POC Accepted
September 15, 2022
Debbie Freeman, RN
Debra Freeman

Morningside of Auburn

Plan of Correction

Facility ID: D4106

Administrator: Kimberly Fields

Survey Exit Date: 8/31/2022

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D4106	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF AUBURN	871 TWIN FORKS AVENUE AUBURN, AL 36830

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A 000	Initial Comments On August 31, 2022, an unannounced licensure survey was conducted for this 49 bed Assisted Living Facility (ALF) with a census of 38. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities. The deficiencies cited pose a risk or potential risk of harm to the residents and requires a plan of correction.	A 000		
A 508	420.5.4-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in an assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review. 1. Incidents which require investigation are: (i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as bruising, pain, or injury that is not consistent with actions necessary in providing day to day care to a resident or for which medical treatment was sought. (ii) A fracture or an injury resulting in medical attention. For the purposes of these	A 508		

Alabama Department of Public Health
Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 508	Continued From page 1 rules, medical attention shall be defined as care that rises above the level of first aid, including but not limited to: a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office. (iii) The onset of wandering behavior by any resident who is not fully cognitively intact. (iv) Elopement by a resident. (v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. (vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules. (vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules. (viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I of Alabama Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or Staphylococcus aureus). (ix) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is	A 508		

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A 508	Continued From page 2 located, or that results in the evacuation or partial evacuation of the facility. (x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (xi) An unplanned occurrence that results in media attention. (xii) A medication error, overdose, or over sedation. (xiii) Ingestion by a resident of a toxic substance that requires medical attention. (xiv) Any indication of malfunction of the sprinkler system, or fire alarm system. 2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following: (i) Names of all residents involved. (ii) Names of all staff involved including person in charge at the time of the incident. (iii) When the administrator was notified (date and time). (iv) Circumstances under which the incident occurred. (v) When the incident occurred (date and time). (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn).	A 508		

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A 508	Continued From page 3 (vii) Immediate actions taken. (viii) The extent and description of injury, if any, to the affected resident or residents. (ix) Immediate treatment rendered. (x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified. (xi) Names, telephone numbers, and addresses of witnesses. (xii) Date and time relatives or sponsor were notified. (xiii) Out-of-facility treatment. (xiv) Follow-up care. (xv) Outcome resolution. (xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future. (xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation. (xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request. (xix) The entire investigative file and documentation of all corrective action taken shall	A 508		

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A 508	Continued From page 4 be retained for a period of not less than 3 years after the resident is discharged or dies. (xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff. 3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident: (i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention as defined in these rules. (ii) Elopement by a resident. (iii) Suspected, alleged, confessed, or witnessed abuse, neglect, or exploitation of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file. (iv) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility.	A 508		

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A 508	Continued From page 5 (v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (vi) An unplanned occurrence that results in media attention. (vii) Any medication error, overdose, or over sedation. The incident shall be immediately reported to the attending physician, facility medical director, or back-up physician. (viii) Ingestion by a resident of a toxic substance that requires medical attention. (ix) Notifiable diseases and health conditions listed in Appendix I of the Alabama Administrative Code Sec. 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 maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than 3 years. (x) Any indication of malfunction of the sprinkler system, or fire alarm system. 4. The report to the Department's Online Incident Reporting System shall include the following: (i) Facility name and direct phone number. (ii) Time and date of the report. (iii) Reporter's name.	A 508		

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A 508	Continued From page 6 (iv) Name of resident(s), staff, or visitor(s) involved in the incident. (v) Names of staff on duty at the time of the incident. (vi) Date and time of the incident. (vii) A brief description of the incident. (viii) Any injury or injuries to resident(s). (ix) Action taken by the facility in response to the incident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to report an incident to the Department's Online Incident Reporting System (OIRS) in which medical attention was sought for a resident. Findings: Resident Identifier (RI)#3 was admitted to the facility on May 7, 2022, and had numerous falls since admission. RI#3 had two (2) falls within 30 days in which the emergency medical services (EMS) was activated. On August 31, 2022, Employee Identifier (EI)#1, Administrator, acknowledged RI#3's falls on July 15, 2022 and July 30, 2022, should have been reported to the OIRS.	A 508	A508 Executive Director will train all managers on proper procedure to utilize On-line Incident Reporting System (OIRS) so that the facility has multiple personnel who can input information into the system. This will provide a pool of qualified individuals who may enter information as required. The Executive Director will provide in-service training for all managers with post-test by 9/30/22.	

