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
	D4551	A. BUILDING: ______ B. WING ______	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER SENIOR LIVING AT UPLAND PARK	**6100 KITT LANE NW HUNTSVILLE, AL 35806**

(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 September 17, 2024, a licensure survey was conducted for this sixty-one (61) bed Assisted Living Facility (ALF) with a census of eighteen (18). No complaints were investigated. 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, Assisted Living Facilities. The deficient practices resulted in the potential for harm to all residents and require a plan of correction.	A 000		
A 405	420-5-4-.04 (6) Personnel. (6) 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. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained in the facility. In addition to any information otherwise required by the 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 assisted living facilities. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the	A 405		

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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 environment safety.

10. Special needs of the elderly, mentally ill, and mentally retarded.

11. Safety and nutritional needs of the elderly.

12. Identifying signs and symptoms of dementia.

(b) Cardiopulmonary Resuscitation. An 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 an 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. An 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

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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 American Red Cross in CPR or AED utilization.

(c) 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.

(d) 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 interviews, the facility failed to maintain documentation of initial staff training.

Findings:

Review of employee files on September 17, 2024 revealed that documentation of training in the following areas was missing from the files for Employee Identifier (EI)#4 and EI#5: State law and rules on assisted living facilities; Identifying and reporting abuse, neglect and exploitation; Basic first aid; Advance directives; Protecting resident confidentiality; Resident fire and environmental safety; Safety and nutritional needs of the elderly; Special needs training in diabetes and oxygen therapy.

During an interview on September 17, 2024, EI#1 stated that SRI had taken over management of

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A 405	Continued From page 3 the facility on August 1, 2024 and the facility was previously managed by Vitality Senior Living. EI#1 added that, at the time of the change in management, representatives of Vitality Senior Living removed employee files from the facility and were currently refusing to release the information in the employee files to SRI even after notification that a state survey was in progress and the information had been requested by state surveyors. EI#1 also stated that the electronic system used by SRI for training of employees was not the same system that had been used by Vitality; therefore, Vitality training records could not be retrieved electronically by SRI. EI#1 further stated that SRI was in the process of creating new employee files for the current employees to include retraining of all employees. On September 12, 2024, following a survey of the specialty care assisted living facility (SCALF) on the same campus, the ALF supervisor contacted the Regional Vice President of Vitality Senior Living to discuss release of employee files to SRI for management of the facility. On September 17, 2024, EI#1 stated that she (EI#1) had spoken with the Regional Vice President of Vitality Senior Living on September 12, 2024 and was informed by the Vice President that she (Vice President) had been contacted by ADPH. However, the Vice President continued to refuse to release the employee files to SRI, stating that the matter was being reviewed by Vitality's legal department. Interviews with staff on September 17, 2024 revealed that the initial training for these employees was likely completed at the time the employees were hired. However, the training was completed during the time that Vitality Senior Living was managing the facility and	A 405		

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A 405	Continued From page 4 documentation of this training had been removed from the facility by Vitality Senior Living and was not provided to SRI Management.	A 405		
A 602	420-5-4-.06 (2) (a) (b) (c) Care of Residents. (2) Medical Examination Record. (a) Initial Physical Examination. Not more than 30 days prior to admission of any resident to an assisted living facility, the resident or prospective resident shall be examined by a physician. For purposes of the initial physical examination only, a currently licensed physician in good standing with the Medical Licensure Commission of any state may complete this physical assessment. The physician shall report his or her findings in writing to the facility. In addition to any information otherwise required by the facility's policies and procedures, and in addition to any other information the physician recommends or believes is pertinent, the initial physical examination record shall contain the following: 1. All of the physician's diagnoses, and the resident's baseline weight and vital signs. 2. Medication presently prescribed (name, dosage, and strength of drug, frequency, and route of administration). 3. A statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact. 4. Documentation of evaluation for	A 602		

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tuberculosis within the previous 12 months.

(b) Annual Physical Examination. In addition to the admission physical examination, each resident shall be examined annually by a physician, and findings from the annual physical examination shall be documented with a copy placed in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent, or recommended by the resident's attending physician, the annual physical examination shall contain the following:

1. The resident's weight and vital signs.

2. Changes in diagnoses.

3. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration).

