Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	**12/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	**155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments This is a 16 bed Specialty Care Assisted Living Facility (SCALF) with a census of 11 on December 9, 2015. There were two complaints investigated during the survey. Complaint number LC#099-2015 and LC#035-2012 were substantiated and deficiencies were cited as a result of the complaint investigations. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practices resulted in harm to four residents and widespread noncompliance.	A 000		
A 301	420-5-20-.03 (1)(a) Administration (1) The Specialty Care Assisted Living Facility Governing Authority. (a) A specialty care 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 day-to-day operation of the facility. In a family and group specialty care assisted living facility, the governing authority and the administrator may be the same individual. A facility must give complete	A 301		

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A 301	Continued From page 1 information to the Department identifying: 1. each person who has an ownership interest of 10% or more of the governing authority; 2. each person or entity who has an ownership interest of 10% or more in the real property or building used by the specialty care 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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, Rizalina Nichols, Governing Authority, Administrator, failed to ensure the facility operated in compliance with the SBOH rules for specialty care assisted living facilities (SCALF). Rizalina Nichols, administrator, who is also a Registered Nurse (RN), failed to adequately perform her duties as administrator to ensure the facility was managed responsibly. This failure resulted in retention of residents whose level of care exceeded the facility's capabilities, poorly trained staff who failed to treat residents with dignity and respect, the use of physical restraints, the inability to meet residents' care and safety needs, the lack of health supervision, poorly developed resident care plans that were not current and did not address resident problem areas with appropriate care actions, failure to follow physician orders, improper medication administration, and failure to maintain a safe	A 301		

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A 301	Continued From page 2	A 301		

environment. These widespread failures resulted in actual harm for four residents and placed all 11 residents at significant risk for harm due to the administrator's failure to apply the rules for the day to day operations of the facility.

Findings:

On December 9, 2015, surveyors with the Alabama Department of Public Health (ADPH) conducted a licensure survey and complaint investigation at the facility. The complaints included allegations regarding resident care issues and the lack of resident activities, both of which were substantiated. Once on site, the surveyors also confirmed the facility had additional resident care and safety issues. The surveyors observed Ms. Nichols' (further identified as Employee Identifier [EI]#1), failure to perform her duties as an administrator and registered nurse, failure to provide staff with effective plans of care, and failure to promptly transfer residents who required care beyond the capabilities of the facility which resulted in an unsafe environment for residents. It should also be noted that Richard Nichols (EI#2), was also an owner and a licensed administrator. There were no other officers on record for this facility.

The surveyors observed during the survey process that EI#1, who was the governing authority, administrator, and the only full time RN employed at the facility, failed to have a working knowledge of the SBOH rules. On several occasions EI#1 told the surveyor she didn't know the SBOH rules for many of the deficient practices cited in the facility. EI#1 was responsible for all the administrative and health care functions in the facility except accounting and payroll. EI#1 was the only nurse actually

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A 301	Continued From page 3	A 301		

employed by the facility and was scheduled 7 days a week for 9 of 9 weeks on the November and December 2015 schedules (scheduled off for only two days in November 2015). EI#1 was also the only nurse on-call 24 hours a day 7 days a week. On December 8, 2015, at 1:15 PM, EI#1 made the following statements to the surveyor during the survey, "I had two RNs, and they both quit...now I'm stuck with it (facility & duties)...been doing this too long... do you know someone who wants to buy a SCALF?... I need to get out..."

On December 8, 2015 at 2:00PM, EI#1 told the surveyor that she didn't have any controlled medications in her facility, "too much trouble..old people don't need narcotic pain meds...dementia residents don't know they have pain, they have constipation, they might be hungry, or something like that, usually extra strength Tylenol or Motrin is enough to control their pain. I don't allow anti-anxiety, anti-psychotic meds either...it's just me, old people don't need that stuff. On December 9, 2015 at 12:35 PM, while discussing controlled medicines and hospice care, EI#1 said to the surveyor "..that's why I don't do hospice unless families are nice like (RI#1's family)..." EI#1 was using physical restraints and providing treatments in her building without documented physician's orders. EI#1 told the surveyor, "You'll probably write me up for this..." and went on to say she gave medications to residents that had been prescribed for other residents, knowing the practice was wrong. EI#1 provided a pureed diet with thickened liquids to RI#1 without a specific order for thickened liquids, which resulted in harm with two separate treatments with antibiotics for symptoms of aspiration pneumonia, not to mention EI#1 didn't even have a registered dietician available to ensure the safety and proper nutrition for RI#1. Three residents aquired

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A 301	Continued From page 4 wounds under the care of EI#1 and her staff. The following deficiencies were identified as a result of EI#1's failure to apply the SBOH's rules for the day to day operations of the facility. 406 - All employees did not have a physical exam prior to resident contact. 415 - The administrator retained residents whose health or safety needs exceeded the capabilities of the facility. 417 - The administrator did not ensure care plans were current and appropriate. 418 - Previously cited deficient practices were not corrected by the administrator. 424 - All employees had not received the required initial training prior to resident contact. 512 - Resident care plans were not current and appropriate. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. 514 - The facility did not maintain copies of the outside provider's certifications and plans of care for all residents receiving home health or hospice services. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. 516 - Incidents were not thoroughly investigated. 522 - Residents were not provided a safe and decent environment. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION	A 301		

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A 301	Continued From page 5 523 - Residents were not treated with dignity nor provided with privacy during personal care. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. 530 - Facility staff did not follow recognized standards for all resident health care. 601 - Physician orders were not followed. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. THIS DEFICIENT PRACTICE WAS ALSO CITED DURING THE SURVEY CONDUCTED ON JANUARY 6, 2011. 604 - Residents were not being adequately monitored for significant weight loss. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. THIS DEFICIENT PRACTICE WAS ALSO CITED DURING THE SURVEY CONDUCTED ON JANUARY 6, 2011. 605 - The RN did not identify all resident care problems, formulate adequate interventions, or re-evaluate if interventions were successful. 608 - Residents were not discharged to a higher level of care when the facility no longer had the capability to meet their care needs. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. 613 - Physical restraints were utilized due to inadequate staff training to meet the safety needs of the residents. 621 - The activity program was not designed to meet the individual needs of each resident. THIS	A 301		

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A 301	Continued From page 6 DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. 628 - EI#1, RN, gave discharged residents' medications to residents for which the medications were not specifically prescribed. 633 - Discharged residents' medications were not disposed of properly. 634 - Cleaning supplies were not supervised or secured at all times. 635 - EI#1 did not document required screenings annually or when there was a significant change in the residents' health status. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. THIS DEFICIENT PRACTICE WAS ALSO CITED DURING THE SURVEY CONDUCTED ON JANUARY 6, 2011. 701 - The administrator did not ensure the services of a dietician were available for all residents receiving a therapeutic diet. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. 705 - Food temperatures were not monitored prior to serving residents. 712 - The facility did not maintain an adequate amount of drinking water for all residents in the event of an emergency. 1101 - Fire drills were not conducted in accordance with the Life Safety Code. 1211 - All fire extinguishers were not inspected annually as required. THIS DEFICIENT	A 301		

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A 301	Continued From page 7 PRACTICE WAS ALSO CITED DURING THE SURVEY CONDUCTED ON JANUARY 6, 2011.	A 301		
A 406	420-5-20-.04 (5)(a) 1. 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. This Rule is not met as evidenced by: Based on observations, interview, and record review the facility failed to ensure that all employees received a physical examination certifying the employees were free of infectious skin lesions or diseases prior to any resident contact. Findings: On December 8, 2015, the surveyors observed EI#4 working as a caregiver with direct resident contact. On December 9, 2015, the surveyor reviewed EI#4's employee file and observed EI#4's physical examination was completed on December 9, 2015. EI#1 said she sent EI#4 to get a physical as soon as she (EI#1) found out EI#4 had not received one. EI#2 told the surveyor that EI#4 was hired on October 22, 2015, and worked the entire month of November 2015, as a full time employee.	A 406		
A 415	420-5-20-.04 (7)(a) 3. Personnel and Training 3. The administrator shall ensure that residents	A 415		

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A 415	Continued From page 8 who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the administrator failed to ensure that residents who had health or safety needs beyond the capability of the facility were safely transferred or discharged to an appropriate setting. This failure resulted in actual harm for three residents and placed the remaining eight residents at significant risk for harm. Findings: One resident of the facility was bedbound, and received a pureed diet with thickened liquids due to her choking potential and swallowing issues. Three residents sustained facility acquired pressure ulcers. Unlicensed staff performed skilled care on one resident who required mechanical compression therapy twice a day, as well as, the application and removal of elastic bandages daily. Four residents required mobility assistance, which made them ineligible for SCALF level of care. However, EI#1 had not issued any discharge notices to these residents. Refer to deficiency #608 and #635 for additional information on these residents' care needs.	A 415		
A 417	420-5-20-.04 (7)(a) 5. Personnel and Training	A 417		

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A 417	Continued From page 9 5. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan. This Rule is not met as evidenced by: Based on observation, record review and interview, the administrator failed to ensure that care plans were current with appropriate interventions to meet the care needs of the residents. This failure resulted in actual harm for 3 of 5 residents (RI#1, RI#4 and RI#5), whose care plans were reviewed, and placed the remaining 8 residents at a significant risk for harm. Findings: Five care plans were identified during record review which were not current and did not contain interventions to address seizures, hospice services, wound care, feeding assistance, safety needs, choking potential, bedbound status, and thickened liquids. Refer to deficiency 512 for additional information on these inadequate care plans.	A 417		
A 418	420-5-20-.04 (7)(a) 6. Personnel and Training 6. The administrator shall ensure that all deficient practices cited by the Department of Public Health are corrected in a timely manner.	A 418		

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A 418	Continued From page 10 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the administrator failed to ensure that all deficient practices cited by the Department of Public Health were corrected in a timely manner and that compliance with the State Board of Health rules was achieved and maintained. Findings: The following deficiencies were repeat deficiencies from the survey conducted on January 6, 2011. 601 - Physician orders not followed. 604 - Residents were not being adequately monitored for significant weight loss. 635 - Required assessments were not completed as required on each resident. 1211 - Fire extiguishers were not inspected annually as required.	A 418		
A 424	420-5-20-.04 (11)(b) Personnel and Training (b) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact. Initial training shall be followed up with refresher training as necessary. An RN shall identify staff refresher training needs and shall provide or arrange for needed training. Prior to providing any resident care, all staff shall complete The DETA (Dementia Education and Training Act) Brain Series Training developed by the Alabama Department of Mental Health and Mental Retardation or equivalent training approved by	A 424		

Alabama Department of Public Health

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A 424	Continued From page 11 the State Health Officer. The training shall be appropriately documented by the facility. In addition, the facility shall ensure that, prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on assisted living facilities and specialty care assisted living facilities. 2. Identifying and reporting abuse, neglect and exploitation. 3. Basic first aid. 4. Advance Directives. 5. Protecting resident confidentiality. 6. Safety and nutritional needs of the elderly. 7. Resident fire and environmental safety. 8. Understanding the Aging Mind. 9. Basic Brain Function. 10. Common Neuropsychiatric Disorders in the Elderly. 11. Basic Evaluation of the Dementia Patient. 12. Cognitive Symptoms of Dementia. 13. Psychiatric Symptoms of Dementia. 14. Behavioral Problems Associated with Dementia. 15. End of Life Issues in Dementia.	A 424		

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A 424	Continued From page 12	A 424		

16. Dementia Other than Alzheimer's.

17. Research and Dementia.

18. Nutrition and Hydration Needs of the Resident with Dementia to include Feeding Techniques.

19. Safety Needs of Residents with Dementia.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure that all employees received the required initial training in accordance with the SBOH rules prior to resident contact.

