Accepted October 24, 2023

Connie Cherry
Cynthia A. Harbinger

Alabama Department of Public Health

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FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P4701	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMP MEADOWS SPECIALTY CARE ASSISTEI	652 TAHOE ROAD WINFIELD, AL 35594

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments This is a 26 bed Specialty Care Assisted Living Facility (SCALF) with a census of 15 on October 5, 2023. There was one (1) complaint investigated during this unannounced licensure and complaint survey. LC#20211004002 was unsubstantiated. There were no deficiencies cited as a result of the complaint investigation. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practices resulted in the potential for harm to all residents and require a plan of correction.	A 000		
A 403	420-5-20-.04 (4) Personnel. (4) Personnel Records. A specialty care assisted living facility shall maintain a personnel record for each employee. This record shall contain: (a) An application for employment which contains information regarding the employee's education, training, and experience. (b) Verification of current certification or licensure, if applicable. (c) Record of required physical examinations and vaccinations. (d) Verification the facility has not hired an individual whose name is on the Alabama Health Care Facilities	A 403	1) Deficiency Number: 420-5-20-.04 Personnel (A 403) The administrator will ensure that each of the employee's personnel files contain a date of initial resident contact. 2) Employees files identified during the survey were immediately updated with the omitted information. 3) All employee files were audited by the administrator immediately to identify any other concerns not identified during the survey and no other omissions were found. 4) An 'Employee File Organizational Guide' was created to ensure that all the required documentation is in place in each chart. This check sheet will be placed in the front of each employee file. The Administrator will utilize this check sheet to ensure proper/required documentation is in each employee file. The administrator will submit the completed audit sheet to the Director of Operations/Governing Authority upon each new hire for 6 months. The administrator will audit all employee files, utilizing the 'Employee File Organization Guide' sheet, once a month for 3 months and then quarterly for the next year. The administrator will forward her audits to the Director of Operations/Governing Authority to ensure compliance with the plan of correction and all audits will be maintained in the administrator's office.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Katie Johnson | TITLE: Administrator | (X6) DATE: 10/17/2023

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A 403	Continued From page 1 Department of Public Health Nurse Aide Abuse Registry. (e) Date of hire. (f) Date of initial resident contact. (g) Date employment ceased. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to maintain all required information in each employee's personnel record. Findings: Review of employee personnel files on October 4, 2023 revealed the following files did not contain a date of initial resident contact: Employee Identifier (EI)#4; EI#5; EI#6. EI#4 had been employed at the facility since May 2022. EI#5 had been employed at the facility since April 2023. EI#6 had been employed at the facility since July 2022. EI#1 agreed the required information had been omitted from these employees' files.	A 403	5) In-Services, audits, and training will be provided on an ongoing basis as needed and/or as determined by the Administrator, Regional Manager, Designee, or Governing Authority. Any evidence of non-compliance or continued deficient practice will result in additional in-servicing of staff on policies and procedures, possible changes to the monitoring process, or appropriate discipline up to and including possible discharge 1) Deficiency Number: 420-5-20-.04 Personnel (A 406) The administrator will ensure that all licensed personnel have completed the Pharmacological Management of Dementia and the Dementia Assessment Series training. 2) Licensed personnel files identified during the survey were immediately updated with the omitted information. 3) All Licensed personnel files were audited by the administrator immediately to identify any other concerns not identified during the survey and no other omissions were found.	
A 406	420-5-20-.04 (9) Personnel. (9) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. An RN shall identify staff training needs and shall provide or arrange for needed training. In addition to any information otherwise required by the	A 406		

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A 406	Continued From page 2 facility's policies and procedures, 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 specialty care assisted living facilities. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire. 5. Identifying and reporting abuse, neglect, and exploitation. 6. Basic first aid. 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environmental safety. (b) Prior to providing any resident care, all staff shall complete The Dementia Education and Training Act (DETA) Care Series Training developed by the Alabama Department of Mental Health or equivalent training approved by the State Health Officer. All licensed staff shall complete DETA Brain Series Training, The Pharmacological Management of Dementia, and the Dementia Assessment Series provided by the	A 406	4) An 'Employee File Organizational Guide' was created to ensure that all the required documentation is in place in each chart. This check sheet will be placed in the front of each employee file. The Administrator will utilize this check sheet to ensure proper/required documentation is in each employee file. The administrator will submit the completed audit sheet to the Director of Operations/Governing Authority upon each new hire for 6 months. The administrator will audit all employee files, utilizing the 'Employee File Organization Guide' sheet, once a month for 3 months and then quarterly for the next year. The administrator will forward her audits to the Director of Operations/Governing Authority to ensure compliance with the plan of correction and all audits will be maintained in the administrator's office. 5) In-Services, audits, and training will be provided on an ongoing basis as needed and/or as determined by the Administrator, Regional Manager, Designee, or Governing Authority. Any evidence of non-compliance or continued deficient practice will result in additional in-servicing of staff on policies and procedures, possible changes to the monitoring process, or appropriate discipline up to and including possible discharge.	

