activity director. At 10:40 AM the surveyor observed six residents playing bingo with EI #3 in the dining area. The residents had been given a snack of four crackers and approximately 8 ounces of water. RI #1 asked EI #3 to peel one of the three oranges sitting on the table in front of her. EI #3 said that RI #1 had already eaten four crackers and then EI #3 stated "you won't eat your lunch if I peel it (orange) now." RI #1 held out the orange, promised to eat her lunch and stated, "I want you to peel this." EI #3 stated, "After bingo, because you'll have juice all over the cards and chips and everything." RI #1stated in a raised, slightly angered voice, "You always have an excuse." EI #3 stated, "Well you will" and continued to call bingo numbers. RI #1 placed the orange back on the table and continued to play bingo. At 11:00 AM, while the bingo activity continued, EI #3 asked RI #1 if she had combed her hair today, loud enough for the six other residents to hear. RI #1 stated in a slightly irritated tone of voice, "Of course I did." EI #3 then stated to RI #1, "(RI #1) you know I love you." RI #1 said something the surveyor could not hear (staff running vacuum in the hallway). EI #3 stated, "You hurt my feelings." RI #1 stated, "You hurt my feelings." EI #3 stated, "I'm sorry. It looks pretty." At 11:25 AM, RI #1 said something to EI #3. EI #3 stated out loud, "(RI #1) what did you say?" RI #1 stated, "You said you'd cut it (orange) up after bingo." EI #3 did not respond or peel the orange for RI #1.	A 522		

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A 522	Continued From page 26 The surveyor observed that when bingo was over, a male resident took one of the three oranges to his room, leaving two. On March 9, 2009, at 2:30 PM, two oranges remained on the dining room table where RI #1 had been sitting during bingo. On March 11, 2009, at 12:15 PM, the surveyors discussed the observed interaction between EI #3 and RI #1 with EI #1, administrator/owner. EI #1 agreed that EI #3's behavior towards RI #1 was unacceptable.	A 522		
A 602	420-5-4-.06(2)(a) Care of Residents (a) Observation. Each assisted living facility shall provide general observation and health supervision of the residents sufficient to develop awareness of changes in all residents' health conditions and physical abilities, and awareness of the need for medical attention or nursing services. Whenever a resident requires medical attention, nursing services, or changes in personal care and assistance with activities of daily living provided by the facility, the facility shall arrange for or assist the residents in obtaining necessary services. This Rule is not met as evidenced by: Based on record review and interview the facility failed to observe for health changes and provide or assist RI #2 to receive necessary ADL assistance, medical attention and nursing services. The facility's failure to provide necessary services resulted in RI #2 developing a pressure sore with cellulitis (infection) on her left heel. This deficient practice affected one of five	A 602		

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A 602	Continued From page 27 sampled residents. Findings include: RI #2's record was reviewed and documented that RI #2 was admitted to the facility on January 08, 2008, with diagnoses which included: cerebrovascular accident with left side hemiparesis, cervical osteoarthritis and osteoporosis with a left hip fracture. There was no documented evidence that RI #2 had any skin issues identified on admission to the facility. On February 5, 2008, (no time specified) EI #2, LPN, documented, "reported (by) sitter that resident (RI #2) had a red area on (left) heel, upon exam noted discolored (medium) size area on inner (left) heel. Instructed sitter to relay message to other sitter/staff to keep heels off bed, as resident is incapable of turning (by) self in bed." EI #2 went on to document the following, "measurement 1 1/2 (centimeter) by 1 (centimeter) wide...Also reddened area on (right) ankle... (Daughter) placed heel protectors on feet." There was no documented evidence that the physician was made aware of this change in condition. On February 8, 2008, (no time specified), EI #2 documented, "Resident (RI #2) condition appears to weaken as (RI #2) refuses to exercise or even allow passive exercise...Lung sounds has diminished a great deal, however (at) intervals a gurgling sound is heard in throat. Encourage deep breathing." There was no documented evidence that the physician was made aware of this change in condition. A Certified Registered Nurse Practitioner (CRNP) note dated February 19, 2008, documented,	A 602		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 602	Continued From page 28 "Right heel and left ankle - stage 1 decubitus (see reference for definition)...Schedule (appointment) in office for skin lesion on left heel to be evaluated by (Attending physician)". There was no documentation that the facility followed up on this order. [Reference: Department of Heath and Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS) State Operations Manual (F314) 42 Code of Federal Regulations 483.25 (c) Pressure Sore...definition for Stages of Pressure Ulcers..."Stage 1 - An observable, pressure-related alteration of intact skin...A defined area of persistent redness in lightly pigmented skin...".] On February 22, 2008, EI #2 documented, "Spoke with (Attending physician's nurse)... (RI #2's) family request to hold (anti-embolism hose) until further notice..." On March 17, 2008, EI #2 documented, "(RI #2 out of facility with) family to (local hospital) for blood transfusion." On March 18, 2008, the physician documented, "nickel size blanchable area on outer portion (left) ankle. Nickel size scab on (clarified as left not right) heel, bruising and swelling extending from area, (not) blanchable; heel protectors in place... (left) heel ulcer (treatment order)... left heel cellulitis (antibiotic order)...refer to (local home health agency) for wound care..." The home health agency record for RI #2 was reviewed and documented that RI #2 was admitted to home health services on March 20, 2008. The home health registered nurse's initial assessment of the left heel wound documented,	A 602		

