## Statement of Deficiencies and Plan of Correction

### A. BUILDING:

**A. PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

P4907

**B. WING:**

______________________

**DATE SURVEY COMPLETED:**

07/13/2016

### NAME OF PROVIDER OR SUPPLIER

GORDON OAKS

3145 KNOLLWOOD DRIVE

MOBILE, AL  36693

### Statement of Deficiencies

This is a 100 bed Specialty Care Assisted Living Facility (SCALF) with a census of 29 on July 13, 2016.

There was one complaint investigated during the licensure survey completed on May 5, 2016. Complaint number LC#046-2016 was substantiated and deficiencies were cited as a result of the complaint investigation.

There were three complaints investigated during the complaint survey completed on July 13, 2016. Complaint numbers LC#079-2016, LC#083-2016, and LC#084-2016 were substantiated and additional deficiencies were cited as a result of the complaint investigations.

Deficiencies were cited during the 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 actual harm for four residents and the potential for harm to the remaining 25 residents.

### Plan of Correction

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.000</td>
<td></td>
<td>Initial Comments</td>
<td>A.000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This is a 100 bed Specialty Care Assisted Living Facility (SCALF) with a census of 29 on July 13, 2016.

There was one complaint investigated during the licensure survey completed on May 5, 2016. Complaint number LC#046-2016 was substantiated and deficiencies were cited as a result of the complaint investigation.

There were three complaints investigated during the complaint survey completed on July 13, 2016. Complaint numbers LC#079-2016, LC#083-2016, and LC#084-2016 were substantiated and additional deficiencies were cited as a result of the complaint investigations.

Deficiencies were cited during the 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 actual harm for four residents and the potential for harm to the remaining 25 residents.

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.301</td>
<td></td>
<td>420-5-20-.03 (1)(a) Administration</td>
<td>A.301</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| (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 |
A 301 Continued From page 1

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 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, the governing authority failed to properly supervise Teresa Davis, Registered Nurse (RN)/Administrator and Linda Tiffany (Regional Director/Acting Administrator after Teresa Davis’ resignation in June 2016) to ensure the facility operated responsibly and in compliance with the SBOH rules for specialty care assisted living facilities. The administrator's failure to responsibly manage the facility resulted in the following: neglect of resident care and safety needs, delayed treatment for a life threatening
A 301 Continued From page 2

emergency that resulted in death, an outbreak of nausea, vomiting, and diarrhea that affected 10 residents and 10 employees, residents not being treated with dignity and respect, resident care plans that were not current and did not address all care needs with appropriate care actions, inadequate investigations of incidents, employees with unmet training needs essential for providing resident care and safety, food that was improperly served and stored, and an environment not maintained in a clean and safe manner and free of objectionable odors. These deficient practices resulted in actual harm for four residents and the potential for harm to the remaining 25 residents.

THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING SURVEYS COMPLETED ON NOVEMBER 03, 2011, AND MAY 09, 2013.

Findings:

On May 3-5, 2016, the Alabama Department of Public Health (ADPH) completed a complaint investigation and a licensure survey with Teresa Davis, RN/Administrator. The complaint was substantiated and deficiencies were cited related to the complaint investigation and the licensure survey.

On July 11-13, 2016, the Alabama Department of Public Health completed a second complaint investigation survey with three complaints investigated during the survey with Linda Tiffany, Regional Director/Acting Administrator. All three complaints were substantiated with additional deficiencies cited as a result of the complaint investigations.

The following deficiencies were cited as a direct...
Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
P4907

(X2) MULTIPLE CONSTRUCTION
A. BUILDING: __________________
B. WING ____________________

(X3) DATE SURVEY COMPLETED
07/13/2016

NAME OF PROVIDER OR SUPPLIER
GORDON OAKS

STREET ADDRESS, CITY, STATE, ZIP CODE
3145 KNOLLWOOD DRIVE
MOBILE, AL  36693

(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 301 Continued From page 3
result of the governing authority's lack of oversight and the administrator's failure to apply the State Board of Health's rules for the day to day operations of the facility.

303 - Employee conduct policies and procedures were not implemented to prevent the neglect of resident care and safety. THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION

402- Employees were not managed and directed in a manner to prevent the neglect of resident care and safety. THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION.

424 - Employees had unmet training needs regarding the provision of resident care and safety in a respectful manner. THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION.

427 - Employees were unable to demonstrate an adequate understanding of the special care and safety needs for residents with dementia and cognitive impairment. THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION.

506 - The local health department was not contacted regarding a disease outbreak affecting at least 10 residents and 10 employees.

516 - Incidents were not adequately investigated. THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION.

519 - Incidents were not reported to ADPH within 24 hours of the incident.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 301</td>
<td>Continued From page 4</td>
<td>A 301</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

523 - Residents were not treated with dignity and respect. THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION.

530 - Employees did not follow recognized standards for all resident health care. THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION.

605 - The RN/Administrator failed to equip staff with accurate, updated resident care plans which included appropriate interventions to promote the health and safety for all residents.

607 - Employees did not demonstrate a responsibility to report resident abuse, neglect, and exploitation. THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION.

624 - Resident care needs were not provided. THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION.

630 - Medications maintained by the facility were not secured or supervised at all times. THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION.

634 - Chemicals and poisons were not securely stored or supervised at all times. THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION.

705 - Food was not served or stored properly. THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY THAT WAS...
A 301 Continued From page 5
CITED DURING THE SURVEY COMPLETED ON MAY 09, 2013.

710 - Menus were not provided with alternate foods adapted to the residents’ preferences. The facility's snack policy didn't meet the requirements of the SBOH rules and regulations.

711 - The menus did not provide an alternate for vegetables or a variety of alternate entrees.

805 - Every resident's bedroom did not contain at least one comfortable chair.

808 - Essential mechanical equipment was not maintained in a safe and sanitary manner.

814 - Kitchen and dining equipment was not kept clean.

1003 - The facility environment was not free of objectionable odors. THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION.

1102 - Fire drills were not completed monthly or quarterly on each shift. THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEY COMPLETED ON NOVEMBER 03, 2011.

1213 - The facility did not maintain documentation onsite that the fire alarm system and kitchen hood suppression system were maintained and inspected in accordance with the Life Safety Code requirements. THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEY COMPLETED ON NOVEMBER 03, 2011.
Summary of Deficiencies and Plan of Correction

**A. BUILDING:**

**B. WING:**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**P4907**

**NAME OF PROVIDER OR SUPPLIER:** GORDON OAKS

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 3145 KNOLLWOOD DRIVE

**MOBILE, AL 36693**

**DATE SURVEY COMPLETED:** 07/13/2016

**FORM APPROVED:**

**NAME OF PROVIDER OR SUPPLIER:** GORDON OAKS

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 3145 KNOLLWOOD DRIVE

**MOBILE, AL 36693**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 303</td>
<td></td>
<td></td>
<td>Continued From page 6</td>
<td>A 303</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A 303</td>
<td></td>
<td></td>
<td>420-5-20-.03 (1)(c)(d) Administration</td>
<td>A 303</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**c** Policies. A specialty care assisted living facility shall establish and implement written policies and shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). Policies shall cover the following:

1. How allegations of abuse, neglect, and exploitation will be handled by the facility.
2. Admission and continued stay criteria.
3. Discharge criteria and notification procedures for residents and sponsors.
4. Facility responsibility when a resident's personal belongings are lost.
5. What services the facility is capable and not capable of providing.
6. Medication administration.
7. Meal service, timing, menus and food preparation, storage, and handling.
8. Fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness.
9. Staffing and conduct of staff while on duty.

**d** Relationship of Staff to Governing Authority. The administrator, medical staff, facility personnel, and all auxiliary organizations shall be directly or indirectly responsible to the governing
### Summary Statement of Deficiencies

**A 303** Continued From page 7

This Rule is not met as evidenced by:

Based on observation, interview, and record review, Employee Identifier (EI)#1, RN/administrator, and EI#19, regional director and acting administrator, failed to implement policies and procedures for staff conduct to prevent resident neglect for care and safety.