Findings:

During the survey completed on December 9, 2015, the surveyors observed EI#4 interact with the residents without smiling, speaking, or even explaining the care EI#4 was about to provide. EI#4 interacted with the residents as if she was dealing with inanimate objects.

EI#4's employee file was reviewed and there was no documented evidence that EI#4 had received the SBOH required initial training. The facility documented that EI#4 had received DETA (Dementia Education and Training Act) care series parts 13-20, but there was no documentation that she had received the following training: DETA brain parts 1-10, DETA care series parts 1-12, resident environmental safety, fire safety, or safety needs for residents with dementia.

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A 424	Continued From page 13 Please refer to deficiency #523 for more details about EI#4's interactions with residents.	A 424		
A 512	420-5-20-.05 (3)(d) 1. & 2. Records and Reports (d) Plan of Care. Based on the individual resident assessment, an RN, in conjunction with the facility staff and the resident's sponsor or responsible family member, shall develop appropriate written plans of care to address the specific problems identified. The nurse shall evaluate both the facility's implementation and the resident's response to the plan of care. The plan of care shall be modified when necessary to meet the needs of the resident, and the resident's sponsor or responsible family member shall be notified of such changes. 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 including bathing, dressing, ambulation, feeding, toileting, grooming, medication assistance, diet, and risk to personal safety. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by:	A 512		

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A 512	Continued From page 14	A 512		

Based on observations, interview, and record reviews, EI#1 failed to ensure care plans were updated and interventions modified to meet the required care needs of 5 out 5 residents whose care plans were reviewed (RI#1, RI#2, RI#3, RI#4 and RI#5).

Findings:

RI#1
RI#1 was a thin, frail 83 year old female, admitted to the facility on July 10, 2010. RI#1 was not able to make her needs known and depended on staff to anticipate and meet all of care needs including bathing, dressing, toileting and feeding. RI#1 had contractures to both upper and lower extremities and depended on staff to turn her in the bed. A facility Physician's Order Form dated June 23, 2015, documented RI#1's diagnoses as Alzheimer's disease, osteoporosis, hyperlipidemia and a history of seizures. A review of RI#1's most current care plan dated March 1, 2015, revealed the care plan did not identify or accurately identify all of RI#1's care and safety needs and there were no written care actions to address her specific problems and assistance needs. RI#1 had a history of seizures, suffered a seizure at the facility in 2013 and was prescribed new seizure medication on June 23, 2015. However, there was no mention of seizures as a problem for RI#1, no written seizure precautions for staff to implement and no documentation of the new medication and its potential side effects. RI#1's diet was listed as a puree diet and that she had difficulty swallowing. R#1's upper extremities were severely contracted and she had to be fed all of her meals by staff, but the facility care plan documented RI#1 only required assistance with cutting food, opening containers and major assistance with feeding. There was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 512	Continued From page 15 documentation that RI#1's arms and hands were contracted and that she could not feed herself. There were no written directives for staff that addressed RI#1's swallowing problem and the potential for choking or aspirating, even though records revealed RI#1 was treated on two different occasions for symptoms of aspiration pneumonia. The facility documented that RI#1 had sustained weight loss every month since April 2015. During the survey, RI#1 was weighed by staff and found to have sustained a significant weight loss of 12 pounds, 11.43 percent of her total body weight, in nine days between November 30, 2015 and December 9, 2015. Weight loss was not identified as a problem on the care plan and there were no care actions for staff to implement to prevent RI#1 from continuing to lose weight. RI#1's care plan also documented falls as a problem for RI#1 and for staff to observe her gait and balance and to ensure RI#1's call light was within reach. Both interventions were totally inappropriate as RI#1's arms and legs were severely contracted and she was bed bound. In addition, RI#1 had a wound on her coccyx that she acquired while in the facility. The care plan did not address the wound on her coccyx nor were there directions for staff to protect RI#1's skin from further breakdown. RI#1 was admitted to hospice on August 7, 2015 with a diagnoses of end stage dementia. The care plan did not reflect that significant change in RI#1's health status nor was the plan updated to show RI#1 now required skilled care through hospice. Refer to deficiency #522, 601, 604, 608, and 635 for additional information about RI#1. RI#2 RI#2 was a thin, frail 104 year old resident, admitted to the facility on October 23, 2013. RI#2	A 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 512	Continued From page 16	A 512		

was incontinent, not able to ambulate, and needed to be fed at meal times. EI#3 told the surveyor RI#2 could not sit upright without assistance. However, RI#2's most current care plan dated March 1, 2015, documented RI#2 was independent with feeding, needed assistance to the bathroom but toileted independently and was independent with feeding. RI#2's care plan was not current and did not accurately identify RI#2's assistance needs.

Refer to deficiency #522, 601, 608 and 635 for additional information about RI#2.

RI#3
RI#3 was a 74 year old female, admitted to the facility on July 31, 2015. On December 8, 2015, RI#3's record and care needs were reviewed with EI#1. RI#3's care plan did not address joint limitations, the use of "vinegar water" for incontinence care, or wheelchair safety, including the use and safety needs for the home made "strap" the surveyor observed in use during the survey. EI#1 told the surveyor, the "strap" was for safety and not a restraint. EI#1 also said the vinegar water was used to prevent odors. EI#1 agreed with the surveyor that RI#3's care plan did not address RI#3's special needs.

Refer to deficiency #522, 530, 608, 613, and 635 for additional information about RI#3's care needs.

RI#4
RI#4 was an 89 year old female who was admitted to the facility on October 23, 2015, after a fall at home, which resulted in a left hip fracture requiring surgical repair. RI#4 was able to communicate verbally, but her speech was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ____ B. WING ____	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

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A 512	Continued From page 17	A 512		

garbled making it difficult to understand her. RI#4 was incontinent of urine and had a history of chronic urinary retention. EI#1 did not identify urinary retention as a problem on the plan of care or devise any interventions that would prevent complications of the urinary tract system. RI#4 was wheelchair bound and required the maximum assistance of two caregivers to safely transfer or assist RI#4 to a standing position. During the survey, RI#4 was seen on two occasions to be extremely anxious and fearful of falling during transfers. The facility plan of care dated November 22, 2015, did not identify any of RI#4's personal care needs or provide a description of the assistance RI#4 required from the facility's staff to safely perform her daily activities. RI#4's anxiety and fear of falling was also not identified or addressed. On November 18, 2015, RI#4 was hospitalized for a possible stroke; however, a computed tomography (CT) scan was negative for intracranial bleeding. RI#4 was returned to the facility on November 21, 2015, with an antibiotic for treatment of a urinary tract infection (UTI). Upon re-admission, EI#1 completed the RN Monthly and Comprehensive Assessments on November 21, 2015. EI#1 documented a 23 pound weight loss, poor appetite, and confusion due to UTI. EI#1 did not update the plan of care to address the significant weight loss of 15.33 percent of her total body weight, or implement any interventions required to address these new problem areas.

Refer to deficiency #522, 604, 608, 613, and 635 for additional information about RI#4.

RI#5
RI#5 was an 85 year old female admitted to the facility on October 30, 2015, with diagnoses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	**155 EGG AND BUTTER ROAD** **COLUMBIANA, AL 35051**

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A 512	Continued From page 18 including, dementia, hypertension, and type 2 diabetes. On December 8, 2015, RI#5's record and care needs were reviewed with EI#1. RI#5 was being treated in the facility for swelling of her lower legs and feet. EI#1 told the surveyor that staff applied and removed RI#5's elastic bandages daily and managed the mechanical compression therapy twice a day for swelling in RI#5's lower legs. RI#5's care plan did not include appropriate instructions and monitoring for the two treatments being used to care for the swelling of RI#5's lower legs. RI#5's care plan dated November 1, 2015, documented that RI#5 had two open areas in both gluteal folds related to pressure and irritation from her incontinence brief, but did not have appropriate interventions to promote healing and to prevent further skin breakdown. EI#1 told the surveyor and home health nurse that RI#5 had a "quarter-sized" open area on her (RI#5's) gluteal fold area, "skin peeled back," from "sitting and diaper rubbing... it (wound) closes (heals) and opens back up." PLEASE NOTE: RI#5 refused a skin assessment for the open area(s) on her gluteal folds by the home health nurse and the surveyor during the survey. Refer to deficiency #522, 605, and 608 for additional information about RI#5.	A 512		
A 514	420-5-20-.05 (3)(d) 5. Records and Reports 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.	A 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 514	Continued From page 19 This Rule is not met as evidenced by: Based on observation, interview, and record reviews, the facility failed to ensure each resident who received care from an outside provider had a certification and plan of care on file. THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION. Findings: RI#1 RI#1 was admitted for hospice services provided by an outside provider on August 7, 2015. The hospice provider's certification and plan of care were not maintained in RI#1's record. EI#1 said she would contact the provider for a copy. On December 9, 2015 at 2:06 PM the hospice provider faxed a copy of the plan of care for RI#1. However, EI#1 was unable to provide the surveyor a provider's certification form. RI#4 RI#4 was receiving physical and occupational therapy from a home health agency. The provider's current Home Health Certification and Plan of Care were not in RI#4's record. EI#1 contacted the home health agency and requested a copy. A faxed copy was received at the facility on December 9, 2015 at 1:48 PM.	A 514		
A 516	420-5-20-.05 (3)(f) 1. Records and Reports Incident Investigation. 1. When an incident as defined below, occurs in a specialty care assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct an investigation, and	A 516		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 516	Continued From page 20	A 516		

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 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 report of incident 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	**155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051**

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A 516	Continued From page 21 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. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to complete a detailed incident report and conduct a thorough investigation of a resident fall with injury requiring treatment in a local emergency room. Findings: On December 8, 2015, the surveyor asked EI#1 for RI#2's November 21, 2014, incident report and investigation regarding a fall with head injury. EI#1 presented the surveyor with a printed version of the online report, which EI#1 had submitted to ADPH on November 24, 2014. EI#1 told the surveyor she (EI#1) was under the impression that the online report was all that was required. EI#1 had no additional documentation regarding the details or investigation for RI#2's November 21, 2014, incident that resulted in a head injury with laceration (required staples for closure) and a left hip fracture that was not treated due to RI#2's surgical risk and advanced age. Note: RI#2 was 103 years old at the time of the fall. During review of the facility policies and procedures, there was no policy or procedure for incident reporting, investigation of incidents, or	A 516		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