4. Changes in treatment.

(c) Change of Condition Physician Examinations. Changes in the resident's condition that require a physician examination and result in a change in diagnoses, medications, or treatments shall be reported to the facility and documented in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent, or recommended by the resident's treating physician, this physical examination shall contain a listing of the following:

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1. New diagnoses.

2. Changes in condition.

3. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration).

4. Changes in treatment.

This Rule is not met as evidenced by:
Based on observation and interview, the facility failed to ensure an annual medical examination was completed for a resident.

Findings:

Resident Identifier (RI)#4 was admitted to the facility on March 31, 2023, with admitting diagnoses of diabetes mellitus Type 2 (DMII), hypertension (HTN), coronary artery disease (CAD), congestive heart failure (CHF), hyperlipidemia (HLD), pulmonary hypertension (PHTN), chronic venous insufficiency (CVI), obstructive jaundice continuous positive airway pressure (OJ CPAP) and polycythemia vera (PV). During a review of the resident's chart, it was revealed that there was an annual medical examination due on March 31, 2024. As of September 17, 2024, there was no annual examination completed.

During an interview with EI#5 on September 17, 2024, EI#5 was unable to locate the current medical examination in chart.

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A 604	420-5-4-.06 (3) (a) (b) Care of Residents.	A 604		

(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

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resident's plan of care. Any decline in resident status requires immediate implementation and documentation of interventions or reassessment of existing interventions.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure monthly assessments were completed for three residents.

Findings:

RI#1 was admitted to the facility on November 30, 2023, with admitting diagnoses of dementia, chronic kidney Disease Stage III (CKD III), diabetes mellitus type II (DMII), hypertension (HTN), hyperlipidemia (HLD), anxiety, gastroesophageal reflux disorder (GERD), insomnia, vitamin D3 deficiency, and history of stroke brain bleed. The record review revealed that monthly assessments were not documented prior to August 2024. The record review revealed that monthly assessments were not performed for the period of January 2024 to August 2024. The record review also disclosed that no medication self-administration assessments were performed for the period January 2024 to August 2024.

RI#2 was admitted to the facility on November 2, 2022, with admitting diagnoses of diastolic heart failure (DHF), atelectasis, pleural effusion, and colostrum difficile colitis (CDif) A record review revealed there were no monthly assessments conducted for RI#2 for eight (8) months; January 2024 to August 2024.

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A 604	Continued From page 9 RI#4 was admitted to the facility on March 30, 2023, with admitting diagnoses of diabetes mellitus type 2 (DMII), hypertension (HTN), coronary artery disease (CAD), congestive heart failure (CHF), hyperlipidemia (HLD), pulmonary hypertension (PHTN), chronic venous insufficiency (CVI), obstructive jaundice continuous positive airway pressure (OJ CPAP) and polycythemia vera (PV). There were no monthly assessments conducted for RI#4 for eight (8) months; January 2024 to August 2024. On September 17, 2024, EI#5 admitted medication self administration assessments were not conducted monthly. EI#5 said she was not appropriately trained.	A 604		
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 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	A 611		

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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 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

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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.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to update resident care plans with interventions that addressed the residents' individual diagnoses.

Findings:

RI#1 was admitted to the facility on November 30, 2023, with admitting diagnoses of dementia, chronic kidney disease stage III (CKD III),

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diabetes mellitus type II (DMII), hypertension (HTN), hyperlipidemia (HLD), anxiety, gastroesophageal reflux disorder (GERD), insomnia, vitamin D3 deficiency, and history of stroke brain bleed. The care plan did not provide specific care actions for caregivers for hyperglycemia, hypoglycemia and for hypertension.

RI#2 was admitted to the facility on November 2, 2022, with admitting diagnoses of diastolic heart failure (DHF), atelectasis, pleural effusion, and colostrum difficile colitis (CDif). The care plan did not provide specific care actions for caregivers for diastolic heart failure and atelectasis.

RI#3 was admitted to the facility on March 2, 2023, with admitting diagnosis of heart failure (HF), chronic obstructive pulmonary disease (COPD), obesity, hypertension (HTN), respiratory failure, hypoxia, back pain, diarrhea, vitamin D deficiency, bacteremia, urinary tract infection (UTI), urinary incontinence, and hyponatremia. The care plan did not provide specific care actions for caregivers for heart failure, and hypertension.

