POC Accepted
April 18, 2022
Debbie Freeman, RN
Debra Freeman

PRINTED: 04/06/2022
FORM APPROVED

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
	D5913	A. BUILDING: _____ B. WING _____	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERBY AT ST VINCENT'S ONE NINETEEN	2700 CORPORATE DRIVE, SUITE 125 BIRMINGHAM, AL 35242

(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 On March 31, 2022, an unannounced complaint investigation was conducted for this 56 bed Assisted Living Facility with a census of 31. There was one (1) complaint investigated during this survey. Intake ID 20220302002 was substantiated and a deficiency was 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 420-5-4, Alabama Administrative Code, for Assisted Living Facilities (ALF). The deficiencies cited pose a risk or potential risk of harm to the residents and requires a plan of correction.	A 000		
A 303	420-5-4-.03 (2) (a) Administration. The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an administrator shall meet all applicable statutory requirements. 4. There must be an individual with	A 303	**A 303 420-5-4-.03 (2) (a) Administration.** •RI #1 moved out of the facility on 03/30/2022 •The administrator reviewed the survey results and state approved plan of correction from the previous licensure survey, conducted on September 30, 2021, with the Director of Wellness and the AL Manager. •The Director of Wellness and the Assisted Living Manager received education and training regarding documentation requirements for monthly assessments and resident care plans. •All resident monthly assessments and care plans have been reviewed, updated, and are current as of 04/13/2022. •The Administrator and/or designee will conduct routine monthly audits for compliance with required monthly assessment and care plan documentation on a random selection of residents. Disciplinary action will be taken for continued non-compliance identified up to termination. •Documentation of audits, identified non-compliance, and actions taken to correct deficiency will be maintained in the Administrator's office.	03/30/2022 04/13/2022 04/11/2022 04/13/2022 Starting on 04/13/2022 and ongoing Starting on 04/13/2022 and ongoing

Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Lee Anne Montgomery — Executive Director — 4/13/2022

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A 303	Continued From page 1 experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences. 5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age. 6. The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character. 7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week. 8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment and adequate care being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement. 9. The facility administrator is responsible for ensuring that required training is provided to all staff. 10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting. 11. The administrator shall ensure that	A 303		

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A 303	Continued From page 2 facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when needed. 12. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan. 13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained. This Rule is not met as evidenced by: Based on record reviews and interview, the Administrator did not ensure all deficient practices cited by the ADPH were corrected in a timely manner. Findings: On September 30, 2021, a licensure survey was conducted for this facility. Employee Identifier (EI)#1 had assumed the role of Administrator on May 19, 2021. During this survey deficiencies were cited for failure to perform monthly assessments (refer to deficiency 604) for all residents and failure to update resident's care plans (refer to deficiency 611). On October 20, 2021, a Plan of Correction was submitted by EI#1 to correct the 604 and 611 deficiencies and to maintain compliance with the rule. However, these two (2) deficiencies were repeated during this survey. EI#1 explained it had been difficult to find qualified staff in the last four (4) months. EI#1 told the surveyor she (EI#1) had hired a new	A 303		

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A 303	Continued From page 3 Director of Wellness (EI#2) on February 14, 2022 and a new ALF Manager on March 15, 2022. EI#1 told the surveyor she (EI#1) had confidence in the new team she (EI#1) had in place that the deficiencies would be corrected and maintained.	A 303		
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 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	A 508	**A 508 420.5.4-.05 (3) (h) Records and Reports.** •The administrator will report the required information from the last two COVID-19 outbreaks to the OIRS by 04/18/2022. •The Director of Wellness and the Assisted Living Manager received education and training regarding reporting requirements for outbreaks. •Confirmation of required reporting of outbreaks will be reviewed and discussed during daily stand-up meetings to ensure reporting is completed within the required 24-hour time frame. Disciplinary action will be taken for continued non-compliance identified up to termination. •Documentation to support the reporting of outbreaks submitted to OIRS will be maintained in the Administrator's office.	04/18/2022 04/11/2022 Starting on 04/13/2022 and ongoing Starting on 04/13/2022 and ongoing

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A 508	Continued From page 4 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 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	A 508		