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A 516	Continued From page 22 documentation requirements related to incidents.	A 516		
A 522	420-5-20-.05 (3)(g) 2. Records and Reports Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, EI#1, facility owner, administrator and only full-time RN, failed to provide a safe and decent environment for all residents by failing to provide adequate health supervision of residents, failing to develop written plans of care that addressed the specific care needs of residents with appropriate interventions; failing to recognize significant weight loss sustained by residents; using unnecessary physical restraints; retaining ineligible residents which required a higher level of care and failing to ensure staff were adequately trained to provide appropriate care for residents with dementia. EI#1's failure to provide the necessary services to ensure a safe and decent environment for all residents resulted in actual harm to four residents and placed all residents at risk for significant harm. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings:	A 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 522	Continued From page 23 RI#1 RI#1 was an 83 year old resident admitted to the facility on July 10, 2010. RI#1 was bed bound, her legs and arms were contracted and she had to be turned in the bed by staff at least every two hours. RI#1 could not make her needs known and depended on facility staff to meet all of her care and safety needs. Because RI#1 had swallow safety concerns and was at risk for aspiration the physician prescribed thickened liquids. However, the physician failed to specify the consistency for RI#1's liquids and there was no documentation that EI#1 ever followed up with the physician for clarification. In addition, the facility served RI#1 a pureed diet, but there was no physician order for the special diet. On November 18, 2015, RI#1's hospice nurse said she watched EI#1 place two whole pills in a teaspoon of oatmeal and then give it to RI#1. The surveyor asked if RI#1 choked on the medication. The nurse said "not that time" and explained that RI#1 was on aspiration precautions. Observations and interviews during the survey revealed that facility staff were not trained on how to properly prepare food for a pureed diet or to thicken liquids. Neither the food or water served to RI#1 was altered appropriately according to established therapeutic guidelines. The surveyor observed two meals where RI#1 was not offered any protein, a necessary nutrient for maintaining weight and promoting wound healing. Records revealed RI#1 was treated twice for symptoms of aspiration pneumonia and sustained significant weight loss while in the facility. EI#1 did not provide the services of a dietician for RI#1's multiple dietary problems and admitted to the surveyor that she did not have a dietician available for any of the residents. RI#1 developed a wound on her coccyx approximately four months prior to the survey that had advanced in size. RI#1's hospice nurse told the surveyor	A 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 522	Continued From page 24	A 522		

that in order for the pressure ulcer to heal it had to be covered continuously with a special dressing (Duoderm). EI#1 had been informed of RI#1's prescribed treatment plan; however, EI#1 did not replace the dressing when it came off as instructed. On December 8, 2016, at 8:30 AM, the surveyor with EI#3, assessed RI#1 and observed that RI#1's incontinence brief was dry, no urine or stool, and there was no Duoderm dressing applied to RI#1's wound. Again, on December 9, 2015, at 10:25 AM, the surveyor observed there was no Duoderm dressing on RI#1's wound. At 1:30 PM, on December 9th, EI#1 told the surveyor, "I know I told you I would replace the Duoderm, but I forgot." EI#1 said the hospice nurse told them the wound needed to be covered at all times. EI#1 said the dressing comes off when RI#1's diaper is wet or soiled. EI#1 said, "The caregivers must be pulling it (Duoderm) off, it rolls up around the edges, it won't stay on good." RI#1's hospice nurse documented that she found RI#1's wound uncovered on multiple occasions. EI#1 did not develop and provide staff with a working care plan for RI#1 that identified RI#1's multiple problems and assistance needs including RI#1's risk for aspiration, physical limitations, wound care, history of seizures and weight loss. In addition, EI#1 did not complete the required cognitive assessments for RI#1 and allowed RI#1 to remain in the facility, even though RI#1's physical functioning abilities exceeded the level of care the facility was licensed to provide and staff was trained to provide. RI#1 was not safe and suffered actual harm because EI#1 did not transfer or discharge RI#1 to an appropriate setting qualified to meet her special needs.

RI#2
RI#2 was a very, frail, 104 year old, resident. During an interview, EI#3 described RI#2 as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ___ B. WING ___	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 522	Continued From page 25	A 522		

being totally dependant on staff for "everything" and that RI#2 could not walk or sit upright without assistance. RI#2 was observed restrained in bed by bed rails. EI#7 said the rails were used to keep RI#1 from rolling out of bed. RI#2's care plan, developed by EI#1, was not current and did not accurately identify RI#2's assistance needs. In fact EI#1's assessment of RI#2's assistance needs was that RI#2 was independent with feeding and toileting and only needed moderate assistance with dressing and grooming. EI#1 also did not complete cognitive assessments, including the PSMS, as required. A PSMS for RI#2, completed by EI#1 on October 24, 2014, documented RI#2 used a wheelchair to ambulate. However, during an interview with EI#1, EI#1 told the surveyor that RI#2 could not propel herself in a wheelchair. EI#1 did not complete a new PSMS with the significant change in RI#2's health status and EI#1 told the surveyor she thought she had a full year before RI#2 needed to be assessed again. The fact that RI#2 could not propel her chair impacted RI#2's eligibility to reside in the facility per SBOH rules. On December 9, 2015 at 12:35PM, when the surveyor discussed RI#2's PSMS scores and the SBOH rule with EI#1, EI#1 said, she didn't know that residents had to be able to propel themselves. In fact EI#1 stated, "I thought if they (residents) were on hospice, then they could die here." EI#1's lack of knowledge of the rules or failure to apply the rules resulted in RI#2 being retained in a facility that was not licensed to provide the level of care she (RI#2) required placing RI#2 in an unsafe environment and at risk for harm.

RI#2 was prescribed Clonidine for hypertension on October 7, 2015. The surveyor reviewed the order and observed there was a mistake in the written order that required clarification from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ___ B. WING ___	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 522	Continued From page 26	A 522		

physician. On December 8, 2015, when the surveyor asked EI#1 about the order, EI#1 told the surveyor what the order should have said; however, there was no documentation that the physician had been contacted to clarify the order. EI#1 also told the surveyor that RI#2 did not want Clonidine, and that RI#2's son was aware. Again, EI#1 had no documentation to support the physician's or son's notification regarding the lack of care being provided for RI#2's history of high blood pressure. The order also would have required that RI#2's blood pressure be taken daily to ensure RI#2's pressure was within safe parameters. Facility records showed only intermittent blood pressure checks were conducted between October 2015 and December 2015.

RI#3
RI#3 was 74 years old and was admitted to the facility on July 31, 2015, from another SCALF in the area. RI#3 was not able to feed herself, could not ambulate and could not propel herself in a wheelchair. The surveyor observed that RI#3 was bedridden more than half the time during the survey. Records from RI#3's previous facility contained documentation that RI#3 was in that same condition on July 30, 2015, when she was discharged from their facility. When RI#3 was up in the wheelchair the surveyor observed that RI#3 was restrained in her wheelchair by a handmade cloth strap. EI#1 admitted she made the strap, stating it was not a restraint, and that it was used to keep RI#3 from sliding out of the wheelchair. RI#3 was also observed restrained in bed by bed rails and a strategically placed, locked wheelchair. EI#1's assessment and documentation of RI#3's physical functioning abilities on August 1, 2015, did not reflect the condition of RI#3 that the previous SCALF staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ____ B. WING ____	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

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A 522	Continued From page 27	A 522		

assessed her abilities to be, just two days prior. Record review, observations, and EI#1's own admission that RI#3 could not propel herself, revealed RI#3's level of care exceeded the level of care the facility was licensed to provide, placing RI#3 in an unsafe environment and at risk for harm.

RI#4
RI#4 was an 89 year old resident admitted to the facility on October 23, 2015. RI#4 fell at home prior to admission and was extremely anxious and afraid of falling in the facility. On two occasions, the surveyor observed outside agency staff encourage RI#4 to move herself from one location to another in her wheelchair but RI#4 refused both times. EI#1 did not develop a proper care plan with care actions for staff to follow that addressed RI#4's anxiety and safety. In addition, EI#1 did not ensure RI#4 was weighed accurately every month as required and RI#4 sustained significant weight loss in the facility. EI#1 did not identify and address RI#4's weight loss with interventions to protect RI#4 from continuing to lose weight. EI#1 did not accurately complete the required cognitive assessments to reflect RI#4's current physical functioning abilities. RI#4 could not or would not propel her own wheelchair therefore, she required a higher level of care than the facility was licensed to provide. EI#1 did not ensure RI#4 was transferred or discharged to an appropriate setting.

RI#5
RI#5 was an 85 year old resident admitted to the facility on October 30, 2015. EI#1 documented on RI#5's admission assessment dated October 30, 2015, that RI#5 had bilateral Lymphedema to her lower extremities. Seven days later, RI#5 was admitted to home health for skilled nursing care;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 522	Continued From page 28	A 522		

however, EI#1 allowed unlicensed staff to perform skilled care including mechanical compression therapy twice a day and the application and removal of RI#5's elastic bandages daily. RI#5 developed a wound to her upper thigh, lower buttock area due to pressure and irritation from her incontinence brief, while in the facility. EI#1 did not develop an appropriate care plan for RI#5 that addressed her multiple care needs including instructions and monitoring for the two treatments being performed by staff to care for the swelling of RI#5's lower legs. RI#5 was harmed because EI#1 failed to transfer or discharge RI#5 to an appropriate setting able to provide the skilled nursing care she required.

RI#9
The complaint investigation revealed that former resident, RI#9, was admitted to the facility in 2013 and discharged home with family prior to the survey, in September 2015. On January 20, 2016, during a telephone interview, RI#9's family member stated when RI#9 was admitted to the facility in 2013, RI#9 could not walk and could only stand with assistance. The family member stated RI#9 was incontinent of bladder and bowel and unable to propel herself in a wheelchair. RI#9's family member told the surveyor RI#9 was given a pureed diet, developed contractures of her arms and legs and acquired a large wound on her coccyx while living at the facility. The family member described the wound as black and the "size of a baseball, all the way to the bone." She said EI#1 did not keep the wound clean and did not follow instructions for wound care. She said RI#9 had an order for pain medication but EI#1 refused to give it to RI#9 and told her (the family member), "for an extra $350.00 a month we will give her something for pain." During an interview with RI#9's hospice nurse on November 18,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 522	Continued From page 29 2015, the surveyor was told that RI#9 was admitted to hospice on July 29, 2015 and she confirmed that RI#9 had a wound on her coccyx; a stage IV wound. The nurse described RI#9 as bed bound and requiring total care from staff for all of her needs including being fed. She stated the facility did not provide the prescribed wound care and that RI#9's wound covering was never in place when she arrived at the facility. The nurse also stated that EI#1 informed her the facility was a "non narcotic facility", that narcotic pain medication was not administered to residents, even though she (hospice nurse) said it was obvious RI#9 was in pain. She stated EI#1 finally agreed to give RI#9 extra strength Tylenol for pain.	A 522		
A 523	420-5-20-.05 (3)(g) 3. Records and Reports Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure employees treated residents with dignity and respect for their personal privacy. THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION. Findings: During the survey, the surveyors observed EI#4	A 523		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	**155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051**