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A 406	Continued From page 3 DETA Program or equivalent training approved by the State Health Officer prior to resident contact. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained. (c) 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. (d) Cardiopulmonary Resuscitation. A specialty care assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of a specialty care assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within 90 days of hire. A specialty care assisted living facility equipped with an automated external defibrillator (AED) shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or the American Red Cross in CPR or	A 406		

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A 406	Continued From page 4 AED utilization. (e) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training. (f) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure all licensed staff completed required training prior to resident contact. Findings: Review of employee personnel files on October 4, 2023 revealed the following licensed staff had not completed The Pharmacological Management of Dementia and Dementia Assessment Series training: EI#4, Licensed Practical Nurse (LPN); EI#5, LPN. EI#4 was employed at the facility from May 2022 until February 2023 and EI#5 was employed at the facility from April 2023 until July 2023. EI#1 agreed the required training had not been completed for these two licensed employees.	A 406		
A1002	420-5-20-.10 (2) Sanitation and Housekeeping. (2) Housekeeping and Physical Plant Maintenance. The facility must provide a safe,	A1002		

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A1002	Continued From page 5 functional, decent, sanitary, and comfortable environment for residents, staff, and the public. (a) Equipment and Supplies. The home shall maintain an adequate quantity of housekeeping and maintenance equipment and supplies. (b) Bathtubs and Lavatories. Bathtubs and lavatories shall be kept clean and in proper working order, and shall not be used for laundering. (c) Resident Bedrooms. Resident bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance. (d) General Storage. 1. Broken beds, extra mattresses, mop buckets, and dust rags shall not be kept in hallways, closets, corners, or occupied resident rooms. Such items must be stored neatly and orderly in designated storage rooms. 2. The use of attics for storage of combustible materials shall be prohibited unless protected by an automatic sprinkler system and then only in small quantities so as not to create a hazardous condition. 3. Basements used for storage shall meet acceptable standards for storage and shall be designed and constructed in a manner that protects against fire hazards. 4. Flammable materials such as gasoline, motor fuels, lighter fluid, turpentine,	A1002	1) Deficiency Number: 420-5-20-.04 Personnel (A 1002) The facility will maintain a decent and sanitary environment for residents, staff, and the public. 2) The Governing Authority was immediately notified of the deficiency. The Governing Authority will deep clean or replace if necessary the badly stained carpet within 3 months of the acceptance of this plan of correction. 3) All carpeted areas throughout the residence were assessed by the administrator immediately to identify any other stains/ concerns not identified during the survey and no other concerns were found. 4) The administrator will oversee the cleaning or installation of the new carpet. The administrator/designee will observe all carpeted areas throughout the facility once a month for 3 months and then quarterly for the next year. The administrator will forward her observations to the Director of Operations/ Governing Authority to ensure any issues with the carpet are immediately resolved in a timely manner. All documentation and monitoring will be sent to the Director of Operations/ Governing Authority and maintained in the administrator's office. 5) In-Services, audits, and training will be provided on an ongoing basis as needed and/or as determined by the Administrator, Regional Manager, Designee, or Governing Authority. Any evidence of non-compliance or continued deficient practice will result in additional in-servicing of staff on policies and procedures, possible changes to the monitoring process, or appropriate discipline up to and including possible discharge.	

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A1002	Continued From page 6 acetone, and oil based paint shall not be stored in the facility. Unless prohibited by a facility's own policies, however, a cognitively intact resident who uses lighter fluid to fill a personal cigarette lighter, or one who uses flammable materials such as paint or glue in connection with a personal hobby, may store small quantities of those materials in a safe and secure manner within his or her own room. 5. Poisonous or External Use Substances. Facility cleaning supplies and poisons shall be attended at all times or shall be kept in a secure area. This Rule is not met as evidenced by: Based on observations and interview, the facility failed to maintain a decent and sanitary environment for residents, staff and the public. Findings: Upon entering the facility on the morning of October 4, 2023, the surveyor noted the carpet to the right in the front common area (living area) was badly stained in several areas. In addition, the carpet in the hallway to the left leading from the dining room was badly stained in several areas. This hallway led to residents' rooms. EI#1 stated the carpet in both areas had been cleaned but the stained areas did not go away. CONNIE CHERRY, REGISTERED NURSE	A1002		