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

**Findings:**

On July 11, 2016, at 5:07 AM, the surveyor observed the facility halls were very dark. The only lights observed by the surveyor came from a television in the activity room, the nurses station, and a light by the dining rooms. The activity room was so dark, the surveyor did not immediately see the three employees, EI#21, resident assistant (RA), EI#22, RA, and EI#23, RA, in the darkened activity room. Once the surveyor turned on the activity room light, she observed all three employees sound asleep in soft chairs. When the surveyor spoke to the employees, they woke up, started stretching and gathering their personal items.

Resident Identifier (RI)#13 was observed barefoot and ambulating in the darkened hallways, which placed RI#13 at risk for a fall with injury.

RI#2 and RI#7 were both fully dressed including shoes and asleep in chairs in their rooms. EI#21 verified that neither resident had received bedtime care nor been assisted to sleep in their...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**: GORDON OAKS  
**STREET ADDRESS, CITY, STATE, ZIP CODE**: 3145 KNOLLWOOD DRIVE, MOBILE, AL 36693

<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
</table>
| A 303 | Continued From page 8  
bed. When EI#20 removed RI#2's shoes there were clearly defined indentation's on RI#2's swollen feet from the straps of RI#2's shoes.  
RI#11 was scheduled to have a shower during the night shift (11 PM - 7 AM) on July 10, 2016. On July 11, 2016 at 8:30 AM, the surveyor observed RI#11 sitting in the dining room with shoulder length hair that hung in greasy strands. RI#11's scalp could be seen between the greasy strands of hair. EI#20 was asked if RI#11 looked like a shower had been received during the night shift. EI#20 answered, "No."  
On July 13, 2016, EI#19 told the surveyor, "I (EI#19) know (EI#1) knew they (11:00 PM - 7:00 AM shift) were sleeping, they (11:00 PM - 7:00 AM shift) had been reported several times. (EI#1) protected the night shift... I don't know why... (EI#1) had her favorites. I (EI#19) couldn't catch them sleeping. The maintenance man was supposed to be coming in at night checking on them..."  
Review of the facility employee handbook documented, "Rules of Conduct...Any employee who violates one of the following rules may be subject to disciplinary action up to and including termination of employment at the sole discretion of the company. ...Sleeping on the job...". | A 303 | | |
| A 402 | 420-5-20-.04 (2) Personnel and Training  
(2) The administrator of a specialty care assisted living facility must manage and direct the activities of employed staff members in a manner that results in adequate care actually being provided. If a facility has a sufficiently large number of staff members on duty to meet the | A 402 | | |
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>A 402</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A 402</strong></td>
<td>Continued From page 9</td>
<td></td>
<td></td>
<td>care needs of all residents, but adequate care is not being provided, then the facility does not meet this administration and management requirement.</td>
</tr>
</tbody>
</table>

This Rule is not met as evidenced by:

Based on observation, interview, and record review, the administrator, failed to manage and direct the activities of employees to ensure resident rights, care, and safety needs were met.

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

**Findings:**

On July 11, 2016, at 5:07 AM, the surveyor observed all three caregivers for the SCALF unit sound asleep in the activity room with the lights off.

**RI#13 was barefoot and wandering the darkened hallways without supervision.**

On July 11, 2016, the surveyor observed that RI#2 and RI#7 were both fully dressed including shoes and asleep in chairs in their rooms. Both residents' beds were neatly made and did not look slept in. EI#21 told the surveyor that both residents had been, "combative and were left alone." EI#21 verified that neither resident had received bedtime care nor been assisted to sleep in their bed. The surveyor observed that RI#2’s feet were sitting on the floor and RI#2’s skin was swollen around and between the straps of RI#2’s shoes. When EI#20 removed RI#2’s shoes there...
A. BUILDING: ____________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
P4907

(X2) MULTIPLE CONSTRUCTION/A. BUILDING: ____________________
B. WING _____________________

(X3) DATE SURVEY COMPLETED: 07/13/2016

NAME OF PROVIDER OR SUPPLIER: GORDON OAKS
STREET ADDRESS, CITY, STATE, ZIP CODE: 3145 KNOLLWOOD DRIVE
MOBILE, AL 36693

(X4) ID PREFIX TAG
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

A 402  Continued From page 10
were clearly defined indentation's on RI#2's swollen feet from the straps of RI#2's shoes. RI#2 continued sleeping while EI#20 removed the shoes.

On July 11, 2016, the surveyor noted that RI#11 was scheduled to have a shower during the previous shift (11 PM - 7 AM). The surveyor observed RI#11 sitting in the dining room eating breakfast. RI#11's hair was shoulder length and hung in greasy strands. RI#11's scalp could be seen between the greasy strands of hair. EI#20 was asked if RI#11 looked like they had received a shower during the previous shift. EI#20 answered, "No." The last documented bath/shower for RI#11 was dated July 6, 2016 (5 days prior to the surveyors observation).

EI#9, LPN (Licensed Practical Nurse) charge nurse, told the surveyor that the night shift staff completed "bath sheets" and put them under the unit coordinator's door. EI#20, RN/unit coordinator, told the surveyor that staff assignment and bath sheets were submitted to EI#20 daily. EI#20 had a stack of assignment and bath sheets in her office that were in no particular order. The staff assignment and bath sheets for July 1 - 10, 2016, were reviewed with EI#20. The surveyor noted that there were many residents with missing shower documentation when compared to the shower schedule. EI#20 told the surveyor that she was aware that the staff were not documenting resident showers as required.

On July 12, 2016, the surveyor observed two staff waiting to serve lunch. There were 24 residents waiting for lunch in the two dining rooms. EI#8 told the surveyor that none of the residents could be served until all the residents were in the dining

(X5) COMPLETE DATE

A 402
Continued From page 11

room. After 15 minutes the other two staff arrived with 4 more residents. EI#8 began plating food. There were four staff observed working in the two dining rooms during lunch. However, the staff only served one plate to a table at a time, leaving 2 - 3 residents sitting and waiting for their food to be served. Some residents would sit and wait for the other residents at the table to be served before eating their food. EI#15 agreed that each table of residents should be served all their meals at the same time.

On July 12, 2016, the surveyor spoke with EI#15 regarding the staff to resident interactions observed. EI#15 was unable to explain why RI#2's room and bathroom doors were locked on the night shift. EI#15 also could not explain why RI#17 and RI#18’s room doors were locked and the resident's didn't have access to their rooms throughout the dayshift. EI#15 told the surveyor that they were aware of a problem with care staff in the facility having the opinion of, "I (caregiver) work here and you (resident) will do what I tell you (instead of), this is your home and I appreciate you letting me earn a living by helping you."

EI#15 went on to say that they were working on changing the way staff interact with the residents, or replacing the staff.

EI#15 also told the surveyor that the LPN charge nurses "weren't charge nurses". EI#15 and EI#19 agreed the LPN charge nurses were not ensuring the residents received proper care in accordance with the care plan and were not holding staff accountable when care was not provided.

On July 13, 2016, employee files were reviewed with EI#19. There were no job descriptions in the employees files explaining each employees responsibilities while working in the facility. EI#19
| A 402 | Continued From page 12  
agreed the employees should have job descriptions so they knew what their job responsibilities were.  
For additional information please refer to deficiencies #301, #522, #607, #624, #630, #634, and #710. |
|---|---|
| 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 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.
13. Psychiatric Symptoms of Dementia.
15. End of Life Issues in Dementia.
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 and interview, the Registered Nurse (RN) failed to identify and provide staff with refresher training as needed.
A 424 Continued From page 14

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

Findings:

On May 3 through May 5, 2016, the surveyor identified the following staff training needs: how to thoroughly investigate required incidents, what incidents required reporting within 24 hours to the ADPH, what types of incidents required reporting to the local health department, how to properly test food temperatures, appropriate food serving temperatures, when and how to accurately calibrate a thermometer, how to clean and sanitize the steam table, dining room, dining room tables and placemats, the importance of frequent incontinence care and proper use of protective undergarments, proper sanitation to prevent infections, how to safely evacuate the second floor residents in the event of a fire and effective pain management.