(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 523	Continued From page 30 interact with the residents without smiling, speaking, or even explaining the care she was about to provide. On December 8, 2015 between 7:15AM and 8:15AM, the surveyor observed the following interactions between EI#4 and residents. EI#4 approached several residents from behind and placed an apron over the residents' head, without speaking. EI#4 provided incontinence care to RI#3, without the privacy of a closed room door, or speaking to RI#3 to explain the care that EI#4 was going to perform. EI#4 sat at a table with two residents, but did not talk or interact with the residents. EI#4 provided drinks to the residents in the dining room. EI#4 placed two drink cups in front of RI#3, but out of RI#3's reach. EI#4 did not offer RI#3 anything to drink until RI#3's food plate was served, even though EI#4 sat at the same table as RI#3 and waited 10 minutes for all the residents' food to be prepared by the cook. EI#4's interactions with the residents while completing care tasks was emotionless and mechanical instead of pleasant, courteous, and caring. EI#4 interacted with the residents as if she was dealing with inanimate objects. On December 9, 2015 at 12:35PM, when EI#1 was asked about the way EI#4 interacted with residents, EI#1 said she was aware there were problems with the care EI#4 provided to residents. Please refer to deficiency #424 for information related to EI#4's lack of training.	A 523		
A 530	420-5-20-.05 (3)(g) 10. Records and Reports Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to receive or reject	A 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

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A 530	Continued From page 31 medical care, dental care, or other health care services except those required to control communicable diseases. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that all resident health care was provided in accordance with recognized community standards. Findings: INCONTINENCE CARE/INFECTION CONTROL On December 8, 2015, the surveyor observed EI#4 provide incontinence care for RI#3. EI#4 did not speak or explain what care she was going to provide to RI#3. RI#3's room door was left wide open while EI#4 removed RI#3's pants, urine soiled brief, and provided incontinence care. After EI#4 removed RI#3's urine soiled brief, EI#4 sprayed RI#3's pubic area one time with "vinegar water" then without washing or wiping RI#3's perineal area or associated skin folds, EI#4 applied a clean brief. EI#4 did not change her gloves appropriately, did not wash RI#3's perineal area, buttocks, or associated skin folds, and did not put on clean gloves or wash her hands after removing RI#3's urine soiled brief before applying a clean brief. When the above observations were discussed with EI#1, EI#1 told the surveyor, "She's (EI#4) new, but she knows better... she's (EI#4) supposed to wipe the residents with the vinegar water, not just spray it."	A 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 530	Continued From page 32	A 530		

BLOOD GLUCOSE MONITORING/INFECTION CONTROL

On December 8, 2015, the surveyor observed EI#1 perform blood glucose monitoring on two different residents (RI#7 and RI#8) using the same glucometer and the same lancet holding device. Neither of the devices were cleaned after being used on RI#7 or before they were used on RI#8. The soiled glucometer and lancet holding device were then placed back into a plastic bin with clean supplies and stored back on the shelf in an unlocked room where the medication cart was stored. EI#1 completed blood glucose monitoring for RI#7 and RI#8 without washing or sanitizing her hands between residents.

MEDICATION SCHEDULES

On December 8, 2015, the surveyor observed medication administration and reviewed medication administration records (MAR) accompanied by EI#1. The surveyor observed EI#1 pour a Verapamil capsule for RI#5 into the cup with RI#5's morning medications. The Verapamil bottle was labeled "Give at Bedtime". EI#1 told the surveyor she did not know why the pharmacy labeled the Verapamil to be given at bedtime, because the doctor had ordered it to be given daily. RI#5's December 2015 MAR had the Verapamil scheduled for "0900" with doses signed off as given at 0900. When asked, EI#1 told the surveyor that she (EI#1) generated the printed MAR. EI#1 used her ink pen and changed the time of the Verapamil from 0900 (9:00 AM) to 1700 (5:00 PM), while the surveyor observed. EI#1 did not make a new entry on the MAR for the time change. The surveyor also observed that the vast majority of medications were scheduled between the hours of 9:00 AM and 5:00 PM, even

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 530	Continued From page 33 medications the physician had ordered to be given at bedtime. EI#1 told the surveyor, "I (EI#1) used to have two other RNs, and they quit, now I'm stuck with it all." The surveyor asked if EI#1 had physician orders that documented the physician's approval for the bedtime medications to be given at 5:00 PM. EI#1 told the surveyor "Don't have documentation... we do it all (discuss physician orders) verbally."	A 530		
A 601	420-5-20-.06 (1) Care of Residents Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician. (a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her choice. If the resident is unable to designate an attending physician, or does not wish to designate an attending physician, the facility shall assist the resident in identifying an attending physician who will serve the resident. A resident shall be permitted to change the designation of his or her attending physician at any time. Whenever a resident requires medical attention, an attempt shall first be made to contact the resident's attending physician, except in medical emergencies requiring activation of the local Emergency Medical Services system (911 or other emergency call). (b) Back-up Physician Support. Each specialty care assisted living facility shall have an agreement with one or more duly licensed physicians to serve in those instances when a resident's own attending physician cannot be reached, and to provide temporary medical	A 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 601	Continued From page 34	A 601		

attention to any resident whose attending physician is temporarily not available.

(c) The use of the word, "physician" in these rules shall not be deemed to preclude a properly licensed nurse practitioner or a physician assistant from performing any function in a specialty care assisted living facility that otherwise would be required to be performed by a physician so long as that function is within the nurse practitioner's or physician assistant's scope of practice. A nurse practitioner or physician's assistant shall not serve as the medical director of a specialty care assisted living facility.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure that all resident care and treatments were under the direct supervision of a physician.

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

THIS IS A REPEAT DEFICIENCY FROM THE PRIOR SURVEY COMPLETED ON JANUARY 6, 2011.

Findings:

RI#1
On December 8, 2015 at 7:20 AM, the surveyor observed thickener mixed in RI#1's drinking water for breakfast. EI#5 told the surveyor the thickener was only added to RI#1's water and not other liquids or foods. EI#5 told the surveyor during an interview at 11:50 AM,"The hospice nurse told me (EI#5) to add one scoop of thickener to a cup and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

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A 601	Continued From page 35 a half of water for her (RI#1)." EI#5 was asked what was the desired consistency of RI#1's water. EI#5 replied,"It is like honey." At 8:10 AM, EI#3 opened a carton of Boost at RI#1's bedside. No thickener was added to the Boost before it was given to RI#1 to drink. On December 9, 2015, EI#5 told the surveyor RI#1 was given one carton of Boost daily because three cartons gave RI#1 diarrhea. The monthly assessments completed by EI#1 on September 30, 2015, and October 31, 2015, documented that one can/carton of Boost was given three times a day. The discrepancy regarding one carton versus three cartons of Boost daily was discussed with EI#1 on December 9, 2015. EI#1 assured the surveyor the Boost was served to RI#1 three times a day. There were no physician orders in RI#1's facility record pertaining to the use of thickener or Boost. The surveyor contacted the hospice provider for verification of the orders and received the following physician orders via facsimile. On September 16, 2015, the physician had ordered to add thickener to all liquids given to patient. However, the order did not specify the amount of thickener to add or what consistency the liquids should be. EI#1 did not follow-up with the physician to clarify the order to ensure the proper consistency was reached prior to giving to RI#1 to drink. On October 7, 2015, the physician had ordered Boost, 1-2 cartons to be given daily, not three cartons as EI#1 stated. In addition, RI#1's care plan documented RI#1 received a pureed diet and observations were that RI#1 was not served a regular diet. The facility cook also told the surveyor RI#1 received a pureed diet. There was no physician order for a pureed diet for RI#1. On December 9, 2015 at 10:00 AM, the surveyor discussed the wound care treatment for RI#1 with the hospice nurse. The hospice nurse told the	A 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 601	Continued From page 36 surveyor she had informed EI#1 of the orders to follow if the dressing (Duoderm) came off RI#1's coccyx wound for any reason. The order was to clean the wound with cleanser, apply a thin layer of hydrogel ointment and cover the wound with Duoderm. The hospice nurse documented in her weekly progress notes EI#1 verbalized understanding of the care that was to be provided. The hospice nurse also left the necessary supplies with EI#1 to use if the dressing came off. The surveyor observed these supplies at the bedside during the survey. The hospice nurse visited RI#1 twice a week and documented in the nurse's progress notes the wound was frequently found uncovered. The surveyor also observed the coccyx wound exposed on both days of the survey and brought this to the attention of EI#1. EI#1 acknowledged to the surveyor on December 9, 2015 at 1:30 PM, she knew the Duoderm was to stay on the wound at all times and should be replaced whenever it came off. RI#2 On December 8, 2015, the surveyor reviewed RI#2's record with EI#1. RI#2 was hospitalized on October 1, 2013 with a diagnosis of hypertensive urgency (severe high blood pressure without organ damage). RI#2's May 31, 2015, monthly RN assessment documented an elevated blood pressure of 189/91. On October 3, 2015, RI#2's blood pressure was 190/98. RI#2's physician order form dated October 7, 2015, documented, "Clonidine 0.1 (milligrams one tablet sublingual every day as needed for systolic blood pressure [SBP] greater than 170 or [SBP] greater than 100). There was no documented clarification of the order. The surveyor asked EI#1 where RI#2's daily	A 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 601	Continued From page 37 blood pressures were documented. EI#1 told the surveyor, "The order should say diastolic blood pressure (DBP) greater than 100, and we take her (RI#2's) blood pressure weekly, she (RI#2) doesn't want any medicine and her son is aware." EI#1 had no documentation to support the physician's or son's notification regarding the lack of care being provided for RI#2's ongoing high blood pressure problem. Review of RI#2's MAR for January 2015 through December 2015, did not have any blood pressure monitoring documented daily or weekly. The vital sign logs were reviewed with EI#1 and showed intermittent documentation of blood pressure monitoring for RI#2 between October 7, 2015 and December 8, 2015. RI#3 On December 8, 2015, the surveyor observed RI#3 in a wheelchair with a handmade restraint which secured RI#3 into the wheelchair. On July 27, 2015, RI#1's physician documented that RI#3 did not require chemical or physical restraint or confinement. EI#1 and EI#4 both told the surveyor RI#3's restraint was used because EI#3 "slides out of the wheelchair." EI#1 told the surveyor she didn't think the handmade device used to keep RI#3 seated in the wheelchair was a restraint. For additional details regarding restraints refer to deficiency #613. RI#5 On December 8, 2015, the surveyor observed that RI#5 had elastic bandages on both of her lower legs and a mechanical compression therapy machine in her room. EI#1 told the surveyor that facility staff applied and removed RI#5's elastic bandages every day and provided	A 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

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A 601	Continued From page 38 mechanical compression therapy to RI#5's lower legs twice a day. When the surveyor asked about a physician's order for the treatments to RI#5's lower legs, EI#1 told the surveyor that home health probably had the orders, but there were no orders in RI#5's facility record. Please refer to deficiency #608 for additional information regarding RI#5's care needs.	A 601		
A 604	420-5-20-.06 (2)(c) Care of Residents (c) Assessment. The RN shall perform a comprehensive assessment of each resident upon admission, when a significant change in health status or behavior occurs, and when the monthly assessment identifies a problem in any of the following areas: 1. Weight loss: (i) Each month, the facility shall accurately weigh and record the weight of each resident. (ii) A comprehensive assessment and plan of care is required when a resident experiences a significant unplanned weight loss. (iii) 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 an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician.	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 604	Continued From page 39	A 604		

2. Falls.

3. Elopements (a cognitively impaired resident exits a secure perimeter without immediate and appropriate staff intervention).