RI#4 was admitted to the facility on March 30, 2023, with admitting diagnoses of diabetes mellitus type 2 (DMII), hypertension (HTN), coronary artery disease (CAD), congestive heart failure (CHF), hyperlipidemia (HLD), pulmonary hypertension (PHTN), chronic venous insufficiency (CVI), obstructive jaundice continuous positive airway pressure (OJ CPAP) and polycythemia vera (PV). The care plan did not provide specific care actions for caregivers for congestive heart failure and diabetes mellitus.

During an interview with EI#5 on the morning of

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A 611	Continued From page 13 September 17, 2024, EI#5 agreed the care plans needed care actions and she would revise them.	A 611		
A 901	420-5-4-.09 (1) (2) Laundry. (1) General. (a) Direction and Supervision. Responsibility for laundry services shall be assigned to an employee. (b) Linen. Linens shall be handled, stored, processed, and transported in a manner consistent with generally accepted infection control practices. (2) Location and Space Requirements. (a) Each assisted living facility shall have laundering facilities unless commercial laundries are used. An on-site laundry shall be located in a specifically designated area, and there shall be adequate rooms and spaces for sorting, processing, and storage of soiled material. Laundry rooms in Group and Congregate facilities shall not open directly into resident rooms or food service areas. Domestic washers and dryers which are for the exclusive use of residents may be provided in resident areas, provided they are installed in such a manner that they do not cause a sanitation problem or offensive odors. (b) Each assisted living facility shall have a system in place to keep clean linen and dirty linen separated and to prevent the reuse of dirty linen before it is cleaned. Dirty linens and clothing shall not be stored, even temporarily, in the area set aside for clean linen.	A 901		

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A 901	Continued From page 14 (c) Ventilation of Laundry. Provisions shall be made for proper mechanical ventilation of the laundry, if located within the assisted living facility. Provisions shall also be made to prevent the re-circulation of air in commercial equipment laundries into the heating and air conditioning systems outside the laundry area. (d) Lint Traps. Adequate, effective, and clean lint traps shall be used in all dryers. This Rule is not met as evidenced by: Based on observation, and interview, the facility failed to ensure lint traps were clean in all dryers. Findings: During a tour of the facility on the morning of September 17, 2024, the surveyor observed the second-floor laundry dryer lint trap was not cleaned. The lint trap was occluded with lint presenting a potential fire hazard. During an interview, on the afternoon of September 17, 2023 with EI#1, EI#1 concurred with the surveyor's observation. EI#1 had staff clean the lint trap.	A 901		
A1101	420-5-4-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All assisted living facilities shall maintain a current written fire safety, relocation, and evacuation	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D4551	A. BUILDING: ______ B. WING ______	C 09/17/2024

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A1101	Continued From page 15	A1101		

plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place.

(b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift of Group and Congregate facilities. All fire drills shall be 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 currently adopted Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years.

(c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 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.

(d) Roller latches are prohibited on doors separating corridors from adjacent spaces.

(e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that:

1. Minimizes leaks and spills.

Alabama Department of Public Health

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A1101	Continued From page 16	A1101		

2. Adequately protects against inappropriate access.

3. Complies with the requirements of the currently adopted Life Safety Code.

(f) Fire Alarm and Sprinkler System.

1. 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).

2. Fire alarm and sprinkler system outages of more than 4 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 within 12 hours or no later than the next duty day, and shall be corrected expeditiously.

3. The fire alarm system and the sprinkler system shall be inspected by licensed, trained, and qualified personnel at least semiannually for compliance with the respective codes. Inspection and testing reports shall be maintained in the facility for a period of at least 3 years.

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A1101	Continued From page 17 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to document fire drills as required. Findings: On the afternoon of September 17, 2024, the surveyor reviewed the facility's fire drill reports and fire alarm and sprinkler inspection reports for 2024 and 2023. No fire drills were documented during the following months of 2023: April 2023 and May 2023. During an interview with EI#1 on the same afternoon, EI#1 concurred with the surveyor's observation that fire drills were not conducted for the months of April 2023 and May 2023. CONNIE CHERRY, REGISTERED NURSE GREGORY ZEITLIN, REGISTERED NURSE	A1101		