On July 11 through July 13, 2016, the surveyor identified additional staff training needs: employees responsibility to report abuse and neglect, how to care for residents with dementia and cognitive impairment, resident rights, supervisory and leadership skills, job responsibilities, cardiopulmonary resuscitation (CPR), and caring for residents in a dignified and respectful manner.

This is not an all inclusive list of training needs, but merely an example of some of the training needs that the surveyor observed or identified through staff interviews during the surveys.

A 427 420-5-20-.04 (11)(e) Personnel and Training

A 424
**A 427** Continued From page 15

All staff who have resident contact shall be able to demonstrate diversional methods and redirection. All staff shall be able to demonstrate an understanding of the implications of caring for residents with agnosia, amnesia, aphasia and apraxia. All staff shall be able to demonstrate an understanding of the facility’s fire and evacuation plan and all other policies regarding safety, including policies for preventing elopements, responding to elopements, and fall prevention.

This Rule is not met as evidenced by:

Based on observation and interview, the facility staff failed to demonstrate understanding of diversional methods, redirection, and caring for residents with agnosia, amnesia, aphasia, and apraxia.

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

**Findings:**

During the survey completed on July 13, 2016, the surveyor observed the following staff to resident interactions.

EI#25 was observed walking 10 feet or more ahead of RI#18 and repeatedly telling RI#18 “come on” instead of walking with RI#18 to the dining room from the activity room. RI#18 was easily distracted.

The surveyor heard yelling coming from RI#14’s room. RI#14 was very frustrated with being rushed by EI#22 to go to the activity room without...
Continued From page 16

getting their hair brushed. RI#14 also cursed and told EI#22 they couldn't leave their room without their glasses. RI#14 apologized for yelling and had to ask EI#22 for assistance with putting on their shoes.

When RI#11 asked a caregiver where the bathroom was, RI#11 was told a room number and the caregiver pointed down the hall. The caregiver then told EI#15 and the surveyor, (RI#11) knows where to go. RI#11 had lived in the facility less than 6 months and had a diagnosis of Alzheimer's dementia.

RI#22 was in a wheelchair and trying to get to their room after the evening meal was completed. EI#26 was observed holding the handles of RI#22's wheelchair preventing RI#22 from going down the hall until the other residents were ready. EI#26 held the wheelchair until RI#22 cursed and yelled out loud. EI#26 was heard telling RI#22 to wait for the other residents.

EI#27 was overheard making the following comment in a loud voice, "This is my hall." There were staff and residents in the area, it is not known who the comment was actually directed to.

RI#9 was discouraged by staff from leaving the activity room when RI#9 attempted to leave was told to sit down. However, RI#9 was not involved in a conversation or offered an activity to keep RI#9 occupied in the activity room.

On July 12, 2016, the surveyor spoke with EI#15 regarding the staff to resident interactions observed. EI#15 told the surveyor that they were aware of a problem with care staff feeling they were in control of the residents instead of helping the residents in their home.
A 506 420-5-20-.05 (2)(b)(1) Records and Reports

(b) Reports. The following reports shall be made by a specialty care assisted living facility.

1. Disease Reporting. Notifiable diseases and health listed in Appendix I to Alabama Administrative Code Section 420-4-1-.04 shall be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1.04. The facility shall also report notifiable diseases and health conditions to the Division of Health Care Facilities. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than three years.

This Rule is not met as evidenced by:

Based on record review and interview, the facility failed to notify the local county health department of an outbreak of nausea, vomiting, and diarrhea affecting at least 10 residents and 10 employees.

Findings:

On April 28, 2016, the ADPH was notified by the facility of an outbreak of nausea, vomiting, and diarrhea that started on April 3, 2016. At least 10 residents and 10 employees had been affected with one or more symptoms. At least one resident, RI#10, was admitted to the hospital for treatment of nausea, vomiting, and dehydration.

On May 3, 2016, EI#1 told the surveyor she was not aware that she was required to report disease outbreaks to the local county health department until April 28, 2016, when she reported the outbreak.
Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

P4907

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: ________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED

07/13/2016

NAME OF PROVIDER OR SUPPLIER

GORDON OAKS

STREET ADDRESS, CITY, STATE, ZIP CODE

3145 KNOLLWOOD DRIVE

MOBILE, AL  36693

(X4) ID PREFIX TAG

(X5) COMPLETE DATE

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

A 506

Continued From page 18

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 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).
### Summary of Deficiencies

A 516 Continued From page 19

- (iv) Immediate treatment rendered.
- (v) Names, telephone numbers, and addresses of witnesses.
- (vi) Date and time relatives or sponsor were notified.
- (viii) Symptoms of pain and injury discussed with the physician, and the date and time the physician was notified.
- (ix) The extent of injury, if any, to the affected resident or residents.
- (x) Follow-up care and outcome resolution.
- (xi) The action taken by the facility to prevent the occurrence of similar incidents in the future.

This Rule is not met as evidenced by: Based on observations, record review, and interview, the facility failed to thoroughly investigate falls and a disease outbreak.

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

Findings:

**FALLS**

RI#1

On May 4, 2016, RI#1's record was reviewed with EI#1. RI#1 had a fall documented on March 10, 2016, at 3:30 AM, that resulted in a head injury.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 516</td>
<td>Continued From page 20</td>
<td></td>
<td>The investigation did not document if there was a functioning night light in RI#1's room, if RI#1's walker was in reach, or if RI#1 was responding to a toileting need. The facility put an intervention of remove/rearrange furniture, even though the investigation documented the pathway was clear. The focus of RI#1's fall investigation was on where the incident occurred and what was done for the resident's injuries, instead of what may have contributed to the fall and how similar falls could be avoided in the future. There was no documented conclusion or summary as to what may have caused RI#1's fall.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| A 516 | | | RI#2
On May 4, 2016, RI#2's record was reviewed with EI#1. RI#2 had a fall documented on April 1, 2016, at 10:50 AM which resulted in a skin tear to RI#2's nose. The investigation documented that RI#2 slid out of a wheelchair. There was no further investigation into how or why RI#2 slid out of the wheelchair, how the injury to RI#2's nose may have occurred, or how a similar incident could be prevented. On April 13, 2016, at 8:40 PM, RI#2 was found on the floor with a skin tear to the left knee. The investigation said RI#2 was found on the floor asleep and the resident couldn't explain what happened. The investigation did not document if RI#2's walker or wheelchair were in reach, if RI#2 was responding to a toileting need, or any conclusion or summary as to what may have happened. The facility's intervention was to have the family bring in a bed alarm. RI#4
RI#4 was a 97 year old resident with cognitive decline, who used a walker for mobility, and required supervision for safety in the shower. On

Health Care Facilities
STATE FORM

If continuation sheet 21 of 57
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

| (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P4907 |
| (X2) MULTIPLE CONSTRUCTION |
| A. BUILDING: __________________________ |
| B. WING __________________________ |
| (X3) DATE SURVEY COMPLETED 07/13/2016 |

| NAME OF PROVIDER OR SUPPLIER GORDON OAKS |
| STREET ADDRESS, CITY, STATE, ZIP CODE 3145 KNOLLWOOD DRIVE MOBILE, AL 36693 |

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 516</td>
<td>Continued From page 21</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

April 29, 2016, RI#4 reported a fall to the facility staff. The facility investigation documented RI#4 had bruising of two toes on the left foot and one toe on the right foot. The investigation went on to say that RI#4’s daughter reported that she was told by RI#4 that RI#4 fell while leaving the shower. The time of the incident was documented as, “Unknown”. There were no interventions to prevent reoccurrence of a similar incident.

**DISEASE OUTBREAK**

On April 28, 2016, the ADPH received a late facility report of an outbreak of nausea, vomiting, and diarrhea. The facility documented that the outbreak started on April 3, 2016, and affected at least 10 residents and 10 employees. The focus of the investigation was on what interventions were put into place to prevent dehydration, but there was no documentation about what may have caused the outbreak. There were no lab studies completed. There were no observations of dining room or kitchen sanitation practices. There were no observations to ensure proper food serving temperatures had been implemented, and there were no interviews with employees, family members, visitors, or residents regarding the origin of the outbreak.