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A 604	420-5-4-.06 (3) (a) (b) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility shall assess prospective residents for facility eligibility. This assessment shall document identified care needs and serve as a baseline for future assessments. (b) Monthly Assessments. The facility shall assess each resident monthly and more often when necessary to identify changes in resident's status. In addition to other items that may be required by the facility's own policies and procedures, the monthly assessment shall: 1. Assess the resident's ability to safely self-manage medications or safely self-administer medications with assistance. 2. Accurately weigh and record the weight of each resident. A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half or greater weight loss in a period of three months or less, or a ten percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician. 3. Document identified changes in resident status. 4. Assess the appropriateness of each resident's plan of care. Any decline in resident	A 604		

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A 604	Continued From page 8 status requires immediate implementation and documentation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to perform resident assessments every month. In addition, the "Monthly Assessment" forms was not signed and dated by the person completing the assessment. Findings: Review of residents' records revealed monthly assessments were not completed every month for all residents. RI#1, RI#2, and RI#4, did not have documentation a monthly assessment was completed for March 2022. On August 31, 2022, EI#1. Administrator, acknowledged the assessments were missed for March 2022. The monthly assessment forms completed for January 2022 through July 2022 had not been signed or dated by the person completing the assessment. EI#1 said she (EI#1) would remind the staff the forms are to be signed when completed.	A 604	A604 DRC/designee will conduct chart audit for missing documentation, three charts a day will be audited Monday thru Friday normal business days for 90 day period, then weekly for four weeks. Monthly assessments are in a hybrid of electronic Point Click Care and paper charting. Going forward the monthly assessments will be conducted by electronic medical records (PCC) permitting auditing for missing information. Weekly report audit will be conducted for 90 day period to ensure accuracy of assessments. PCC will automatically register the signature of entry person electronically. This will prevent any missing signatures going forward. In-service of all nursing staff on proper Monthly assessment completion will be conducted by 9/30/22.	
A 611	420-5-4-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the	A 611		

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A 611	Continued From page 9 plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall be based on the initial medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be reviewed and updated based on the annual examination, and all other physician examinations, diagnoses, and recommendations of the resident's treating physician, and the resident's monthly assessments. The plan of care shall be developed and updated in cooperation with the resident and, if appropriate, the sponsor. All entries on the plan of care shall be accurately dated. 1. The plan shall at all times reflect the current condition of the resident and document the personal care and services required from the facility by the resident. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following: 2. A listing of the resident's individual needs or problems that require intervention by the facility. 3. A listing of interventions provided by the facility to address the resident's identified needs or problems. 4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for	A 611		

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A 611	Continued From page 10 each resident receiving care from an outside provider. 5. Activities of Daily Living. Residents of assisted living facilities 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. (i) 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 necessary or requested. (ii) 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. (iii) Hair. Resident's hair shall be kept clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be provided assistance with personal safety. 6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented.	A 611		