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A 602	Continued From page 29 "left heel...pressure ulcer...unstageable... full thickness...1.4 (centimeters in length) by 1.5 (centimeters in wide)... (Sign or symptom of infection - swelling)...black eschar (see reference for definition)...surrounding redness... " [Reference: Department of Heath and Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS) State Operations Manual (F314) 42 Code of Federal Regulations 483.25 (c) Pressure Sore... Definitions ... "Eschar" is described as thick leathery, frequently black or brown in color, necrotic (dead) or devitalized tissue that has lost its usual physical properties and biological activity. Eschar may be loose or firmly adhered to the wound."] RI #2's record had no written care plan which addressed RI #2's care needs. RI #2's nurses notes had no further assessment of the wounds after the initial assessment documented by EI #2 on February 5, 2008. On March 11, 2009, at 10:00 AM, the surveyor asked EI #2 if RI #2 went to the physician's office for evaluation of the heel wound as ordered by the CRNP on February 19, 2008. EI #2 said no, the family didn't take RI #2 to the doctor's office. The surveyor asked if the facility had reported or treated the heel wound prior to the physician visit on March 18, 2008. EI #2 said no, the heel wasn't open until the physician visited on March 18, 2008. On March 11, 2009, at 12:15 PM, the surveyor discussed RI #2's pressure ulcer care and documentation with EI #1, administrator/owner. EI #1 said she understood the problems with RI #2's pressure ulcer and was not aware that EI #2	A 602		

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A 602	Continued From page 30 wasn't documenting like she should have been.	A 602		
A 703	420-5-4-.07 (2)(a) Food Service (a) Dish and Utensils Washing, Disinfection and Storage. 1. Wash water shall be changed with sufficient frequency to avoid gross contamination, and final rinse water shall be kept clean and clear. 2. Hand washed repeated service and multi-service utensils and dishes, after washing and rinsing, shall be sanitized by either of the following methods: (A) Utensils and dishes shall be completely immersed for a period of not less than 30 seconds in water that is at least 171 degrees Fahrenheit (pouring scalding water over utensils and dishes does not meet this requirement); or (B) A cold water sanitizer. A sanitizing solution shall be used in accordance with manufacturer's instructions. Utensils and dishes shall be completely immersed for a period of not less than 10 seconds in a clean solution containing not less than 50 ppm, and not more than 200 ppm, of available chlorine bleach, or 30 seconds in 12.5 ppm of iodine or the amount of time set by the manufacturer in a 200 ppm quaternary ammonium solution. Water temperature must be at least 75 degrees Fahrenheit. Water temperatures and chemical concentrations shall be monitored and documented prior to dish washing. A record of each test shall be maintained for at least three months. 3. Dishes and utensils shall be allowed to air dry. 4. After washing, rinsing, sanitizing, and air-drying, all repeated use serviceware (utensils	A 703		