On May 3, 2016, the surveyor observed an improper serving temperature (approximately 80 degrees Fahrenheit) for the breakfast eggs, was told there had been recent unreported problems with the steam table functioning properly, and also observed problems with inadequate dining room and steam table sanitation.

During an interview with EI#3, the surveyor was told the reasons the employee felt the outbreak
A. BUILDING: ______________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
P4907

(X2) MULTIPLE CONSTRUCTION
A. BUILDING: ______________________
B. WING ___________________________

(X3) DATE SURVEY COMPLETED
07/13/2016

NAME OF PROVIDER OR SUPPLIER
GORDON OAKS

STREET ADDRESS, CITY, STATE, ZIP CODE
3145 KNOLLWOOD DRIVE
MOBILE, AL 36693

(X4) ID PREFIX TAG

(X5) COMPLETE DATE

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 516</td>
<td></td>
<td></td>
<td>Continued From page 22</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>symptoms spread was because of the lack of gowns available for employee protection, lack of housekeeping staff, and no proper cleaning supplies for a &quot;problem like that.&quot; The outbreak started on a weekend and there was no housekeeping staff scheduled on the weekends. Caregivers had to provide the cleaning for incidents related to vomiting and diarrhea.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>On May 3, 2016, the surveyor accompanied by EI#1 observed the housekeeping cart available to caregivers when housekeeping staff was not scheduled. The cart contained empty cleaning product bottles and soiled rags. The caregivers housekeeping closet did not contain any type of cleaning supplies for staff use except furniture polish. Clorox spray was found in a cabinet in the room where caregivers stored personal items.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>On May 3, 2016, the outbreak investigation was reviewed with EI#1 who agreed there were a lot of questions that were not answered regarding the cause of the outbreak and how the investigation of the outbreak was handled. The investigation was not thorough enough to conclude what may have caused the outbreak and also did not include interventions to prevent recurrence.</td>
</tr>
<tr>
<td>A 519</td>
<td>420-5-20-.05 (3)(f) 4. Records and Reports</td>
<td></td>
<td>4. The report to the Assisted Living Facilities Report Fax line shall be made within 24 hours of the incident and shall include the following:</td>
</tr>
<tr>
<td></td>
<td>(i) Facility name and direct phone number;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(ii) Time and date of the report;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A 519 Continued From page 23

(iii) Reporter's name;

(iv) Name of resident(s), staff or visitor involved in the incident;

(v) Names of staff on duty at the time of the incident;

(vi) Date and time of the incident;

(vii) Any injury or injuries to resident(s);

(viii) Action taken by the facility in response to the incident.

This Rule is not met as evidenced by:

Based on record review and interview, the facility failed to notify the ADPH within 24 hours of an outbreak of nausea, vomiting, and diarrhea affecting at least 10 residents and 10 employees.

Findings:

On April 28, 2016, the ADPH received a late report from the facility regarding an outbreak of nausea, vomiting, and diarrhea affecting at least 10 residents and 10 employees. The report documented that the outbreak had started on April 3, 2016 (25 days prior to the ADPH report). The outbreak started in the Specialty Care Assisted Living Facility (on the second floor of the building) and had spread to the Assisted Living Facility (on the first floor of the building).

On May 3, 2016, El#1 told the surveyor she was not aware of the SBOH rules for reporting a disease outbreak.

Please refer to deficiencies #506 and 516 for...

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 519</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A 519  Continued From page 24
additional information.

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, the Governing Authority and the facility
staff including the Administrator, failed to provide
a safe and decent environment for all residents
by: allowing staff to sleep while on duty and
neglect resident care and safety needs, delaying
treatment for a life threatening emergency that
resulted in death, not reporting, adequately
investigating, or implementing appropriate actions
to prevent spreading of an outbreak of nausea,
vomiting, and diarrhea that affected 10 residents
and 10 employees, failing to manage and direct
employees in a manner to prevent the neglect of
resident care and safety, failing to treat residents
with dignity and respect, failing to implement the
facility's own policies and procedures, failing to
ensure that employees followed recognized
standards for all resident health care, failing to
appropriately assess, plan, and implement
actions to meet each resident's specific care and
safety needs, failing to evaluate if planned
actions were implemented or required revision,
failing to identify employees with unmet training
needs essential for providing resident care and
A 522
Continued From page 25

safety for incapacitated residents with dementia, failing to serve and store food appropriately, failing to provide general observations and health supervision, failing to secure all medications, poisons, and chemicals, failing to maintain essential equipment in a fire safe manner, failing to maintain smoke compartments, failing to have the sprinkler and hood suppression systems inspected as required, and failing to maintain the fire alarm system in accordance with the Life Safety Code. These failures resulted in actual harm for at least four residents, placed the remaining 25 residents and any future residents at significant risk for harm.

THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION

Findings:

The Governing Authority did not provide oversight to the facility administrator and did not implement the facility’s policies and procedures to protect the residents from harm and neglect. Refer to deficiencies #301 and #303 for additional information regarding these failures.

Staff Sleeping on Duty

On July 11, 2016, at 5:07 AM, the surveyor observed all three night shift caregivers for the SCALF unit sound asleep in soft chairs in the activity room. All the SCALF unit lights had been turned off except for a television at one end of the activity room, a light at the nurses station, and a light by the dining rooms. Twenty-nine residents with known cognitive impairment were neglected and unsupervised for unknown periods of time while the employees entrusted with their care slept. All 29 residents were at significant risk for
Continued From page 26

...harm and even death from medical emergencies, falls, injuries, elopement, skin breakdown, or ingestion of unsecured medications and chemicals. The surveyor requested an immediate plan of action to secure a safe environment for all of the facility residents from EI#15 and EI#20. Refer to deficiencies #402 and #607 for additional information regarding these failures.

Delayed Treatment for a Life Threatening Emergency

RI#12 was an 90 year old resident admitted to the facility with diagnoses including Alzheimer's dementia and high blood pressure. RI#12 was seen on June 8, 2016, by the certified registered nurse practioner for swelling of the lower extremities and low potassium levels. On June 17, 2016, RI#12 was sitting in the activity room when RI#12 was identified by EI#4 as being unresponsive, not breathing, and without a heartbeat. EI#4 called out to EI#14 for help, EI#14 then called for EI#19, LPN. Instead of immediately starting life saving CPR, RI#12 was taken to a room 16 doors away from the activity room and placed on a bed before possibly life saving CPR treatment was started. RI#12 was pronounced dead upon arrival at a local hospital.

Disease Outbreak

On April 28, 2016, the ADPH was notified by the facility of an outbreak of nausea, vomiting, and diarrhea that had actually started on April 3, 2016, (25 days before it was reported). At least 10 residents and 10 employees were affected with one or more symptoms. At least one resident, RI#10, was hospitalized for treatment of nausea, vomiting, and dehydration. EI#1 had not reported...
<table>
<thead>
<tr>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(EACH DEFICIENCY MUST BE PRECEDED</td>
<td>PREFIX</td>
<td>TAG</td>
<td>(EACH CORRECTIVE ACTION SHOULD</td>
<td>DATE</td>
</tr>
<tr>
<td>BY FULL REGULATORY OR LSC</td>
<td>PREFIX</td>
<td>TAG</td>
<td>BE CROSS-REFERENCED TO THE</td>
<td></td>
</tr>
<tr>
<td>IDENTIFYING INFORMATION)</td>
<td>PREFIX</td>
<td>TAG</td>
<td>APPROPRIATE DEFICIENCY)</td>
<td></td>
</tr>
<tr>
<td>A 522</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Continued From page 27

the outbreak to the local health department as required, and therefore important lab studies were not completed to help determine the actual cause of the outbreak. Pertinent actions were not implemented to prevent the spread of the outbreak such as increased housekeeping services, proper sanitation practices, or the monitoring of food temperatures. There were no actions implemented to prevent another similar outbreak which placed even more residents at risk for harm or even death. For additional information please refer to deficiencies #506, #516, and #519.