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A 611	Continued From page 11 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, residents' care plans were not based on medical exam diagnoses and did not list the problems/needs with the appropriate interventions to meet the care needs of the residents. In addition, the facility nurse did not provide medication assistance according to recognized community standards. Findings: PLAN of CARE: RI#1 was admitted to the facility on April 12, 2019, with a significant past medical history of cerebrovascular accident (CVA) with hemiplegia (right side). The surveyor observed RI#1 ambulating via a wheelchair with limited use of her/his right arm and leg. The plan of care did not mention the CVA with hemiplegia as a "Focus" and the interventions to address those problems/needs. RI#2 had been a resident since October 10, 2017. The annual Medical Exam/Plan of Care was completed by the physician on October 31, 2021. The physician listed the following as current diagnoses, pacemaker due to bradycardia, Type I diabetes mellitus, atrial fibrillation, right atrial thrombus, history of urinary tract infection (UTI), glaucoma and diarrhea. The plan of care was revised on August 25, 2022, however none of the diagnoses were listed as a "Focus" for the staff to monitor. RI#3 was admitted to the facility on May 7, 2022.	A 611	A 611 Executive Director (ED)/Director of Resident care (DRC)/designee will conduct chart audit of Plan of Care (Individual Service Plans) to ensure current diagnosis/condition of resident is reflected in service plan documentation, three charts a day Monday through Friday will be audited for 90-day period. Plan of Care (Individual Service Plans) are in process of a hybrid implementation of electronic Point Click Care and paper charting. Going forward the Individual Service Plans will be conducted by electronic medical records (PCC) permitting auditing for missing information and ease of updating. Weekly report audit will be conducted for 90-day period to ensure accuracy of Service Plans by nursing staff. In-service of all nursing staff on proper completion of Individual Service Plan updating will be conducted by 09/30/22 for all currently employed nurses have been retrained. Inservice records will be kept by the Executive Director/Director of Resident Care A 611 RI#1 Service Plan has been updated to reflect current diagnosis's and resident condition. A 611 RI#2 Service Plan has been updated to reflect current diagnosis's and resident condition A 611 RI#3 Service Plan has been updated to reflect current diagnosis's and resident condition	

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A 611	Continued From page 12 The admission Medical Exam/Plan of Care was dated May 4, 2022, and the physician listed falls and weakness as diagnoses. RI#3 had seven (7) falls in the last three (3) months since admission. The plan of care was revised on August 25, 2022, and identified RI#3 as a fall risk with some fall interventions listed. However, the dates of the seven (7) falls were not listed on the plan of care with clearly identified interventions to address each specific fall. RI#4 was admitted to the facility on November 23, 2021, with diagnoses to include, atrial fibrillation with pacemaker, abdominal aortic aneurysm without rupture, hypertension, peripheral neuropathy, history of CVA, hemorrhoids, irritable bowel syndrome (IBS), and chronic anticoagulation (Xarelto). RI#4's diagnoses were listed on the first page (#1) and the last page (#6) of the plan of care but there were no applicable interventions listed with the diagnoses. RI#4's atrial fibrillation was being treated daily with an anticoagulant but the plan of care did not mention bleeding precautions as a "Focus". On August 31, 2022, the surveyor reviewed the care plan deficiencies with EI#1, Administrator. EI#1 verbalized understanding and agreed to update the care plans accordingly. COMMUNITY STANDARDS: On August 31, 2022 at 11:40 AM, the surveyor entered RI#2's room and observed ten (10) tablets in a clear plastic medication cup that had been placed on the end table in the sitting room. RI#2 was lying down in her/his bedroom and told the surveyor she/he did not feel good and was going to take the pills later. The surveyor brought this to the attention of EI#4, Licensed Practical	A 611	A 611 RI#4 Service Plan has been updated to reflect current diagnosis's and resident condition A 611 In-service of all licensed nursing staff on proper medication administration completed by 9/30/22. The staff will be tested and must obtain 100% on post-test. If 100% not obtained on post-test, staff member will be re-in-serviced and retested. Executive Director/Director of Resident Care will keep a record of in-service and posttest.	

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A 611	Continued From page 13 Nurse (LPN) and EI#10, Clinical Specialist. EI#4 explained RI#2 was nauseated and unable to take her/his medications at 8:00 AM as scheduled. EI#1, Administrator, told the surveyor the staff should never leave medications in a room for a resident to take later. EI#1 said this would be addressed immediately.	A 611		
A 615	420-5-4-.06 (7) (j) Care of Residents. (j) All medications administered to residents and all medications self-administered with assistance of facility staff in an assisted living facility shall be contemporaneously recorded on a standard medication administration or medication assistance record. "Contemporaneously recorded" means recorded at the same time or immediately after medications are administered. The medication administration or medication assistance record shall include at least the following: 1. The name of the resident to whom the medication was administered or assisted. 2. The name of the medication administered or assisted. 3. The dosage of the medication administered or assisted. 4. The method of administration or assistance. 5. The site of injection or application, if the medication was injected or applied. 6. The date and time of the medication administration or assistance.	A 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D4106	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF AUBURN	871 TWIN FORKS AVENUE AUBURN, AL 36830