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A 703	Continued From page 31 and dishes) shall be stored in a clean, dry place that is protected from pests, dust, splash, and other contaminants. Utensils shall be handled in such a way as to prevent contamination from hands and clothing. 5. The results from the use of dish washing machines shall be equivalent to those obtained from the method outlined above, as documented in material provided from the manufacturer and kept on file at the facility. This Rule is not met as evidenced by: Based on observation, review of the policy and procedure titled, "Food Handling" and interview, the facility failed to ensure that multi-service utensils and dishes were properly washed and sanitized. This deficient practice affected all fifteen residents living in the facility. Findings include: The policy and procedure titled, "Food Handling" (no effective date) documented, "...Procedure: ...b. Hand washed repeated service and multi-service utensils and dishes... i. are washed and rinsed as above... ii. Are completely immersed in water at least 170 degrees Fahrenheit for 30 seconds or more or iii. A cold water sanitizer shall be used... Rinsing, spraying, or swabbing with a chemical sanitizing solution (a hypochlorite solution of 50 to 200 parts per million (PPM), at a temperature of at least 75 degrees (Fahrenheit)...d. All repeated service and multi-use utensils and dishes are stored after	A 703		

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A 703	Continued From page 32 washing, rinsing, disinfecting, and air drying..." On March 9, 2009, at 8:45 AM, the surveyor observed EI #4, cook, washing dishes in a three compartment sink. The three compartment sink had soapy water in the left sink, clear rinse water in the middle sink and water with sanitizer in the right sink. The surveyor observed the dishes were washed with soapy water then placed in the right sink for approximately 1 - 2 minutes then rinsed in the middle sink with clear water. The surveyor observed that there was no steam coming from the rinse water. The surveyor asked EI #4 how she was sanitizing the dishes. EI #4 said she had mixed four Steramine tablets in the right sink full of water. The surveyor asked EI #4 how she knew the right sink water had the proper level of sanitizing agent. EI #4 showed the surveyor how to test the water in the middle and right sinks with sanitizer test strips. The sanitizer strips did not change color except where EI #4's fingers touched the strips. EI #4 said the strips were supposed to turn purple, which meant the water had 200 PPM of sanitizer in it. EI #4 used a second sanitizer strip to test the middle and right sinks for sanitizer levels. The testing strip remained white again except where EI #4's finger touched the strip. EI #4 said she had mixed four Steramine tablets in the right sink with warm and cold water, so that was why the strips weren't too, "colorful". The Steramine bottle label stated to use 1 tablet for each 1 and a 1/2 gallons of water. EI #4 then tried to test the water temperature of the middle and right sinks with a meat thermometer. The meat thermometer's plastic cover was cracked. The meat thermometer did not register the temperature of the dish water. EI	A 703		

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A 703	Continued From page 33 #4 said the thermometer was broken and went on washing dishes and flatware . The surveyor observed there was no steam from the three compartment sinks and checked the water with her finger, the water was warm, but not hot. The surveyor observed EI #4 wipe a handful of flatware at a time. EI #4 would wipe the handful of flatware two to three times and then put the flatware in the right sink. EI #4 then grabbed another handful of flatware and wiped the flatware two to three times, and put the flatware into the right sink, rinsed the flatware in clear water then placed the flatware in the strainer to dry. On March 11, 2009, at 12:15 PM, the surveyor discussed the dish sanitation issues with EI #1, administrator/owner. EI #1 was surprised that EI #4 was not washing the flatware one piece at a time and said that she had an inservice planned for the staff who worked in the kitchen.	A 703		
A 708	420-5-4-.07 (2)(c) 4. Food Service 4. Refrigerators shall maintain a maximum temperature of 41 degrees Fahrenheit. Freezers shall be maintained at a maximum temperature of 0 degree Fahrenheit. Thermometers shall remain in refrigerators and freezers at all times. This Rule is not met as evidenced by: Based on observations and interview, the facility failed to ensure that thermometers were kept in the refrigerators and freezers at all times. This deficient practice affected all fifteen residents living in the facility.	A 708		

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A 708	Continued From page 34 Findings include: On March 9, 2009, at 9:15 AM, the surveyor accompanied by EI #4, cook, observed the two refrigerators and the three freezers in the kitchen. Two of two refrigerators had no thermometer and two of three freezers had no thermometer. On March 11, 2009, at 12:15 PM, the surveyor discussed the missing thermometers in the refrigerators and freezers with EI #1, administrator/owner. EI #1 said the thermometers were always coming up missing.	A 708		
A 710	420-5-4-.07 (2)(c) 6. Food Service 6. Potentially hazardous hot foods shall be at a minimum temperature of 135 degrees Fahrenheit and cold foods at a maximum temperature of 41 degrees Fahrenheit. Frozen food must be maintained at a temperature where it is kept frozen solid. This Rule is not met as evidenced by: Based on observation and interview the facility failed to monitor food temperatures prior to serving. Failure to serve food at the appropriate temperatures can result in food borne illness. This deficient practice affected all fifteen residents living in the facility. Findings include: On March 9, 2009, from 12:20 PM through 12:30 PM, the surveyor made continuous observations in the kitchen. The surveyor observed EI #4,	A 710		