Resident Rights Violated

During the survey completed on July 13, 2016, the surveyor observed residents were not treated in a respectful, caring, and dignified manner. During interviews with various staff members, who wished to remain anonymous due to previous retaliation by the facility, the surveyor was told about resident neglect, staff frustration with resident behaviors, resident care that wasn't provided, and reports of the night shift staff sleeping. Some staff said they had not reported resident abuse or neglect because of fear of retaliation by administration and/or other staff members. Employees lacked the proper training to protect and care for residents with dementia or cognitive impairment. This lack of training placed all 29 residents at significant risk for emotional harm related to verbal abuse, as well as, physical harm from falls, injuries, neglect, and physical abuse. Refer to deficiencies #301, #303, #402, #424, #427, #516, #523, #530, #605, #607, #624, #630, #634, #705, #710, and #805 for additional information regarding these failures.

Fire Safety

Health Care Facilities
There were no fire drills documented for the months of February, March, or April, 2016. There was no fire alarm inspection documentation for April 2015 or April 2016. There had been no kitchen exhaust hood cleaning or inspection of the hood suppression system documented since October 2015. Smoke doors and fire doors had not been maintained resulting in the lack of adequate compartmentalization of smoke and fire. The fans for both elevators were so full of dust that piles had accumulated in the light covers beneath the fans creating a significant risk for a fire. The facility's widespread neglect for staff training and proper inspection and maintenance of the fire safety features of the building placed all residents, visitors, and staff at a significant risk for harm or death in the event of a fire in this two story building with 29 cognitively impaired residents living on the second floor. Refer to deficiencies #808, #814, #1102, and #1213 for additional information regarding these failures.

When the surveyor discussed the above observations and concerns with EI#15 and EI#19, regional directors for the governing authority, they both said they knew there were problems with the previous administrator, the current charge nurses, and the current caregivers. However, none of these issues were addressed by the governing authority.

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 observations and interviews, the facility residents were not always treated with dignity and respect.

THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION

Findings:
During the survey completed on July 13, 2016, the surveyor observed the following staff to resident interactions.

RI#17 and RI#18's room doors were locked and the residents didn't have access to their rooms throughout the dayshift unless caregivers unlocked the doors.

RI#2's room and bathroom doors were both locked during the night shift.

RI#18 was observed eating scrambled eggs with their fingers and staff did not cue RI#18 to use a spoon until after all the scrambled eggs had been eaten.

EI#25 walked 10 feet or more ahead of RI#18 and repeatedly told RI#18 in a short demanding tone, "Come on."  EI#25 should have walked with RI#18 to the dining room from the activity room, while engaging RI#18 in a conversation to help keep RI#18 on task.

EI#25 was also observed performing tasks for residents without speaking to the residents and
## A 523
Continued From page 30

explaining what EI#25 was doing. Two residents were at a dining room table talking to each other while waiting for their food. EI#25 walked up to the table and without speaking to either resident, just shoved a plate of food in front one resident and walked away. The residents were visibly startled by the rude interruption of their conversation and the unannounced presence of EI#25.

EI#27 was overheard making the following comment in a loud voice, "This is my hall." There were staff and residents in the area, it is not known who the comment was directed to.

EI#26 was observed telling RI#22 to wait for the other residents while holding the handles of RI#22's wheelchair preventing RI#22 from going down the hall. EI#26 held the wheelchair until RI#22 cursed and yelled out loud. EI#26 let go of the wheelchair after RI#22 got upset.

During various interviews with current and previous staff, the surveyor was told that resident requests for assistance were ignored by caregivers, staff demanded residents do things immediately instead of asking and residents were talked to in a rude manner.

On July 12, 2016, during an interview with EI#15, EI#15 could not explain why RI#2's room and bathroom doors were locked during the night shift or why other resident room doors were locked during the dayshift. EI#15 agreed that there needed to be some staff training on caring for residents with dignity and respect.

## A 530
420-5-20-.05 (3)(g) 10. Records and Reports

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 523</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A 530</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**NAME OF PROVIDER OR SUPPLIER**
GORDON OAKS

**STREET ADDRESS, CITY, STATE, ZIP CODE**
3145 KNOLLWOOD DRIVE
MOBILE, AL  36693

**A 530**
Continued From page 31

Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to receive or reject medical care, dental care, or other health care services except those required to control communicable diseases.

This Rule is not met as evidenced by:

Based on observation and interviews, the facility failed to utilize protective undergarments and provide cardiopulmonary resuscitation (CPR) in accordance with recognized community standards. This deficient practice resulted in actual harm for RI#12.

This deficiency was cited as the result of a complaint investigation.

Findings:

**PROTECTIVE UNDERGARMENT USE**

On May 3 through 5, 2016, the surveyor noted consistent stale urine odors in the SCALF. During interviews with multiple staff members, they told the surveyor that they had routinely found more than one resident wearing two or three adult protective undergarments at one time. When this practice was reported to EI#1 and EI#15, EI#15 told the surveyor, “Some of these things you can train and train, but they (caregivers) still do it.”

On July 11, 2016, the surveyor accompanied by EI#21 observed RI#18 was wearing two layers of pull-up type incontinence undergarments. Each pull-up also contained an additional incontinence...
### A 530
Continued From page 32

The incontinence liners are frequently used alone for moderate urinary leakage. The pull-up type incontinence undergarments are also used alone for heavier incontinence episodes. The use of multiple liners and undergarments on a resident at one time promotes odors and skin breakdown.

### DELAYED CPR TREATMENT

On July 12, 2016, the surveyor interviewed EI#9 about RI#12's death on June 17, 2016. EI#9 told the surveyor that RI#12 was observed in the activity room by staff to be unresponsive, without respirations, without a pulse, and with blue coloring of the fingers. RI#12's physician had documented that RI#12 was considered to be full code status (treatment required if resident stops breathing and has weak or no pulse). After discovery in the activity room, RI#12 was propelled in a wheelchair to a room 16 doors away from the activity room and placed on a bed before CPR was initiated. EI#9 said RI#12 was taken to the other room because there were people in the hallway by the activity room.

RI#12's CPR was unnecessarily delayed by critically important minutes when RI#12 was transferred to a room 16 doors away. Any residents or other people could have been removed from the hallway and the activity room while critical and lifesaving treatment was rendered to RI#12 immediately upon discovering RI#12 was not breathing and had no heartbeat.

### 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
A 605
Continued From page 33

formulate written interventions to address those problems, and to evaluate if the planned interventions were successful. An RN shall 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 observation, record review, and interview, the Registered Nurse (RN) failed to identify resident care needs and formulate appropriate care plan interventions to address those needs. The RN also failed to address all required care areas on the monthly assessment.

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

Findings:
On May 5, 2016, all of the following records were reviewed with EI#1, who confirmed the surveyor's concerns regarding the lack of specific care plan interventions to address the needs of the residents in the following examples.

RI#1 was an 89 year old resident with dementia, who utilized a walker for mobility. RI#1 had a physician's order for a daily medication which slowed blood clotting times. On March 10, 2016, RI#1 had a fall with a head injury. There were no interventions on RI#1’s care plan to address the
A 605 Continued From page 34

head injury treatment or monitoring.

RI#2 was an 86 year old resident with dementia, resistive behaviors, and required assistance with all activities of daily living (ADL). On April 15, 2016, RI#2 was sent to the hospital for treatment of an impaction. The only documented interventions on RI#2's care plan regarding the impaction were to offer fluids and update the nurse. RI#2 also had a fall from a wheelchair on April 1, 2016, with no interventions to prevent the incident from happening again.

RI#3 was a 95 year old resident with dementia and required assistance with all ADL. RI#3 had problems with swelling of the legs and feet, which was being treated with diuretics and a potassium supplement by the Certified Registered Nurse Practitioner (CRNP). In February 2016, RI#3 had a change in condition with altered mental status, unsteady gait, and increased weakness. RI#3 was found to have an elevated potassium level of 5.5 milliequivalents per liter (normal range is 3.5 - 5.3 mEq/L). RI#3's Physical Self Maintenance Scale (PSMS) score went from 19 in November 2015, to 23 in February 2016. RI#3's March monthly assessment did not reflect a significant change in status or RI#3's emergency room visit for treatment of an adverse medication reaction (elevated potassium level).