(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 615	Continued From page 14 7. Any adverse reaction to the medication. 8. The printed name, initials, and written signature of the individual administering the medication or assisting the resident with self-administration of the medication. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility staff failed to contemporaneously record medication assistance on the Medication Administration Records (MAR). In addition, the staff did not record the injection site of insulin on the MAR or include the printed name, initials, and written signature of the individual assisting the resident with medications. Findings: On August 31, 2022 at 11:40 AM, the surveyor observed the 8:00 AM scheduled oral medications had not been taken by RI#2. However, the MAR had been initialed by EI#4, LPN, to indicate the medications had been taken by RI#2 at 8:00 AM. See deficiency 611 for addition information. RI#2 had been a resident at the facility since October 10, 2017. The medical diagnoses included Type 1 diabetes mellitus, pacemaker, atrial fibrillation, gastroesophageal reflux disease, and glaucoma. RI#2 received insulin injections three (3) times a day at 8:00 AM, 12:00 noon and 8:00 PM. A review of the MAR revealed the staff did not utilize the correct injection site codes as listed on the MAR. Also the employees assisting	A 615	A 615 In-service of all nursing staff on proper medication administration and post- test will be completed by 09/30/22. In-service to focus on documenting site location for injections. The staff must pass post-test with 100%. Executive Director/Director of Resident Care will keep copy of record of in-service and post-test. A 615 In-service of all nursing staff on proper medication administration and post- test will be completed by 09/30/22. In-service to focus on documenting site location for injections. The staff must pass post-test with 100%. Executive Director/Director of Resident Care will keep copy of record of in-service and post-test.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D4106	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 615	Continued From page 15 with medications did not include their signatures or initials on the back page of the MAR. On August 31, 2022, the surveyor discussed these findings with EI#1, Administrator. EI#1 told the surveyor the staff would be re-educated immediately on how to correctly record on the MAR. DEBRA FREEMAN, REGISTERED NURSE	A 615		

Medication Administration in the Assisted Living

Morningside of Auburn

9/9/22

Contents

1. Responsibilities of the Nurse 3
2. Provisions and Procedure 3
3. Medication Administration Record (MAR) 3
4. Controlled Substances 5
5. Privacy 5
6. Hand Washing and Hand Sanitation 5
7. General Administration of Medications 5
8. References 6
9. Post Test 6

1. Responsibilities of the Nurse

The Registered Nurse (RN) or Licensed Practical Nurse (LPN) is responsible for administering medications to residents in the community. The nurse may administer medications to residents only in accordance with physician orders and the Nurse Practice Act.

2. Provisions and Procedure

Any resident who is not aware of their medications shall have medications administered only by an individual who is currently licensed to practice medicine or osteopathy, or licensed as a Physician Assistant by the Medical Licensure Commission of Alabama, or by an individual who is currently licensed by the Alabama State Board of Nursing as a Nurse Practitioner, Registered Nurse or Licensed Practical Nurse.

Medications of any kind , including over the counter (OTC) medications, legend drugs and controlled substances, may be administered to a resident only after the drugs have been prescribed specifically for the resident by an individual currently licensed to prescribe medications in Alabama.

Medications are to be obtained from a licensed pharmacy; each container is labeled with the following information:

1. Name of pharmacy
2. Name of resident
3. Name of the prescriber
4. Name and dosage unit of the medication
5. Date of dispensing and prescription number
6. Directions for use

3. Medication Administration Record (MAR)

Medication Administration Records (MAR) for each resident are used and compared with physician's order to confirm that the medication is properly administered. All medications are contemporaneously[1] documented on the resident's MAR.