4. Behavioral symptoms.

5. Adverse reactions to prescribed medications, or circumstances which contraindicate medications that have been prescribed for the resident.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, EI#1, RN, failed to provide monthly oversight of the weights taken by the caregivers to ensure the weights were accurate and the residents were being monitored for significant weight loss.

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

THIS IS A REPEAT DEFICIENCY FROM THE PRIOR SURVEY COMPLETED ON JANUARY 6, 2011.

Findings:

According to a complaint reported to the ADPH on November 18, 2015, facility residents were losing weight and were not being weighed monthly.

On December 8, 2015 at 6:15 AM, EI#3, caregiver, was asked to explain the facility's procedure for weighing residents. EI#3 said the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 604	Continued From page 40 residents were weighed on the 30th of every month, using a wheelchair scale or a standing scale. Later that day at 1:58 PM, EI#1 informed the surveyors the caregivers weighed the residents and the weights were recorded on the weight logs by EI#2. EI#2 was responsible for calculating the percentage of weight gained or lost. EI#1 also denied any knowledge of residents with significant weight loss. The resident weight logs were reviewed by the surveyors and there was no documentation that any resident had sustained significant weight loss. In fact, the weight logs revealed that several of the residents had gained weight since admission. Yet, when the surveyors asked facility staff to weigh two residents, RI#1 and RI#4, the results were that both residents had sustained a significant weight loss. On December 9, 2015, with the surveyor observing, EI#3 weighed RI#1 and RI#4 on the wheelchair scale. EI#3 was unsure how to adjust the scale and repeatedly fiddled with the weighing mechanisms. When weights were finally obtained, EI#3 was unable to accurately subtract the weight of the wheelchair from the total weight to arrive at a correct weight for the residents. The surveyor had to provide extensive oversight in an effort to obtain a correct weight for both residents. On November 18, 2015, at 3:50 PM, during a telephone interview, a hospice nurse providing care to RI#1 stated that during one of her visits in November, she observed that the facility's weight logs for September 2015 and October 2015 were blank, no weights were recorded for the residents. However, on her next visit that same month, the logs were complete with weights documented for each resident. The nurse stated it appeared the facility was not really weighing the residents. The surveyor asked RI#1's nurse if it was possible for the facility to accurately weigh	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 604	Continued From page 41	A 604		

RI#1. She said , "the only way she (RI#1) could be weighed is if a Hoyer lift was used or a bed scale." On December 9, 2016, at 10:00 AM, the hospice nurse told the surveyor she had never seen RI#1 out of bed. Note: RI#1 was seen by that nurse twice a week since August 7, 2015.

RI#1
On December 9, 2015, at 11:58 AM, the surveyor observed EI#3 transfer RI#1 from the bed to the wheelchair so she could be weighed. RI#1's room door was left open allowing anyone in the hallway to see RI#1's exposed lower body and incontinent brief. EI#3 lifted RI#1 to a sitting position by pulling on her neck and contracted left arm. EI#3 put one arm under RI#1's contracted legs, and her other arm around RI#1's upper back. EI#3 cradled RI#1 in her arms and then strategically balanced RI#1 in the wheelchair, as RI#1 was unable to support herself in the wheelchair. RI#1's arms were contracted across her chest. RI#1's left leg was bent, with her left knee almost touching her chest, and her left foot resting in the seat of the wheelchair. EI#3 told EI#4 to make sure that RI#1 didn't slip out of the wheelchair and constantly reminded EI#4 to make sure that RI#1 did not move and to be ready to catch RI#1 if she started to slip out of the wheelchair.

RI#1's monthly assessment for October 2015 documented RI#1 weighed 105 pounds, a four pound loss (3.67%) from September 30, 2015. While this was not a significant weight loss, RI#1's weight had been on a steady decline since May 2015. Although EI#1 did not complete a RN monthly assessment for November 2015, facility weight logs documented that RI#1's weight remained at 105 pounds for November. However, on December 9, 2015, only nine days after the 30th of the month when EI#3 said all residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	**155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051**

(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 604	Continued From page 42 were weighed, RI#1's weight had dropped to 93 pounds, a significant weight loss of 12 pounds, 11.43% of her total body weight, in a little over a week. Refer to deficiency 512, 522, 601, 608, 635 and 701 for additional information on RI#1. RI#4 On December 9, 2015 at 11:50 AM, the surveyor observed staff transfer RI#4 from a chair to her wheelchair to be weighed. It took two staff to lift RI#4 up and out of the chair. RI#4's knees were bent, her feet were crossed and she could not bear weight on her legs. The surveyor observed staff pull on RI#4's arms and shoulders and at her clothing during the transfer. RI#4's initial medical examination, dated October 22, 2015, documented RI#4's weight as 157 pounds (lbs). One day later, RI#4 was admitted to the facility and EI#1 assessed and documented RI#4's weight as 150 lbs. However, RI#4's "new admit" weight was listed as 145 lbs on the facility's weight log for October (admit month). Three different weights were recorded in two days therefore, no baseline weight was established for RI#4. To further complicate the discrepancy in weights, on November 5, 2015, two weeks after RI#4 was admitted to the facility, RI#4 visited her cardiologist who documented that RI#4 weighed 161 lbs. On November 18, 2015, RI#4 was admitted to the hospital with a urinary tract infection (UTI) and hospital records listed 150 lbs as RI#4's "stated" weight and also revealed a low total serum protein (5.6 g/dl) and a low serum albumin (2.1 g/dl) on arrival to the emergency department, indicating a lack of protein in RI#4's diet. RI#4 was without swelling and no diuretics were administered during the three day	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 604	Continued From page 43 hospitalization. RI#4 was discharged from the hospital and upon readmission to the facility EI#1 recorded RI#4's weight as 127 lbs on the monthly assessment dated November 21, 2015 and 123 lbs on the comprehensive assessment dated that same day. Since there were so many discrepancies in RI#4's documented weights, it was difficult to determine the actual amount of weight RI#4 lost. Based on the November 5 physician's weight of 161 lbs, RI#4 would have lost 38 lbs in less than a month. When EI#1 was asked to explain how RI#4 sustained such a significant weight loss, EI#1 said the weight loss was due to RI#4's hospitalization, even though RI#4 was only hospitalized for three days and there was no documentation of a medical reason for RI#4 to have sustained such a loss. It was clear to the surveyor that the facility did not accurately assess and record weights for RI#4, an important requirement for monitoring significant changes in RI#4's health status. Upon review of the residents' weight logs and observed weights with EI#1 and EI#2, they both agreed with the surveyor that they had not previously supervised the actual caregivers' performance of residents' weights, but agreed they needed to supervise the performance of residents' weights in the future to ensure accuracy and adequate monitoring for significant weight loss.	A 604		
A 605	420-5-20-.06 (2)(d) Care of Residents (d) Resident Care Problem Areas. An RN shall identify resident care problem areas and formulate written interventions to address those problems, and to evaluate if the planned interventions were successful. An RN shall	A 605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	**155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051**

(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 605	Continued From page 44	A 605		

perform a monthly assessment of each resident in the specialty care assisted living facility. The monthly assessment shall include a review of monthly weights, falls, incidents, elopements, behavioral symptoms, significant changes and medications.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, EI#1, RN/administrator, failed to identify significant resident care problems and failed to develop written interventions that were appropriate to address those problems

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

THIS IS A REPEAT DEFICIENCY FROM THE PRIOR SURVEY COMPLETED ON JANUARY 6, 2011.

Findings:

RI#1
RI#1 was an elderly bed bound resident who had difficulty swallowing, required a pureed diet and because of contractures to her upper extremities, depended on staff to feed her at every meal. Facility records revealed RI#1 sustained continued weight loss over a six month period, from May 2015 through October 2015. Four out of six monthly assessments completed by EI#1 and other facility RNs during that time period, contained documentation that RI#1's appetite was good and that she ate "most of" or 100% percent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 605	Continued From page 45	A 605		

of her meals. Yet, the nurses own assessments showed that RI#1 was steadily losing weight. On December 9, 2015, RI#1 was weighed by facility staff at the request of the surveyors and was found to have sustained a significant weight loss of 12 pounds in nine days. EI#1, RN, did not identify, through observation and monthly assessments, that weight loss was a problem for RI#1 that required intervention and implementation of care actions that would help RI#1 maintain her weight and protect her from further weight loss. In addition, EI#1, RN, was aware RI#1 had acquired a pressure ulcer on the coccyx four months prior to the survey. EI#1 was also aware of the prescribed treatment plan which had been ordered by the physician. However, EI#1 did not identify the wound as a problem in RI#1's plan of care and did not provide staff with instructions on how to care for the pressure ulcer. In fact, on multiple occasions, the hospice nurse observed and documented that RI#1's wound was left uncovered and that facility staff, including EI#1, RN, did not ensure RI#1's wound was cared for as prescribed by the physician.

Refer to deficiency 512, 522, 601, 608, and 701 for additional information on RI#1.

RI#4
A review of RI#4's record and facility documentation of RI#4's weights, revealed multiple discrepancies in the weights recorded for RI#4. Even though the numbers varied, it was apparent that RI#4 had lost a significant amount of weight in the facility. On November 21, 2015, upon readmission to the facility after a short, 3 day, stay in the hospital, EI#1 documented that RI#1 had a poor appetite and she had a significant weight loss of 23 pounds. However, EI#1 did not identify RI#4's weight loss as a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 605	Continued From page 46 problem and did not provide any interventions to assist the staff in preventing RI#4 from losing more weight. RI#4 fell and fractured her hip, at home, prior to admission to the facility. On December 8, 2015, the surveyor observed that a home health occupational therapist (OT) was encouraging RI#4 to transfer from the recliner to a wheelchair. RI#4 was extremely anxious and stated repeatedly, "Don't let me fall." Despite maximum assistance from the OT, RI#4 would not attempt to stand or transfer. The OT physically lifted RI#4 from the recliner and sat her in the wheelchair. EI#1 did not identify RI#4's anxiety and fear of falling as problems and did not address them with appropriate interventions. Please refer to deficiency 604 for details regarding the discrepancies in the weights recorded for RI#4. RI#5 On December 8, 2015, RI#5's record and care needs were reviewed with EI#1. RI#5 was admitted to the facility on October 30, 2015, with diagnoses including, dementia and type 2 diabetes. RI#5's care plan dated November 1, 2015, documented that RI#5 had two open areas on both gluteal folds related to pressure and irritation from her incontinence brief, but did not have appropriate interventions to promote healing and to prevent further skin breakdown. EI#1 told the surveyor and home health nurse that RI#5 had a "quarter-sized" open area on her (RI#5's) gluteal folds, "skin peeled back," from "sitting and diaper rubbing... it (wound) closes (heals) and opens back up." Please refer to deficiency #512 for more	A 605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 605	Continued From page 47 information regarding RI#5's care needs.	A 605		
A 608	420-5-20-.06 (2)(g) Care of Residents (g) Services Beyond Capability of Specialty Care Assisted Living Facility. Whenever a resident requires hospitalization, medical, nursing, or other care beyond the capabilities of the specialty care assisted living facility, arrangements shall be made to discharge the resident to an appropriate setting, or to transfer the resident promptly to a hospital or other health care facility able to provide the appropriate level of care. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to transfer or discharge residents whose care needs exceeded the level of care the facility was licensed to provide. THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION. Findings: RI#1 RI#1 was a very thin, frail 83 year old female resident who was admitted to the facility on July 10, 2010, and had been receiving hospice care since August 7, 2015, due to end stage Alzheimer's disease. RI#1 was bed bound and had severe contractures of her upper and lower extremities. RI#1 could not make her needs known, was unable to perform any activities of daily living, and required total care by staff including being turned. EI#3 told the surveyor, "It is hard to keep her (RI#1) turned from side to	A 608		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 608	Continued From page 48	A 608		