RI#4 was a 97 year old resident with cognitive decline, who used a walker for mobility, and required supervision for safety in the shower. On April 29, 2016, RI#4 reported a fall in the shower to staff. The surveyor accompanied by E1#1 observed RI#4 had bruising of both feet, toes, and the left buttock. The care plan had not been followed for supervision in the shower. There had been no changes to the care plan to address
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** P4907

**Multiple Construction Building:**

**Wing:**

**Date Survey Completed:** 07/13/2016

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider’s Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 605</td>
<td>Continued From page 35</td>
<td>RI#4’s fall to prevent reoccurrence.</td>
<td></td>
</tr>
</tbody>
</table>

RI#5 was an 80 year old resident with dementia. The monthly assessment for April 2016, documented that RI#5 had experienced a significant weight loss of 12 pounds or 9% of RI#5's total body weight in 3 months. There were no care plan interventions to address RI#5's significant weight loss.

RI#6 was a 74 year old resident admitted to the facility on March 20, 2015, with diagnoses including atrial fibrillation. RI#6 had falls documented on March 26, 2016 and April 28, 2016. The only care plan intervention was that RI#6 was "safety aware" and knew to call for help. On March 24, 2016, RI#6 was diagnosed with diverticulitis, the problem was not adequately addressed on the care plan. The only care plan intervention was to report pain, bloating, diarrhea, and chills. On April 11, 2016, RI#6 was sent to the emergency room for pain related to a kidney stone. Upon RI#6's return to the facility, the care plan documented the following interventions: medication adjustments, pain medication ordered, antibiotics, offer fluids; however, the care plan did not adequately address RI#6's care needs. RI#6 was readmitted to the hospital on April 21, 2016, and returned to the facility on April 26, 2016, following treatment for a urinary tract infection (UTI). RI#6's care plan did not adequately address RI#6's care needs upon return from the hospital after treatment for a UTI.

On May 3, 2016, at 9:50 AM, the surveyor interviewed RI#6 about the current level of pain RI#6 was having. RI#6 rated the pain a 10 on a scale of 1-10, with 10 being the resident's worst level of pain. RI#6 was asked if pain medication had been received. RI#6 told the surveyor that...
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A605</td>
<td>Continued From page 36</td>
<td></td>
<td>the nurse probably gave RI#6 something for pain, but RI#6 wasn't going to question the nurse because, &quot;She's (nurse) real good.&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>On May 5, 2016, at 4:25 PM, RI#6 was again questioned about RI#6's level of pain. RI#6 sounded frustrated and told the surveyor that the nurse would only give pain medication every eight hours regardless of RI#6's level of pain. RI#6 told the surveyor that telling the nurse about RI#6's level of pain didn't matter, because the nurse would only give pain medication if it was time to get it and, &quot;They (nurses) fuss if I tell them about it (pain)...I'm tired of dealing with it.&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>RI#9 was an 84 year old resident with dementia, who returned to the SCALF from the hospital on April 5, 2016, with a new diagnosis of a renal mass. RI#9's care plan was not updated with interventions to address RI#9's new diagnosis and care needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A607</td>
<td>Care of Residents</td>
<td></td>
<td>420-5-20-.06 (2)(f) Care of Residents</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(f) Each facility shall develop and implement a policy and procedure to ensure that each resident of the facility is free from abuse, neglect and exploitation. The facility shall ensure that all staff can demonstrate an understanding of what constitutes abuse, neglect, and exploitation and shall ensure that all staff understands his or her responsibility to immediately report suspected incidents of abuse, neglect or exploitation of a resident to the administrator. When abuse, neglect, or exploitation is alleged or suspected, the facility shall conduct and document a thorough investigation and take appropriate action to prevent further abuse. All allegations and suspicions shall be reported to the Assisted</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
GORDON OAKS
3145 KNOLLWOOD DRIVE
MOBILE, AL 36693

A. BUILDING: ________________
B. WING ________________

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

PRINTED: 09/01/2016
FORM APPROVED

NAME OF PROVIDER OR SUPPLIER
GORDON OAKS

STREET ADDRESS, CITY, STATE, ZIP CODE
3145 KNOLLWOOD DRIVE
MOBILE, AL 36693

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

A 607
Continued From page 37

Living Unit of the Alabama Department of Public Health and to the victim's sponsor or responsible family member within 24 hours. Suspected abuse, neglect, or exploitation of a resident shall be reported to the Department of Human Resources or law enforcement in accordance with Code of Ala., 1975, Section 38-9-8. At any time that a resident has been the victim of sexual assault or sexual abuse perpetrated by a staff member or visitor, local law enforcement authorities shall be immediately notified.

This Rule is not met as evidenced by:
The facility administration failed to implement policies and procedures to prevent neglect of resident care and safety. All facility staff did not demonstrate a responsibility to report resident abuse, neglect, and exploitation.

THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION

Findings:

On July 11, 2016, the surveyor observed all three night shift caregivers for the SCALF unit asleep while RI#13 wandered around barefoot in the dark. Two residents slept in their clothes and shoes because caregivers had not assisted the residents with bedtime care or helped them get into bed. One resident had not been showered for 5 days. Residents were not treated in a dignified or respectful manner. One resident was not given prompt life saving treatment when they were found unresponsive and not breathing.
During interviews with current and previous staff the surveyor was told about resident neglect, staff frustration with resident behaviors, resident care that wasn't provided, and reports of night shift staff sleeping. Some staff said they reported concerns to administration and other staff had not reported resident abuse or neglect because of fear of retaliation by administration and/or other staff. Staff stated they had witnessed other staff talk "sharp" to residents, ignore residents who asked for assistance, leave residents in wet/soiled diapers, threaten residents with harm and grabbing or "snatching" a resident.

When the surveyor discussed the above observations and concerns with EI#15 and EI#19, regional directors for the governing authority, they both said they knew there were problems with the previous administrator, the charge nurses, and the caregivers. However, none of these issues were addressed by the governing authority.

For additional information please refer to deficiencies # 301, #303, #402, #427, #523, and #530.

(d) Activities of Daily Living. Residents of a specialty care assisted living facility shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident.

1. Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when
A 624
Continued From page 39
necessary.

2. Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips.

3. Hair. Residents’ hair shall be kept clean, neat, and well-groomed.

4. Manicure. Fingernails and toenails shall be kept clean and trimmed.

5. Shaving. Men shall be assisted with shaving or to be shaved as necessary to keep them clean and well groomed.

6. Food service. Food service shall be provided in a resident’s room during temporary illness if necessary.

7. Personal Safety. Residents shall be provided assistance with personal safety.

8. Appointments. Residents shall be assisted in making and keeping appointments.

This Rule is not met as evidenced by:
Based on observations, record review, and interview the facility failed to ensure that residents received assistance to maintain a clean, well-kept appearance.

THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION
Findings:
RI#11 was an 84 year old resident admitted to the
facility on January 23, 2016 with diagnoses including Alzheimer's dementia. RI#11's care plan documented that RI#11 required checks for bladder and bowel incontinence every 2 hours and required assistance with showers as needed. Review of the shower schedule for July 11, 2016, documented that RI#11 was due for a shower on the 11PM - 7AM shift that had just ended. At 8:30 AM on July 11, 2017, the surveyor, accompanied by EI#20, observed RI#11's hair hung in greasy strands with scalp showing between the strands of hair. EI#20 agreed that RI#11 did not look like they had been given a shower on the previous shift. Bath sheets were reviewed with EI#20. The last documented shower for RI#11 was dated July 6, 2016, (5 days prior to the surveyors observation). Later that same morning the surveyor was told by EI#4, that RI#11 told EI#4 that "it felt good" to get a shower.