The MAR includes at the minimum the following:

1. The name of the resident to whom the medication is to be administered
2. The name of the medication to be administered
3. The dosage of the medication to be administered
4. The route or method of administration
5. The site of injection or application, if the medication is to be injected or applied
6. The date and time of the medication administration
7. Any adverse reaction to the medication

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[1] Contemporaneously means occurring at the same time.

8. The printed name and signature of the individual administering the medication.

Any refusal by the resident to take the medication or any other difficulty is noted I the record. In the event the dose of a regular scheduled medication is withheld or not given, the service provider's notation for that dose is circled on the MAR and an explanation is written on the reverse of the MAR. Nurse is to ensure that they sign each page of the MAR, and sign off administration of medication AFTER the resident consumes the medication, NEVER leave medication at the bedside.

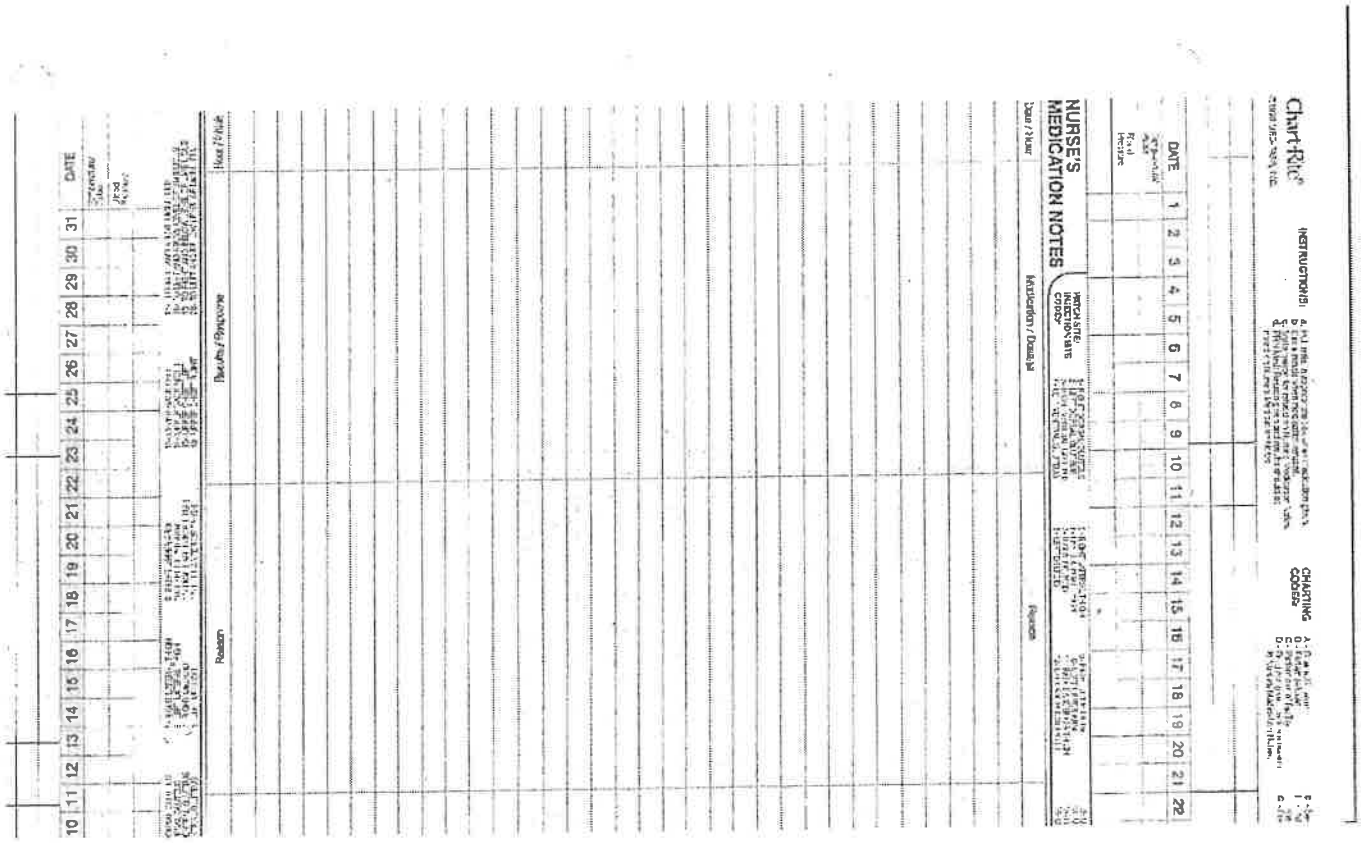
All required information on any new medicine or refill of any medicine is recorded or verified in the resident's MAR before being stored with the resident's other medications. Any discrepancy is resolved immediately through the pharmacist or resident's information.