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A 508	Continued From page 5 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). (vii) Immediate actions taken. (viii) The extent and description of injury, if any, to the affected resident or residents. (ix) Immediate treatment rendered.	A 508		

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A 508	Continued From page 6 (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 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.	A 508		

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A 508	Continued From page 7 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. (v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (vi) An unplanned occurrence that results in media attention.	A 508		

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A 508	Continued From page 8 (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. (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.	A 508		

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A 508	Continued From page 9 (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 record reviews and interviews, the facility failed to report an outbreak of a contagious disease to the Department's Online Incident Reporting System (OIRS) within 24 hours of the diagnosis (Code 420-4-1-.04). Findings: A review of the OIRS on March 29, 2022, by the surveyor revealed no positive cases of COVID-19 had been reported by the facility. However, while on site, the surveyor learned there had been two (2) outbreaks of COVID at the facility. The morning of March 30, 2022, the surveyor discussed this with EI#1, Administrator. EI#1 explained the positive cases had been reported to the COVID-19 National Healthcare Safety Network (NHSN) in December 2021 and January 2022. However, the facility did not report the outbreak to the ALF OIRS within 24 hours of the positive test results for residents or employees. The surveyor reviewed the disease reporting requirements with EI#1 and she (EI#1) verbalized understanding and agreed to comply.	A 508		

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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	**A 604 420-5-4-.06 (3) (a) (b) Care of Residents.** •RI #1 moved out of facility on 03/30/2022 •The administrator reviewed the survey results and state approved plan of correction from the previous licensure survey conducted on September 30, 2021, with the Director of Wellness and the AL Manager. •The Director of Wellness and the Assisted Living Manager received education and training regarding documentation requirements for monthly assessments. •All resident monthly assessments have been reviewed, updated, and are current as of 04/132022. •The Administrator and/or designee will conduct routine monthly audits for compliance with required monthly assessment documentation on a random selection of residents. Disciplinary action will be taken for continued non-compliance identified up to termination. •Documentation of audits, identified non-compliance, and actions taken to correct deficiency will be maintained in the Administrator's office.	03/30/2022 04/13/2022 04/11/2022 04/13/2022 Starting on 04/13/2022 and ongoing Starting on 04/13/2022 and ongoing

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A 604	Continued From page 11 status requires immediate implementation and documentation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to complete monthly assessments for all residents. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON SEPTEMBER 30, 2021. Findings: During record reviews on March 30, 2022, the surveyor found the monthly assessments had not been completed for all residents. Resident Identifier (RI)#1 had been residing at the facility since May 20, 2021. The record for RI#1 did not have documentation of monthly assessments completed for October 2021, December 2021, January 2022 and February 2022. The surveyor discussed the missing documentation with EI#1. EI#1 told the surveyor she (EI#1) had looked for the missing monthly assessments but could not locate them. EI#1 told the surveyor the monthly assessments may not have been completed due to the turnover in staffing.	A 604		
A 611	420-5-4-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The	A 611		

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A 611	Continued From page 12 facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the 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	A 611	**A 611 420-5-4-.06 (4) (a) (b) Care of Residents.** •RI #1 moved out of facility on 03/30/2022 •The administrator reviewed the survey results and state approved plan of correction from the previous licensure survey conducted on September 30, 2021, with the Director of Wellness and the AL Manager. 04/13/2022. •The Director of Wellness and the Assisted Living Manager received education and training regarding documentation requirements for resident care plans. 04/11/2022. •All resident care plans have been reviewed, updated, and are current as of 04/13/2022. •The Administrator and/or designee will conduct routine monthly audits for compliance with required care plan documentation on a random selection of residents. Disciplinary action will be taken for continued non-compliance identified up to termination. •Documentation of audits, identified non-compliance, and actions taken to correct deficiency will be maintained in the Administrator's office.	03/30/2022 04/13/2022 04/11/2022 04/13/2022 Starting on 04/13/2022 and ongoing Starting on 04/13/2022 and ongoing

LeeAnn Montgomery, ED 4/13/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D5913	A. BUILDING: _____ B. WING _____	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERBY AT ST VINCENT'S ONE NINETEEN	2700 CORPORATE DRIVE, SUITE 125 BIRMINGHAM, AL 35242