(i) If controlled substances prescribed for residents of any specialty care assisted living facility are kept in the custody of the specialty care assisted living facility, they shall be stored in a manner that is compliant with state law, federal law, the requirements of the Alabama State Board of Pharmacy, and any requirements prescribed by the Alabama State Board of Health. At a minimum, controlled substances in the custody of the facility shall be stored using a double lock system, and the facility shall maintain a system to account for all controlled substances in its possession. All other medications in the custody of the facility shall be stored using at least a single lock. This shall include medications stored in a resident's room when the staff and not the resident have access to the medications.
| SUMMARY STATEMENT OF DEFICIENCIES |  | PROVIDER'S PLAN OF CORRECTION |
|-----------------------------------|  | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |
| (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |  | (X5) COMPLETE DATE |
| A 630 Continued From page 41 |  |  |
| Medications may be kept in the custody of an individual resident who is aware of his or her medications and who can safely manage his or her medications. Such medications may be stored in a locked container accessible only to the resident and staff, or may be stored in the resident's living quarters, if the room is single occupancy and has a locking entrance. |  |  |
| This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications managed by the facility were secured or supervised at all times. |  |  |
| THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION |  |  |
| Findings: |  |  |
| On July 11, 2016, the surveyor accompanied by EI#20, observed the nurses station was unlocked and unsupervised. There was a medication refrigerator in the nurses station that was also unlocked and contained three vials of insulin and three vials of tuberculin testing liquid. An unlocked cabinet in the nurses station contained a bin with approximately 75 - 100 insulin syringes and three 16 ounce partially full bottles of rubbing alcohol. |  |  |
| A 634 420-5-20-.06 (5) Care of Residents |  |  |
| (5) Storage of Medical Supplies and Poisons. |  |  |
| (a) First Aid Supplies. First aid supplies shall be maintained in a place readily accessible to |  |  |
A 634 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 ensure that poisons and chemicals were secured or supervised at all times.

THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION

Findings:
On July 11, 2016, the surveyor accompanied by EI#20, observed a partial gallon of Pine Sol concentrated liquid and a 19 ounce can of Lysol spray in a diaper bag hanging in the unlocked, unsupervised, nurses station bathroom.

(c) Protection of Food from Contamination.

1. Food and food ingredients shall be stored, handled, and served so as to be protected from pests, dust, rodents, droplet infection, unsanitary handling, overhead leakage, sewage backflow, and any other contamination. Sugar, syrup, and condiment receptacles shall be provided with lids and shall be kept covered when not in use.
<table>
<thead>
<tr>
<th>A 705</th>
<th>Continued From page 43</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Medication, biologicals, poisons, detergents, and cleaning supplies shall not be kept in the refrigerator nor in other areas used for storage of food.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>5. All leftover foods shall be labeled and dated, (month, day, year) and consumed within three days.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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 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 41 degrees Fahrenheit. All food preparation areas used by the facility shall be subject to the</td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>PREFIX</td>
</tr>
<tr>
<td>----</td>
<td>--------</td>
</tr>
<tr>
<td>A 705</td>
<td>Continued From page 44</td>
</tr>
<tr>
<td></td>
<td>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).</td>
</tr>
<tr>
<td></td>
<td>9. Laundry shall not be brought through the food preparation or service area.</td>
</tr>
<tr>
<td></td>
<td>This Rule is not met as evidenced by: Based on observations and interview, the facility failed to ensure hazardous foods were transported and served at a minimum of 135 degrees Fahrenheit. The facility also failed to properly store foods in a manner to prevent contamination from overhead leakage.</td>
</tr>
<tr>
<td></td>
<td>THIS IS A REPEAT DEFICIENCY FROM A PRIOR SURVEY COMPLETED ON MAY 9, 2013.</td>
</tr>
<tr>
<td></td>
<td>THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION.</td>
</tr>
<tr>
<td></td>
<td>Findings:</td>
</tr>
<tr>
<td></td>
<td>On May 3, 2016, the surveyor observed EI#17, resident assistant, serve several plates of food with scrambled eggs. The surveyor requested EI#17 check the temperature of the scrambled eggs. EI#17 removed the thermometer from the pocket of a three ring binder and with out sanitizing the thermometer, tested the temperature of the grits (120 degrees Fahrenheit), wiped the thermometer with a napkin, then tested the scrambled eggs. The</td>
</tr>
<tr>
<td>ID</td>
<td>PREFIX</td>
</tr>
<tr>
<td>----</td>
<td>--------</td>
</tr>
<tr>
<td>A 705</td>
<td>Continued From page 45</td>
</tr>
</tbody>
</table>
## Summary Statement of Deficiencies

### A 710

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>420-5-20-07 (3)(a)(b) Food Services</td>
<td>A 710</td>
<td>A 710</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(a) Number of Meals. No fewer than three meals shall be provided each twentyfour hours. The diet shall be well-balanced, palatable, properly prepared, and sufficient in quantity and quality to meet the nutritional needs of the residents in accordance with Dietary Reference Intakes of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The food must be adapted in type and preparation to the habits, preferences, and physical abilities of the residents.

(b) Timing of Meals. A time schedule for serving meals to residents and personnel shall be established. Meals shall be served approximately five hours apart with no more than fourteen hours between the evening meal and breakfast. The time schedule of meals shall be posted with the menu. The facility shall make evening snacks available after service of the evening meal. The facility shall provide fluids throughout the day and shall make between meal nourishment (snacks) available.

This Rule is not met as evidenced by:

Based on record review and interview, the facility failed to provide menus and alternate foods adapted to the preferences and physical abilities of the residents. The facility also failed to have snacks available and a snack policy that met the requirements of the SBOH rules and regulations.

**THIS DEFICIENCY WAS CITED AS THE RESULT OF A COMPLAINT INVESTIGATION**
Findings:

On May 3, 2016, the facility served pork chops to the residents for the lunch meal. The baked pork chops had not been cut up prior to serving. The residents had only been given a spoon and a fork to eat with, therefore several residents picked up the baked pork chops and ate them with their fingers.

The surveyor also observed that the only snacks available in the refrigerator for residents were nutritional supplements (resident specific), applesauce, and whole milk. The freezer was empty, and there were no other snacks observed in the SCALF dining area.

On July 11, 2016, the surveyor observed the only snacks or drinks available in the SCALF dining area was a 3 gallon container of orange sherbet and nutritional supplements or drinks labeled with specific residents' names. There were Styrofoam bowls available but no spoons were observed.

The facility snack policy documented, "Snacks shall be made available upon request." The facility policy should not require residents with cognitive impairment to request snacks, the snacks should be available and offered.

On July 12, 2016, the surveyor observed residents were served thick skinned sausages on buns. Some of the residents received a sausage that was approximately 2 inches thick. Residents were observed removing the skin of the sausages for other residents who were having trouble eating the sausage whole. Another resident made the comment, "that's (sausage) not going in my mouth, it's too big."
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 711</td>
<td></td>
<td></td>
<td>Continued From page 48</td>
<td>A 711</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A 711</td>
<td></td>
<td></td>
<td>420-5-20-.07 (3)(c)(d) Food Services</td>
<td>A 711</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(c) Menu. The menu shall be planned and written at least one week in advance. The current week’s menu shall be posted in the food service area and shall be kept on file for the following two weeks. For any resident with a physician’s order for a therapeutic diet, the facility shall have a copy of the diet and the facility shall document the adjustment of its menu to accommodate the resident’s needs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(d) Alternate food selections or substitutes shall be made available to all residents.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>This Rule is not met as evidenced by: Based on observations and interviews, the facility did not have an alternate vegetable available.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Findings:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>On May 3 through the 5, 2016, the surveyor observed several different meals. The surveyor observed that only one type of entree and one type of vegetable were available for serving to residents. El#13 told the surveyor that there was no vegetable alternative available and the alternate entrees were not delivered unless ordered for a specific resident.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A 805</td>
<td></td>
<td></td>
<td>420-5-20-.08 (3)(f) Physical Facilities</td>
<td>A 805</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(f) Bedroom furnishings. The resident has the right to furnish his or her room as he or she so chooses, within the facility’s guidelines. If the facility offers to provide some or all of the</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Continued From page 49

furniture, as a minimum, bedrooms shall contain the following for each resident:

1. A suitable built-in clothes closet or wardrobe with shelving space and clothing pole.

2. A bed with good springs and mattress and sufficient clean bedding. In no case shall a cot or rollaway bed be provided for residents.