MAR and written physician orders for all over the counter (OTC), legend drugs and controlled substances are retained for a period of not less than three years. They are made available for inspection at reasonable times by residents who are not cognitively impaired and by the sponsors of residents who are cognitively impaired.

All medications under the control of and distributed by the community is properly labeled and stored in a locked cabinet of sufficient size to prevent crowding of the medication.

4. Injection Site Documentation

It is imperative that accurate injection site documentation occurs and is accurate so that no harm is done to the resident and recorded site administration is correct.



These patch site/injection codes include the following:

1-Right Dorsal Gluteus 2-Left Dorsal Gluteus 3-Right Ventral Gluteus 4- Left Ventral Gluteus 5-Right Lateral Thigh

6-Left Lateral Thigh 7-Right Deltoid 8-Left Deltoid 9-Right Upper Arm 10-Left Upper Arm

11-Right Anterior Thigh 12-Left Anterior thigh 13-Upper Back Left 14-Upper Back Right 15-Upper Chest Left

16-Upper Chest Right 17-To Right and above umbilicus 18-To Left and above level of umbilicus

19-To Right and below the level of umbilicus 20- To Left and below level of umbilicus

5. Controlled Substances

All controlled substances prescribed for residents that are kept in the custody of the community shall be stored using a double lock system. The community maintains a system to account for all controlled substances in its possession.

6. Privacy

Resident privacy is of primary concern when assisting the resident in taking medications. Residents are encouraged to meet the nurse either in the privacy of hier room or in the Nurse Station Wellness Area when receiving their medications.

7. Hand Washing and Hand Sanitation

The nurse washes their hands between each resident contact and medication dispersion. Hand sanitation by use of antimicrobial agent is permitted except for eye medications. Gloves are used as appropriate.

8. General Administration of Medications

Each time before administering medications to a resident, the nurse identifies the resident by the following:

1. By the photograph of the resident on the resident's MAR
2. Additional methods of identification may include:
    a. Having another team member who knows the resident confirm the resident's identification
    b. Asking the resident to identify self by name and date of birth
3. Medications kept in the custody of an individual resident who is aware of their medications and who can safely manage their own medications are under direct supervision of that resident or stored and locked in a safe area of their apartment. A physician's order must be obtained in order for he resident to keep medication in their room.
4. Medications may be stored in a locked container accessible only to the resident and staff, or may be stored in the resident's apartment, if the apartment is single occupancy and has a locking entrance.
5. Medication containers with soiled, damaged, incomplete, illegal or makeshift labels shall be returned to the pharmacy for relabeling or disposal.
6. Medications cannot be transferred between containers. Medications for each resident must be stored in the original prescription container/unit dose package.
7. All medications requiring refrigeration are kept in a designated refrigerator, with a locking capacity or behind a locked door.
8. Medications for external use only are kept in a locked cabinet marked "Externals" and separate from other medications. Other poisonous substances such as cleaning and germicidal agents, are not stored in medication storage areas.
9. All eye, ear, and nasal medications are stored apart from oral medications, and from other topical medications.