side because of her arms and legs. She (RI#1) rolls over on her back." RI#1 was observed with bilateral hand rolls for the contractures of her hands and heel booties to protect her heels from breakdown. The surveyor was informed by EI#3 on December 8, 2015, that RI#1 had been in that condition for about a year. RI#1 was unable to feed herself and had been on a pureed diet for almost a year due to trouble swallowing. In addition, RI#1's physician ordered thickener to be added to all liquids on September 15, 2015. RI#1 was at high risk for aspiration and had been treated twice in 2015 (September and November) with antibiotics for symptoms of aspiration pneumonia. Records revealed RI#1 also sustained significant weight loss as a resident of the facility. The hospice nurse identified a pressure ulcer on RI#1's coccyx area during the initial assessment on August 7, 2015. The pressure ulcer continued to advance in size over the past four months without signs of healing. RI#1 scored a five in ambulation (bedridden more than half the time) on the Physical Self Maintenance Scale which exceeded the allowable score for a SCALF resident. In spite of RI#1's declining condition, cognitive assessment scores and her need for skilled care, no discharge notice had been given.

RI#2
RI#2 was a very frail, 104 year old woman admitted to the facility on October 23, 2013. RI#2 required assistance with all activities of daily living including incontinence care. RI#2 was able to communicate some of her care needs. RI#2 was unable to sit unsupported on the bed, could not walk, and required the maximum assistance of two staff for transfers. The surveyor observed that RI#2 did not bear weight on her legs during a transfer from her bed to her wheelchair. RI#2 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ____ B. WING ____	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	**155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051**

(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 608	Continued From page 49	A 608		

mobile using a transport wheelchair propelled by staff. The surveyor observed that RI#2's feet did not touch the floor when she was sitting in the wheelchair and there were no footrests on the wheelchair. EI#3, caregiver, told the surveyor that, "She (RI#2) can't sit and can't walk." During an interview with EI#1, she told the surveyor that RI#2 could not propel herself in a wheelchair, and went on to say "I (EI#1) didn't know they had to (self propel a wheelchair)." Even though RI#2's functional abilities did not meet requirements for a resident of a SCALF, no discharge notice had been given.

RI#3
RI#3 was a 74 year old elderly woman, who was admitted to the facility on July 31, 2015, with advanced dementia. RI#3 was unable to communicate her needs, and required total assistance with all activities of daily living, including incontinence care and eating. RI#3 was observed with limited movement of her arms and was restrained in her wheelchair with a handmade restraint. EI#1 told the surveyor the restraint was used, "because she (RI#3) slides out of the wheelchair..." RI#3 was observed during the survey to only be out of bed for meals and during a visit from her spouse. The surveyor observed that RI#3 could not sit unsupported on the side of the bed, did not bear weight or straighten her knees during transfers, and did not or could not straighten her arms when pulled on by EI#4 during a transfer. In spite of RI#3's poor physical functioning abilities and cognitive assessment scores that caused RI#3 to be ineligible for SCALF residency, no discharge notice had been given.

RI#4
RI#4 was an 89 year old female admitted to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 608	Continued From page 50 facility on October 23, 2015, after a recent left total hip repair. RI#4 required assistance with all activities of daily living, including incontinence care. RI#4 was alert and attempted to verbally communicate but her speech was garbled making it difficult to understand. RI#4 was able to sit unsupported in her wheelchair but required the maximum assistance of two staff members for safe transfers. Two different times, the surveyor observed outside agency staff heavily cue RI#4 to propel herself to her room; however during both encounters RI#4 did not attempt to self propel her wheelchair, the staff member had to transport RI#4 to her room. Even though the ability to self propel a wheelchair is a required functional ability of a SCALF resident, no discharge notice was given. RI#5 RI#5 was admitted to the facility on October 30, 2015, with diagnoses including, dementia, hypertension, and type 2 diabetes. RI#5 was being treated in the facility by unlicensed care staff for swelling of her lower legs and feet. RI#5 required application and removal of elastic bandages daily and mechanical compression therapy twice a day. RI#5 had two open areas on both gluteal folds related to pressure and irritation from her incontinence brief. EI#1 told the surveyor and home health nurse that RI#5 had a "quarter-sized" open area on her (RI#5's) gluteal fold areas, "skin peeled back," from "sitting and diaper rubbing... it (wound) closes (heals) and opens back up." In spite of RI#5's need for skilled nursing services, no discharge notice was issued. RI#9 RI#9 was admitted to the facility in 2013. According to family, at the time of her admission RI#9 required total care, could not ambulate and	A 608		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 608	Continued From page 51 could not propel her wheelchair. As a resident of the facility, RI#9 developed contractures to her arms and legs and acquired a large wound to her coccyx while under the care of EI#1. Interviews with RI#9's hospice nurse confirmed RI#9 was bed bound, required total care and had a Stage IV wound as a resident of the facility when she was admitted to hospice on July 29, 2015. RI#9's family moved RI#9 out of the facility in September 2015, stating poor care as the reason for moving her out of Shangri-la.	A 608		
A 613	420-5-20-.06 (2)(o) Care of Residents (o) Mechanical Restraint and Seclusion. No form of restraint or seclusion shall be applied to residents of a specialty care assisted living facility except in extreme emergency situations when the resident presents a danger of harm to himself or herself or to other residents. In such an event, the facility shall immediately notify the resident's physician and sponsor, and appropriate treatment, transfer to an appropriate health care facility, or both shall be provided without any avoidable delay. In no event shall emergency behavioral symptoms of residents be treated with sedative medications, antipsychotic medications, anti-anxiety medications, or other psychoactive medications in an assisted living facility. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility utilized mechanical restraints, during non-emergency situations when proper staff supervision, more appropriate medical equipment, or a higher level of care would have been an adequate safety measure.	A 613		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 613	Continued From page 52	A 613		

Findings:

RI#2
RI#2 was able to communicate some of her care needs and required assistance with all activities of daily living. On December 8, 2015 at 5:45 AM, the surveyor observed RI#2 asleep in the bed with two half side rails in the up position. The surveyor asked EI#7 what was the reason for the raised side rails and EI#7 stated, "We keep the side rails up so she (RI#2) won't get up or fall off the bed."

RI#3
RI#3 was unable to communicate her needs and required total assistance with all activities of daily living. RI#3 was observed with limited movement of her arms and was restrained in a wheelchair with a handmade restraint created by EI#1. The surveyor observed that RI#3's wheelchair was not equipped with foot rests. RI#3's restraint was made from a strip of cloth with loops sewn on each end. Two gait belts were used, with one gait belt pulled through each looped end of the cloth strip. One gait belt was pulled through one end of the cloth strip and secured to RI#3's wheelchair. The other end of the cloth strip was placed under RI#3's bottom, then pulled between RI#3's legs. The second gait belt was pulled through the cloth's other looped end, wrapped around RI#3's waist and secured to RI#3's wheelchair. EI#1 and EI#4 both told the surveyor that RI#3's "strap" was used because RI#3 "slides out of the wheelchair."

EI#1 told the surveyor the facility did not have any restraints, and therefore did not have a restraint policy. When the surveyor asked EI#1 about the "strap" used on RI#3, EI#1 told the surveyor, "...I made that strap (restraint) to keep her (RI#3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 613	Continued From page 53	A 613		

from sliding out of the wheelchair. It's not a restraint, it's for safety." When asked, EI#1 told the surveyor, "Didn't think it was a restraint, didn't think I needed an (physician's) order for it."

On December 8, 2015, the surveyor observed EI#4 position RI#3 in her bed with the right side of the bed against the wall and a half side rail in the up position on the left side of the bed. Then EI#4 placed RI#3's wheelchair, with locked wheels, in the open area between the side rail and the foot of the bed. EI#4 told the surveyor the wheelchair was placed in that specific area, "to keep her (RI#3) from getting up or falling."

RI#4
RI#4 was alert with periods of confusion. RI#4 was wheelchair bound and required assistance with activities of daily living. The surveyor never saw RI#4 walk or attempt to propel her on wheelchair. Staff pushed RI#4's chair for her. On December 8, 2015, the surveyor observed RI#4 eating lunch in the dining room. RI#4's wheelchair was pushed close to the table and the wheels were locked. EI#4 was sitting at the dining table with RI#4 and two other residents. RI#4 was sitting in the wheelchair, looking over her shoulder and sliding her feet forward against the floor. RI#4 made no attempt to unlock the wheels of her chair. EI#4 was present at the table and ignored RI#4's physical cues that suggested RI#4 wanted to move away from the table. At 1:20PM, a physical therapy assistant approached RI#4 at the table and asked RI#4 to go to RI#4's room with her. After a couple of attempts to get RI#4 to respond, the assistant had to unlock RI#4's wheelchair and transport RI#4 to her room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 621	Continued From page 54	A 621		
A 621	420-5-20-.06 (3)(a) Care of Residents (a) Activity Program. There shall be an activity program designed to meet the individual needs of each resident. Every day the facility shall provide activities appropriate to residents with dementia. Residents who have wandering behaviors shall have a documented activity program to manage this behavior. This Rule is not met as evidenced by: Based on observations and interview, the facility failed to provide an activity program that was appropriate for all the residents living in the facility. THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION. Findings: According to a complaint (LC#035-2012) reported to the ADPH, the facility did not provide any activities for the residents other than children's puzzles. During the initial tour on December 8, 2015 at 6:45 AM, the surveyor observed the activity calendar for November 2015, posted on a bulletin board. At 7:15 AM, the surveyor observed EI#1 place the December 2015 activity calendar on the board. The November and December 2015 calendars were identical. The days of the week were listed but no times or dates were given which would help orient the residents to date or time. There were no activities planned for	A 621		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