3. A dresser or chest of drawers.

4. A bedside table and bed lamp.

5. At least one comfortable chair, preferably an armchair or rocker.

6. Window shades, venetian blinds, or other suitable provisions for closing the view from the window.

7. Adequate number of electrical outlets shall be provided. Extension cords, U.L. approved with overload protection capability, may be used for light duty appliances and shall not pose a hazard to residents.

8. A mirror in the bedroom or bedroom suite, unless contraindicated by a resident's condition.

This Rule is not met as evidenced by:

Based on observation and interview, the facility failed to ensure that every resident's bedroom contained at least one comfortable chair.

Findings:

On May 4, 2016, the surveyor accompanied by EI#1 observed that RI#5 did not have a
A 805 Continued From page 50

comfortable chair in her room. EI#1 agreed that the two wooden chairs would not be considered comfortable. EI#1 told the surveyor that she would talk with RI#5’s spouse about getting a comfortable chair for RI#5’s room.

A 808 420-5-20-.08 (3)(h)(i)(j) Physical Facilities

(h) All essential mechanical, electrical and resident care equipment shall be clean and maintained in a safe operating condition.

(i) Bed and bath linens shall be clean and in good condition.

(j) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior shall be provided.

This Rule is not met as evidenced by:

Based on observation and interview, the facility failed to clean and maintain essential mechanical equipment in safe operating condition.

Findings:

On May 3, 2016, the surveyor accompanied by EI#1, observed a pile of dust accumulated on the light covers under the elevator fans for both elevators. EI#1 agreed the accumulation of dust in both elevators’ fans was a fire hazard and they would be cleaned right away.
A 814 Continued From page 51

free of an accumulation of rubbish, dust, grease, dirt, etc.

(l) Clean Equipment. Equipment in the food service area shall be clean and free of dust, grease, dirt, etc.

(m) Clean Counters, Tables, Tablecloths, and Napkins. Tables and counters, which are used for food service, shall be kept clean. Tablecloths and cloth napkins shall be laundered after each use.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure the ice cooler cart, steam table, dining room tables, dining room walls, and floors were kept clean to prevent infections and illness.

Findings:

On May 3, 2016, the surveyor observed the steam table wells were not cleaned between meals as there was floating food debris in the water wells that didn't match the food served at the current meal. There was more than a days worth of dried food and spills on the steam table, sneeze guard, dining room walls by the steam table, and the dining room cabinet doors.

The surveyor observed staff wipe food and crumbs from the dining room tables onto the floor, but the floor was not mopped between meals. El#17 told the surveyor that the dining room floor was sometimes mopped by day shift, but evening shift also mopped the dining room floor.

The Food Service Sanitation policy documented,
### A. BUILDING: ____________________________

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

P4907

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING: ____________________________

B. WING ____________________________

**(X3) DATE SURVEY COMPLETED**

07/13/2016

### B. WING ____________________________

**NAME OF PROVIDER OR SUPPLIER**

GORDON OAKS

**STREET ADDRESS, CITY, STATE, ZIP CODE**

3145 KNOLLWOOD DRIVE

MOBILE, AL 36693

**PRINTED:** 09/01/2016

**FORM APPROVED:**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 814</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1003</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 814</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1003</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 814</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1003</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/13/2016</td>
</tr>
</tbody>
</table>

---

**Healthcare Facilities**

**STATE FORM**

6599  
VVP811

If continuation sheet 53 of 57

---

"Dining and Kitchen area shall be mopped after breakfast, lunch, supper, and on an as needed basis." The surveyor observed the policy had not been followed.

**A1003 420-5-20-.10 (1)(c) thru (g) Sanitation**

(c) Premises. The premises shall be kept neat and clean. The property shall be free of rubbish, weeds, ponded water, or other conditions, which may create a health, safety, or sanitation hazard.

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

(e) Toilet Room Cleanliness. Floors, walls, ceilings, and fixtures of all toilet rooms shall be kept clean and free of objectionable odors. These rooms shall be kept free of an accumulation of rubbish, cleaning supplies, toiletry articles. The use of a common towel and common bar soap is prohibited.

(f) Garbage Disposal.

1. Garbage must be kept in water-tight suitable containers with tightfitting covers. Garbage containers must be emptied at frequent intervals and shall be thoroughly cleaned and aired before using again.

2. Garbage and waste shall be disposed of in accordance with local and state regulations.

(g) Control of Odors. The facility shall be free of
A1003 Continued From page 53

objectionable odors.

This Rule is not met as evidenced by:
Based on observation and interview, the facility
failed to maintain an environment free of
objectionable odors.

THIS IS A REPEAT DEFICIENCY FROM A
PRIOR SURVEY COMPLETED ON MAY 9,
2013.

Findings:
During all three days of the survey completed on
May 5, 2016, the surveyor noted a consistent
stale urine odor throughout the second floor.
Strong urine odors were also noted in RI#1's and
RI#2's rooms.

EI#5, accompanied by EI#1, told the surveyor that
EI#5 routinely used just plain water to mop the
floors, especially if there were problems with
urine on the floors. EI#5 went on to say that if the
urine was "real bad" that EI#5 would use Clorox
spray with bleach. EI#5 also told the surveyor that
she had not received any training on
housekeeping in over five years. The last time
she had received any training was when she
worked as a contracted housekeeper for the
facility.

420-5-20-.11(1)(b)(c) Fire and Safety

(b) Fire Drills. Fire drills shall be conducted at
least once per month in all facilities at varying
times and days, quarterly on each shift of Group
and Congregate facilities. All fire drills shall be
### A1102

Continued From page 54

initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the Code.

(c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9:00 PM and 6:00 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs.

This Rule is not met as evidenced by:

Based on record review and interview, the facility failed to conduct fire drills monthly and quarterly on each shift.

**THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING SURVEYS COMPLETED ON NOVEMBER 03, 2011.**

Findings:

On May 4, 2016, the surveyor accompanied by EI#1, reviewed the facility's fire drill documentation for the year 2016. There were no fire drills documented for the months of February, March, or April, 2016. EI#1 told the surveyor that she could not say for sure that EI#11 had conducted or even knew how to document the fire drills as required. EI#1 told the surveyor EI#18, Regional Maintenance Director, visited about...
A1102 Continued From page 55

EI#1 went on to say that EI#18's primary focus seemed to be on (how the building looked) instead of maintaining the building's fire safety features.

A1213 420-5-20-.12 (3)(s)(t) Physical Plant

(s) Fire Alarm System. Where fire alarm systems are required, a corridor smoke detection system shall be installed on each floor, including areas open to the exit access corridor, to comply with NFPA 72, connected to the facility's fire alarm system. In lieu of corridor smoke detection, smoke detectors connected to the building fire alarm system may be installed in each resident's room, open areas and at smoke doors (except that corridor smoke detection shall not be deleted when its use is dictated by other requirements).

(t) Fire Alarm and Sprinkler System.

1. Fire alarm and sprinkler system outages of more than four hours require evacuation of the facility or the establishment of a continuous fire watch. The fire watch procedure must be coordinated with the Department and the local Fire Marshal. Outages and fire watch documentation shall be reported to the Department of Public Health within 12 hours or no later than the next duty day, and shall be corrected expeditiously.

2. The fire alarm system and the sprinkler system shall be inspected by licensed, trained and qualified personnel at least semi-annually for compliance with the respective codes. Inspection and Testing reports shall be maintained at the facility for a period of at least 2 years.
This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to have at least two years of fire alarm inspection documentation maintained onsite.

Findings:
On May 4, 2016, the surveyor accompanied by EI#1, reviewed the facility’s fire alarm documentation for the years 2014, 2015, and 2016. There was no fire alarm inspection documentation for April 2015 or April 2016. There had also been no kitchen exhaust hood cleaning or inspection of the hood suppression system documented since October 2015. EI#1 told the surveyor that EI#18, Regional Maintenance Director, visited monthly and stayed for a week at a time. EI#1 went on to say that EI#18’s primary focus seemed to be on (how the building looked) instead of maintaining the building’s fire safety features.

TONYA AVENATTI, REGISTERED NURSE