10. The community does not store or possess legend medications except those specifically prescribed for individual residents of the community.
11. Only personnel designated by the administrator shall access to medications.
12. Adverse reactions by the resident or medication errors are reported immediately to the resident's physician. In the event of a severe reaction, any necessary resuscitation procedure is taken, and local emergency authorities are immediately notified (911). An appropriate entry is recorded in the resident health record and an incident report filed.
13. Any medication error, including overdose, hat results in a resident being hospitalized is recorded on an incident Report, thoroughly investigated and reported to the department of Public Health's Assisted Living Facilities Report Hotline within 24 hours of the incident. In the event of an adverse reaction or medication error, the next of kin or legal representative and attending physician are notified immediately.
14. Upon discharge, all medications are returned to the resident and/or sponsor. A statement listing the pharmacy, prescription number, date resident's name and strength of the medication and amount being returned to the resident must be signed by the family member or responsible party upon discharge. This document is maintained on file for here years. Team member's use the "Medication Disposition Record of Discharge or Transferred Residents" to record the above.
15. Resident's medication that has deteriorated or exceeded its safe shelf life; any unlabeled containers and contents; and any unused drugs that remain due to death or discontinuance as recorded in the resident's health record, are to be destroyed by the administrator or nurse, witnessed and documented. Controlled substances and legend medications dispensed to residents that are unused because the medication is discontinued or because the resident dies, are destroyed within 30 days.
16. Medications may not be left at bedside for any reason, even with valid self-administration of medication orders, the resident must maintain control and security of the medications.

9. References

CL-AL-POL-AL1001 Medication Administration (Alabama SCALF)

CL-AL-POL-4000 Medication Management

CL-AL-POL-4002 Controlled Substances and Narcotics

CL-AL-POL-4001 Resident Self-Administration of Medication

10. Post Test

Name: _____ Date: _____ Score: _____

You must score 100 % to successfully complete this learning module.

1. An external medication marked "EXTERNAL USE ONLY" may be stored with other medication in the medication cart. TRUE FALSE
2. A refrigerated medication can be stored only in a MEDICATION REFRIGERATOR with a locking device with the refrigerator marked "MEDICATIONS ONLY". TRUE FALSE
3. The community is administering medications for a resident, the resident states "put it here I don't feel well and will take it later, I have an order "may leave at bedside", you may leave the medication with the resident. TRUE FALSE
4. You have a vial of hydrocodone 5/325 mg Tablets with 2 tablets, and a vial of hydrocodone 5/325 mg tablets 30 tabs, both bottles have the same prescription number, you can pour the two tabs into the container with 30 tablets, so it does not take up so much room in the cart. TRUE FALSE
5. You are administering eye drops to the resident who does not have dexterity to do it themselves do to Parkinson tremors, you sanitize your hands with antimicrobial gel and administer the eye drops. Is this correct? Yes No
6. You administer insulin 70/30, 20 units SQ to the right lower abdomen how would you document the site location?

   1-RIGHT DORSAL GLUTEUS 15- UPPER CHEST LEFT 17-TO RIGHT AND ABOVE UMBILICUS

   18-TO LEFT AND ABOVE LEVEL OF UMBILICUS 19-TO RIGHT AND BELOW LEVEL OF UNMBILICUS

7. There are a minimum of eight items that must be included on the MAR, list the eight items require as a minimum:
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
   f. _____
   g. _____
   h. _____

ANSWER KEY FOR POST TEST

1. FALSE

2. TRUE
3. FALSE
4. FALSE
5. NO
6. 19-TO RIGHT AND BELOW LEVEL OF UNMBILICUS
7. a. The name of the resident to whom the medication is to be administered
   b. The name of the medication to be administered
   c. The dosage of the medication to be administered
   d. The route or method of administration
   e. The site of injection or application, if the medication is to be injected or applied
   f. The date and time of the medication administration
   g. Any adverse reaction to the medication
   h. The printed name and signature of the individual administering the medication.

Number of Wrong	Score	
1	92.8	
2	85.7	
3	78.5	
4	71.4	
5	35.7	
6	57.1	
7	50	
8	42.8	
9	35.7	
10	28.5	
11	21.4	
12	14.2	
13	7.1	
14	0	

Kimberly Fields, EXECUTIVE Director, 9/14/22

Kimberly Fields, EXECUTIVE Director, 9/14/22