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A 621	Continued From page 55 November (Thanksgiving/Veteran's Day) or December (Christmas) that would be recognized as a significant holiday for the local community. The activities were duplicated from month to month and only one activity was scheduled for five days of the week: Sunday-Watching church service on TV, Monday-Exercise, Wednesday-Beauty parlor, Friday-Exercise, and Saturday-Listening to the music. On December 8, 2015 at 8:50 AM, EI#3 was observed playing a card game with two residents. There were seven other residents sitting at the dining tables with no staff interaction. RI#7 was playing a game of Dominos with a sitter. On December 9, 2015 10:45 AM, EI#3, caregiver, was interviewed regarding the activities provided for the residents. EI#3 told the surveyor that most of the residents do not want to participate. EI#3 said the residents wouldn't participate in exercise on Mondays and Fridays because they didn't like it. When EI#3 was asked what types of activities were planned for residents with dementia and for residents who were more alert and oriented, EI#3 said the administrator (EI#1) coordinated and planned all activities. EI#3 said she and one other caregiver provided activities for the residents but denied she had ever received any training on providing activities for residents with dementia. The surveyor asked to see where the activities supplies were kept. EI#3 pointed to a three tiered shelf with baskets in the dining area. Upon surveyor observation, there was a mix of children's puzzles (approximately 20) and music compact discs (approximately 20). EI#3 also said they had games and cards in the conference room. EI#3 was asked if they had any movies or crafts available and EI#3 said no. EI#3 was asked	A 621		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 621	Continued From page 56 to explain the Beauty Parlor activity scheduled every Wednesday. EI#3 said around 1:00 PM the residents nails were cleaned and cut and the men were shaved. EI#3 was asked if a beautician came to the facility to cut or style the resident's hair. EI#3 said no, but EI#1 cuts the resident's hair when they need it. The surveyor only observed Fox News playing on the television in the sitting area during the two day survey. When EI#1 was questioned why the television station remained on Fox News all the time, EI#1 replied that was what one of the residents wanted to watch. The surveyor did not observe the staff providing any group activities as posted on the calendar for survey dates of December 8-9, 2015. EI#1 did not design an activity program which would stimulate or enrich the lives of the residents in her facility.	A 621		
A 628	420-5-20-.06 (4)(f) Care of Residents (f) Medications of any kind, including over the counter medications, legend drugs and controlled substances, may be administered to a resident of a specialty care assisted living facility only after the drugs have been prescribed specifically for the resident by an individual currently licensed to prescribe medications in Alabama. This Rule is not met as evidenced by: Based on interview and record review, the administrator, who is also an RN, administered medications to residents that were not specifically prescribed for that resident. Findings: On December 8, 2015 at 1:40PM, EI#1 told the	A 628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 628	Continued From page 57 surveyor, "I (EI#1) use medicine from other residents who died or discharged, if the medication and dose are the same. I hate to throw it (medications) away and waste it." Review of the facility policies and procedures revealed there was no medication disposal policy.	A 628		
A 633	420-5-20-.06 (4)(l) Care of Residents Disposal of Medications. 1. Controlled substances and legend drugs dispensed to residents, that are unused because the medication is discontinued or because the resident dies, shall be destroyed within 30 days, except unused legend drugs may be donated to a charitable clinic pursuant to Alabama Administrative Code Chapter 420-11-1, et. seq. 2. Medications of residents who are discharged or transferred to another facility shall be returned to the residents. The responsible party will sign a statement that these medications have been received. The statement shall list the pharmacy, prescription number, date, resident's name and strength of the medication and the amount. This statement shall be maintained in a file for at least two years. Discontinued medications shall not be stored or housed in the facility. 3. When medication is destroyed on the premises of the assisted living facility, a record shall be made and filed for at least two years. This record shall include: the name of the assisted living facility, the method of disposal, the pharmacy, the prescription number, the name of the resident, the name, strength, and dosage of the medication, and the amount and the reason for	A 633		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ___ B. WING ___	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	**155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051**

(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 633	Continued From page 58 the disposal. This record shall be signed and dated by the individual performing the destruction and by at least one witness. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to properly dispose of medications for residents who were discharged. Findings: On December 8, 2015 at 1:40PM, EI#1, Administrator, who is also the facility's RN, admitted to the surveyor she retained medications that belonged to deceased and discharged residents and administered those medications to current residents instead of properly disposing of them as required. EI#1 said, "I (EI#1) hate to throw it (medications) away and waste it." On December 9, 2015, the surveyor reviewed RI#6's closed record with EI#1. There was no documentation regarding how RI#6's medications were disposed of on September 27, 2015, when he was admitted to a skilled nursing facility following discharge from a local hospital. EI#1 told the surveyor that she had filled out a disposition form but it was not signed by the sponsor. Review of the facility policies and procedures revealed there was no medication disposal policy or procedure.	A 633		
A 634	420-5-20-.06 (5) Care of Residents	A 634		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 634	Continued From page 59 (5) Storage of Medical Supplies and Poisons. (a) First Aid Supplies. First aid supplies shall be maintained in a place readily accessible to persons providing personal care and services in the specialty care assisted living facility. These supplies will be inspected at least annually to ensure their usability. (b) Poisonous or External Use Substances. Cleaning supplies or poisons shall be attended at all times or shall be kept in a secured area. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to secure or supervise cleaning supplies at all times in the cleaning closet and laundry room. Findings: During the initial tour on December 8, 2015, at 5:45AM the surveyor opened a closet door on the south hall and found the following cleaning supplies unattended: Clorox bleach, Epsom salt, Fabuloso cleaner, Clorox spray, and Lysol toilet bowl cleaner. EI#7, caregiver, approached the surveyor and stated, "I was about to go in there and get the mop." EI#7 acknowledged the door was open and said the key is in the sitting area. At 6:30AM, the surveyor entered the laundry room and saw ECOS laundry detergent and Shout spray sitting on the dryer. EI#6, caregiver, came to the surveyor and said, "I went in there to fold clothes and didn't lock it back."	A 634		
A 635	420-5-20-.06 (6)(a)(b) Care of Residents	A 635		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 635	Continued From page 60 (6) Admission and Retention of Residents with Special Needs. (a) Screening. Residents shall be screened and approved for admission into the specialty care assisted living facility prior to admission to the specialty care assisted living facility. The screening shall include a clinical history, a mental status examination to include aphasia screening, a geriatric depression screen, a physical functioning screen and a behavior screen. (b) Cognitive Assessment Requirements. The Physical Self Maintenance Scale (PSMS) and the Behavior Screening Form contained in Appendix A herein, are required for each resident admitted to the specialty care assisted living facility. The resident's PSMS score shall be no greater than 23 and the resident shall be functioning without unmanageable behavior problems. Residents shall not score a five in feeding, dressing, grooming, bathing, or a four or five in physical ambulation on the PSMS. Each resident shall be carefully evaluated by an RN and by the Unit Coordinator. The Physical Self Maintenance Scale and the Behavioral Screening Forms shall be required annually on each resident. The PSMS and Behavior Screening form shall be completed where there is a significant change in the resident. This Rule is not met as evidenced by: Based on observation, interview, and record review, the RN failed to complete a Physical Self Maintenance Scale (PSMS) and behavior screen annually or when there were significant changes in health status for residents. The facility also retained residents in the facility whose PSMS scores exceeded the allowable scores for a resident of a SCALF.	A 635		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 635	Continued From page 61	A 635		

Continued From page 61

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

THIS IS A REPEAT DEFICIENCY FROM THE PRIOR SURVEY COMPLETED ON JANUARY 6, 2011.

Findings:

RI#1
RI#1 was a very, thin, frail, 83 year old female admitted to the facility, on July 10, 2010, with diagnoses of Alzheimer's. RI#1 was admitted to hospice services due to end stage Alzheimer's disease. Following this significant change in health status, EI#1 did not complete a PSMS or behavior screen for RI#1. The most current PSMS (total score 20) and behavior screen were dated December 31, 2014. The surveyors own observations of RI#1's activities of daily living and interviews with staff regarding RI#1's physical function, assessed RI#1's functional status as follows (scores included); no control of her bladder and bowels (5), required extensive assistance with meals (4), needed major assistance with dressing, but cooperated (4), needed total grooming care (4), bedridden more than half the time (5) and could not wash herself, but was cooperative (4). RI#1's total score was 26, with a 5 in the ambulation. Both scores, total score and ambulation, either in combination or alone, exceeded the allowable scores for a resident of a SCALF.

RI#2
RI#2 was unable to sit unsupported on the bed, could not walk, and required the maximum assistance of two staff for transfers. RI#2 did not bear weight on her legs during an observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 635	Continued From page 62	A 635		

transfer from her bed to her wheelchair. RI#2 was mobile using a transport wheelchair propelled by staff. EI#3, caregiver, told the surveyor that, "She (RI#2) can't sit and can't walk... we do everything (ADL) for her." During an interview with EI#1, she told the surveyor that RI#2 could not propel herself in a wheelchair and went on to say "I (EI#1) didn't know they had to (self propel a wheelchair)." RI#2's most recent PSMS and behavior screens were dated October 24, 2014. RI#2's PSMS documented a total score of 15 and that RI#2 needed reminders for toileting (not observed), needed only moderate assistance with dressing (not observed), grooms self with minor assistance (not observed), and did not reflect that RI#2 could not self propel her wheelchair. The surveyor asked EI#1 about more current assessments for RI#2. EI#1 told the surveyor, "It's only December, I still have time to get them done this year." The surveyor showed EI#1 where the assessments were due in October 2015. EI#1 told the surveyor she didn't know the annual assessments were required to be done in the same month as the previous year.

RI#3
RI#3 had advanced dementia, was unable to communicate her needs, and required total assistance with all activities of daily living, including incontinence care and eating. RI#3 was observed with limited movement of her arms and was restrained in her wheelchair with a handmade restraint, created from a strip of cloth with loops sewn on each end to hold two gait belts. EI#1 told the surveyor the restraint was used "because she (RI#3) slides out of the wheelchair...I (EI#1) made that strap (restraint) to keep her from sliding out of the wheelchair." RI#3 was observed, during the survey, to only be out of bed for meals and during a visit from her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 635		A 635		

Continued From page 63

spouse. RI#3 required support to sit on the side of the bed, did not bear weight or straighten her knees during transfers, and did not or could not straighten her arms, when pulled on by EI#4, caregiver, during a transfer observed by the surveyor.

The only PSMS completed for RI#3 was dated August 1, 2015, and documented a score of 19. RI#3's PSMS documented that RI#3 could feed herself with finger foods (not observed) needed moderate assistance with grooming and dressing (not observed), and did not reflect that RI#3 was bedridden more than half the time as observed by the surveyor during the survey. RI#3's record did not document any significant changes in RI#3's condition since RI#3's admission to the facility 4 months prior to the survey.

Records from the SCALF where RI#3 previously resided revealed RI#3's June 23, 2015, PSMS score was 26 and that RI#3 was bedridden more than half the time. The facility began discharge planning at that time and on July 30, 2015, RI#3 was discharged from the facility. There was no documentation by the previous facility that RI#3's condition had improved before she left. On July 31, 2015, one day after she was discharged from a SCALF because she required a higher level of care, EI#1 admitted RI#3 to Shangri-la, SCALF. On August 1, 2015, EI#1 completed a PSMS for RI#3 and assessed RI#3's total score as 19 and that RI#3 could ambulate by wheelchair with assistance getting in and out of the chair.