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A 710	Continued From page 35 cook, take the food out of the oven and place it on the counter. The surveyor observed a stem thermometer lying on the counter next to the coffee pot, but it was not used by EI #4. At 12:30 PM, EI #4 began preparing the residents' plates and gave them to EI #5, CNA, for serving. EI #4 did not check the food temperatures prior to serving the food. On March 9, 2009, at 2:35 PM, the surveyor discussed the lunch meal observation and lack of food temperature monitoring prior to serving the food with EI #4, cook. EI #4 verified that she had not checked the food temperatures prior to serving the residents. The surveyor asked EI #4 what the hot food serving temperature was supposed to be. EI #4 answered, "50 degrees (Fahrenheit)." The surveyor asked EI#4 what the serving temperature was supposed to be for cold foods. EI #4 told the surveyor she was not sure. On March 11, 2009, at 12:15 PM, the surveyor discussed the lack of food temperature monitoring prior to serving the food with EI #1, administrator/owner. EI #1 said that she had an inservice planned for the staff who worked in the kitchen.	A 710		
A 715	420-5-4-.07 (2)(e) Food Service (e) Kitchen Garbage and Trash Handling. 1. Kitchen garbage and trash shall be placed in suitable containers with tight-fitting lids and properly stored pending removal. Kitchen garbage and trash shall not be allowed to accumulate in the kitchen and shall be removed from the premises at frequent intervals.	A 715		

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A 715	Continued From page 36 2. After being emptied, all garbage cans and trash cans shall be washed and dried before reuse. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure that the trash can in the kitchen had a tight fitting lid and the trash was properly stored until removal. This deficient practice affected all fifteen residents living in the facility. Findings include: On March 9, 2009, at 12:20 PM, the surveyor observed EI #4, cook, and EI #5, CNA, prepare to serve lunch. EI #4 spread out twelve divided plates on the island counter. A trash can without a lid was touching the end of the island where the residents' clean plates were sitting. The trash can was less than a half inch from touching two resident plates. On March 11, 2009, at 12:15 PM, the surveyor discussed the trash can observation with EI #1, administrator/owner. EI #1 said that she knew there was a lid for that trash can and she thought there was a sign on the trash can to keep it covered. EI #1 said she was going to go check the trash can right after we finished talking.	A 715		
A 720	420-5-4-.07 (3) (c) Food Service (c) Menu. The menu shall be planned and written at least one week in advance. The current week's menu shall be posted in the food service area and shall be kept on file for the following two weeks. For any resident with a physician's order	A 720		

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A 720	Continued From page 37 for a therapeutic diet, the facility shall have a copy of the diet and the facility shall document the adjustment of its menu to accommodate the resident's needs. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure that menus were planned and posted at least a week in advance. This deficient practice affected all fifteen residents living in the facility. Findings include: On March 9, 2009, at 9:20 AM, the surveyor asked EI #4 where the menus were posted. EI #4 said that EI #1, administrator/owner, usually posted the menus next to the kitchen door for the residents, but hadn't done it yet. The surveyor asked EI #4 how she knew what to cook. EI #4 showed the surveyor a folder with handwritten menus. The menu for March 9, 2009, had been filled out for breakfast and supper, but had not been completed for lunch. At 9:25 AM, the surveyor observed EI #4, finish filling out the menu for March 9, 2009, and then EI #4 posted the handwritten menu on the bulletin board beside the oven. On March 11, 2009, at 12:15 PM, the surveyor discussed the problem of not planning and posting the menus at least a week in advance with EI #1, administrator/owner. EI #1, said she forgot to post the menu on Sunday. EI #1 also said she didn't know anything about the handwritten menus, the cooks were supposed to be following the menus that EI #1 posted on the	A 720		

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A 720	Continued From page 38 wall. EI #1 stated, "Not sure what's going on there."	A 720		