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A 611	Continued From page 13 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 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	A 611		

Lee Anne Montgomery, ED 4-13-2022

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A 611	Continued From page 14 personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to maintain current and appropriate resident Care Plans along with interventions to address the care and safety needs of all residents. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON SEPTEMBER 30, 2021. Findings: On March 2, 2022, a family member reported to the ADPH the care plan for RI#1 was not being updated with new diagnoses and interventions. On March 31, 2022, the surveyor reviewed the care plan for RI#1 with EI#1 and EI#2, Director of Wellness (DOW), Registered Nurse (RN). RI#1 was admitted to the facility on May 20, 2021 and was currently in rehabilitation after being found on the floor on March 22, 2022. According to the family member RI#1 may have had a transient ischemic attack (TIA) on October 1, 2021, while receiving physical therapy. There was a care plan note that read, "10/1/2021 to ER for neuro consult". However, there was no information provided to explain the reason for the neuro consult or the action to take if a similar episode	A 611		

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A 611	Continued From page 15 occurred. On February 9, 2022, RI#1 was diagnosed with a urinary tract infection (UTI) and treated with an antibiotic (levofloxacin). The care plan did not list UTI as a problem or provide the staff with any signs or symptoms to monitor in the event of another infection. RI#1 had a history of falls documented on the care plan. The last three (3) falls occurred on February 11, 2022, February 14, 2022, and March 18, 2022. These falls were not dated on the care plan nor were there specific interventions developed to address each fall or measures put into place to help reduce the risk of similar falls. On March 31, 2022 at 3:30 PM, the surveyor discussed the care plan expectations with EI#2. EI#2 told the surveyor she (EI#2) had just recently became the DOW on February 14, 2022. EI#2 agreed the care plan was not complete and was in the process of properly training the staff on how to update the care plans by listing the resident's needs or problems that require intervention by the facility.	A 611	**615 420-5-4-.06 (7) (j) Care of Residents.** •RI #1 moved out of facility on 3/30/2022 •EI #12 received disciplinary action and re-education regarding documentation requirements for contemporaneous documentation on the Medication Assistance Record (MAR) when providing medication assistance. 04/11/2022	03/30/2022 04/11/2022
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	A 615	•The licensed nurses and medication technicians (Med Techs) received education and training regarding documentation requirements for contemporaneous documentation on the Medication Assistance Record (MAR) when providing medication assistance. 04/11/2022 •The Director of Wellness and/or designee will conduct routine monthly audits for compliance with medication assistance documentation on a random selection of residents during medication passes. Disciplinary action will be taken for continued non-compliance identified up to termination. •Documentation of audits, identified non-compliance, and actions taken to correct deficiency will be maintained in the Administrator's office.	04/11/2022 Starting on 04/13/2022 and ongoing Starting on 04/13/2022 and ongoing

Lee Anne Montgomery, FD 4-13-2022

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SOMERBY AT ST VINCENT'S ONE NINETEEN	2700 CORPORATE DRIVE, SUITE 125 BIRMINGHAM, AL 35242

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A 615	Continued From page 16 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. 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 record review and interviews, the facility failed to ensure medications were documented contemporaneously on the Medication Assistance Record (MAR). Findings: The afternoon of March 31, 2022, the surveyor performed medication reconciliation on the February 2022 MAR for RI#1. The surveyor noted the scheduled 9:00 AM medications had not been recorded as assisted with on page 1 of 4 of the	A 615		

Lee Anne Montgomery, ED 4-13-2022

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A 615	Continued From page 17 MAR. EI#1 informed the surveyor she (EI#1) was aware of the missing initials on the MAR and the employee (EI#12) had been re-educated by EI#5, ALF Director. The surveyor interviewed EI#12, Med Tech, on March 31, 2022. EI#12 told the surveyor she (EI#12) did assist RI#1 with her/his medications on those dates but failed to sign the MAR contemporaneously. DEBRA FREEMAN, REGISTERED NURSE	A 615		

Lee Anne Montgomery, ED 4-13-2022