RI#4
RI#4 could talk, but her speech was difficult to understand and she had frequent episodes of confusion. RI#4 was able to feed herself, but required total assistance with all other activities of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 635	Continued From page 64 daily living. On December 8, 2015, a male home health occupational therapist (OT) was encouraging RI#4 to transfer from the recliner to a wheelchair. Despite maximum assistance from the OT, RI#4 would not attempt to stand or transfer. The OT physically lifted RI#4 from the recliner and sat her in the wheelchair. RI#4 was transported by wheelchair to her room by the OT. Later that afternoon, the physical therapy (PT) assistant arrived and found RI#4 sitting in her wheelchair. The PT assistant pushed RI#4's wheelchair to her room from the dining area. On both encounters, RI#4 was cued by the OT and PT assistant to return to her room, but RI#4 would not try to self-propel her wheelchair. The only PSMS completed for RI#4 was dated October 25, 2015, with a total score of 14. The PSMS did not indicate RI#4 would not self-propel her wheelchair as observed by the surveyor. RI#4 was taken to a nearby emergency department on November 18, 2015, for complaints of chest pain. RI#4 was admitted for further work up and to rule out a stroke. The cardiologist evaluated RI#4 and determined invasive testing was not necessary. RI#4 was discharged from the hospital back to the facility on November 21, 2015. EI#1 did not evaluate RI#4's physical limitations by completing the PSMS or a behavior screen after re-admission to the facility.	A 635		
A 701	420-5-20-.07 (1)(a) Food Services (1) General. (a) Direction and Supervision. The services of a Dietician shall be made available to	A 701		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

(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 701	Continued From page 65	A 701		

any resident of a specialty care assisted living facility who requires a therapeutic diet. A congregate specialty care assisted living facility shall be under the direction and supervision of a full or part-time professionally qualified dietician or a consulting dietician, that is, licensed in the State of Alabama. Responsibility for the supervision of dietary services shall be delegated to a responsible employee who is a graduate of a Dietary Managers course or has completed an approved course that includes basic sanitation when a dietitian is not employed. The facility shall provide meals, fluids, and snacks to the residents that meet the Dietary References Intakes from the basic food groups. The meals shall be of the quality and quantity necessary to meet the residents' needs, and must be in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure a registered dietician was available for one resident receiving a therapeutic diet. The facility also failed to provide the nutrients necessary to promote wound healing for the resident.

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

Findings:

RI#1 was a thin, frail, bed bound 83 year old female who was admitted to the facility on July 10, 2010. RI#1 did not speak and had severe contractures of her arms and legs. RI#1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANGRI-LA ASSISTED LIVING, LLC	155 EGG AND BUTTER ROAD COLUMBIANA, AL 35051

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A 701	Continued From page 66	A 701		

unable to feed herself, she received a pureed diet and was prescribed thickened liquids because she had difficulty swallowing. The surveyor observed a meal served to RI#1 that consisted of cooked cabbage stirred into mashed potatoes. The surveyor was also told that for breakfast, RI#1's eggs were stirred into her oatmeal. Further observations and interviews revealed only RI#1's water was thickened and RI#1 was not being fed a sufficient amount of protein. The surveyor observed two meals at which RI#1 was not fed any source of protein.

The surveyor interviewed EI#5, Cook, regarding the training she (EI#5) received in preparing pureed food. EI#5 said she had no professional training but had years of experience and "learned how to do it." EI#5 said if she had any questions about RI#1's food she asked EI#1. EI#5 also told the surveyor she (EI#5) trained the new cook on how to mix RI#1's food to a smooth consistency.

RI#1 was at high risk for aspiration and in fact, had been treated with antibiotics for symptoms of aspiration pneumonia on two different occasions. When the surveyor asked EI#5 about RI#1's thickened liquids, EI#5 said RI#1's water should be thickened to honey consistency. EI#5 said the hospice nurse told her to add 1 scoop of thickening powder to a cup and a half of water. However, the amount of powder EI#5 added to RI#1's cup did not comply with the manufacturer's directions for any therapeutic consistency listed on the container.

Facility weight logs revealed that RI#1's weight had steadily declined in 2015. On the last day of the survey, the surveyors discovered RI#1 had sustained a significant weight loss of 11.43% of her total body weight in a little over 1 week.

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	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

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A 701	Continued From page 67 In addition, RI#1 acquired a pressure ulcer on her coccyx approximately four months prior to the survey that had advanced in size. When referring to the wound, RI#1's hospice nurse said,"It (wound) can't seem to make improvements." On December 9, 2015 at 1:30PM, EI#1 was asked if she consulted a dietician for RI#1. EI#1 said, "No because (RI#1) was on a regular puree diet, we put the food in the blender." EI#1 also said they used the food processor to grind meat for RI#1. However, in earlier interviews with EI#5, EI#5 told the surveyor she mixed RI#1's food to a smooth consistency, avoided giving RI#1 chicken because it was stringy, taught the weekend cook how to mix RI#1's food to a smooth consistency, but never mentioned that a blender or food processor was used. The surveyor did not observe the blender or food processor being used during the survey. The facility's policy regarding therapeutic diets stated, ..."This Facility cannot accept any resident's that requires therapeutic diet since the services of a Dietician is not available..." Without the services of a dietician there was no oversight of RI#1's therapeutic diet to ensure RI#1 was getting the proper nutrients, proper consistency, proper caloric intake and food that was palatable. Please refer to deficiency numbers 512, 522, 601, 608 and 635 for more information regarding RI#1.	A 701		
A 705	420-5-20-.07 (2)(c) Food Services (c) Protection of Food from Contamination. 1. Food and food ingredients shall be stored,	A 705		

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	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

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A 705	Continued From page 68	A 705		

handled, and served so as to be protected from pests, dust, rodents, droplet infection, unsanitary handling, overhead leakage, sewage backflow, and any other contamination. Sugar, syrup, and condiment receptacles shall be provided with lids and shall be kept covered when not in use.

2. Medication, biologicals, poisons, detergents, and cleaning supplies shall not be kept in the refrigerator nor in other areas used for storage of food.

3. Food shall not be stored on the floor. All food and food ingredients stored on shelving must be placed on shelving that is at least six inches above the floor.

4. Refrigerators shall maintain a maximum temperature of 41 degrees Fahrenheit. Freezers shall maintain at a maximum temperature of 0 degree Fahrenheit. Thermometers shall remain in refrigerators and freezers at all times.

5. All leftover foods shall be labeled and dated, (month, day, year) and consumed within three days.

6. Potentially hazardous hot foods shall be at minimum temperature of 135 degrees Fahrenheit and cold foods at a maximum temperature of 41 degrees Fahrenheit. Frozen foods must be maintained at a temperature where it is kept frozen solid.

7. Food shall be prepared in the licensed facility or another location even when that location is not part of the licensed facility. The licensed facility is responsible to ensure adequate equipment and measures are used to ensure that food is not

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	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

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A 705	Continued From page 69	A 705		

contaminated in transport and that foods that are transported are held and served at the appropriate temperature at all times. Hot foods must be maintained at a minimum of 135 degrees Fahrenheit and cold foods at a maximum 41degrees Fahrenheit. All food preparation areas used by the facility shall be subject to the same inspection as though part of the licensed facility.

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).

9. Laundry shall not be brought through the food preparation or service area.

This Rule is not met as evidenced by:
Based on observations and interview the facility failed to ensure the food was prepared and served at the appropriate temperatures.

Findings:

While observing breakfast and lunch service on December 8, 2015, the surveyor did not see EI#5 take the temperature of the hot or cold foods prior to serving the residents. The residents were served chicken that had been baked in the oven for lunch. EI#5 was asked how do you make sure the food is cooked to the correct temperature to ensure safety. EI#5 touched the pan and said by making sure it is hot. EI#5 was questioned if food temperatures were taken and EI#5 said, "I don't do it, I will start today."

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	P5901	A. BUILDING: ______ B. WING ______	12/09/2015

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A 712	Continued From page 70	A 712		
A 712	420-5-20-.07 (3)(e)(f) Food Services (e) A facility shall not avoid serving a meal by sending or transporting residents to missions, soup kitchens or other charitable facilities for meals. (f) The amount of food on hand shall be sufficient to serve three meals per day to all residents for three days. Non-perishable food and potable water shall be maintained in the facility in sufficient quantity to serve three meals per day to all residents for three days. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure there was a sufficient supply of potable water maintained to serve all 11 residents for three days, in the event of an emergency. Findings: On December 8, 2015, the surveyor observed with EI#2, the emergency water supply for the facility. A total of 26 gallons was stored in the main pantry. The supply on hand did not meet the requirements (33 gallons) for number of residents (11) currently residing in the facility. EI#2 told the surveyor he thought each resident only needed 1-2 quarts of drinking water each day.	A 712		
A1101	420-5-20-.11(1)(a) Fire and Safety (1) General. (a) Evacuation Plan. Each specialty care assisted living facility shall maintain a current written fire control and evacuation plan. In facilities, which	A1101		

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	P5901	A. BUILDING: ____ B. WING ____	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1101	Continued From page 71 have multiple, smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. Fire control and evacuation plans shall be kept current. Written observations of the effectiveness of the fire drill plan shall be filed and kept for at least three years. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that fire drills were completed monthly, quarterly on each shift, and in accordance with the Life Safety Code. Findings: On December 8, 2015, the surveyor with EI#1 and EI#2, reviewed the facility fire drill documentation for 2015. There was no fire drill completed for the month of August 2015. There was no first shift drill for the third quarter of 2015. The surveyor also noted that all the fire drills completed for the night shift, 6:30 PM to 6:30 AM, were simulated even though there were hours available to conduct an actual drill for night shift employees. EI#1 and EI#2 agreed they missed a fire drill in August 2015, and that actual fire drills could be conducted for the night shift employees.	A1101		
A1211	420-5-20-.12 (3)(o) Physical Plant (o) Fire Extinguishers. Fire extinguishers shall be provided for each hall, kitchen, and laundry, of type and capacity appropriate to the need.	A1211		

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A1211	Continued From page 72	A1211		

1. Each fire extinguisher shall receive an annual inspection with maintenance, and recharging when necessary, by a fire equipment servicing representative. An annual servicing tag shall be attached to the extinguisher reflecting the name of the servicing company, representative, day, month and year of maintenance.

2. A visual inspection of each fire extinguisher shall be conducted monthly by a designated staff of the facility and documented on the attached extinguisher tag by the designated staff person.

This Rule is not met as evidenced by:
Based on observation and interview, the facility failed to ensure all fire extinguishers were inspected annually as required.

THIS DEFICIENT PRACTICE WAS ALSO CITED DURING THE SURVEY CONDUCTED ON JANUARY 6, 2011.

Findings:

On December 8, 2015, the surveyor examined the tags attached to the fire extinguishers located in the laundry room and hallways (North and South). The last annual inspection date documented by the contractor was November 5, 2014. This was brought to the attention of EI#2 who felt this was incorrect. The surveyor and

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A1211	Continued From page 73 EI#2 reviewed the fire inspection tags together. EI#2 told the surveyor he thought the annual fire extinguisher inspection had been done. TONYA AVENATTI, REGISTERED NURSE DEBRA FREEMAN, REGISTERED NURSE	A1211		