STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D3518	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEHALL WEST ASSISTED LIVING	2094 JOHN D ODOM ROAD DOTHAN, AL 36303

(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 August 1, 2024, an unannounced licensure complaint survey was conducted for this 16 bed Assisted Living Facility (ALF) with a census of 16. There was one complaint investigated during this survey. LC#20240221002 was unsubstantiated with 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 420-5-4, Alabama Administrative Code, for Assisted Living Facilities (ALF). The deficiencies cited pose a potential risk of harm to the residents and require 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 experience in the day-to-day operation of the	A 303		

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A 303	Continued From page 1 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 facility staff members observe each resident for	A 303		

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A 303	Continued From page 2 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 observation, interview and record review, the facility administrator failed to ensure residents who had safety and health needs, that exceeded the capability of the facility, were transferred or discharged to an appropriate setting. Findings Employee Identifier (EI)#1 became administrator of the facility in November 2019. During an interview on July 31, 2024, at approximately 3:45 PM, EI#1 stated he/she was aware of the decline in cognition for Resident Identifier (RI)#3, RI#4, and RI#5. EI#1 stated that RI#4 was being discharged in two weeks due to a decline in cognition. EI#1 also advised the surveyor that he/she had spoken to the families of RI#3 and RI#5 about looking for the next level of care. However, upon the surveyors's entrance to the facility no residents had been given a 30-day discharge notice.	A 303		

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A 606	Continued From page 3	A 606		
A 606	420-5-4-.06 (3) (d) Care of Residents. (d) Services Beyond Capability of Assisted Living Facility. Whenever a resident requires hospitalization, medical, nursing, or other care beyond the capabilities and facilities of the assisted living facility, arrangements shall be made to discharge the resident to an appropriate setting, or to transfer the resident promptly to a hospital or other health care facility able to provide the appropriate level of care. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to arrange for or assist residents to obtain necessary services when changes in health conditions and physical abilities occurred or when the residents' care needs were above the level allowed in an ALF. Findings RI#3 was admitted to the facility on December 2, 2019, with diagnosis which includes spinal stenosis, hemiplegia, anemia, chronic kidney disease stage 3, gastroesophageal reflux disease, hypertension, hyperlipidemia, dementia late onset, trigeminal neuralgia, and low back pain. The surveyor asked EI#1 during an interview on July 31, 2024, about RI#3, and EI#1 was aware of the cognitive decline for RI#3. EI#1 stated that RI#3 would not be able to pass a medication awareness test. On July 31, 2024, at approximately 4:15 PM, the surveyor met RI#3 during a facility tour. RI#3 always had a sitter that	A 606		

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A 606	Continued From page 4 was present with RI#3 during daytime hours. The surveyor conducted an interview with EI#4 on August 1, 2024, at approximately 1:26 PM. EI#4 identified RI#3 as not being appropriate for an ALF. EI#4 stated that RI#3 had been declining over the last year. EI#4 stated that RI#1 was confused. EI#4 stated that RI#3 could not read the medication labels due to the decline in RI#3's eyesight. RI#4 was admitted to the facility on December 18, 2023, with diagnosis which includes atrial fibrillation, hyperlipidemia, dementia, and congestive heart failure. The surveyor asked EI#1 during an interview on July 31, 2024, about RI#4, and EI#1 was aware of the cognitive decline for RI#4, and stated RI#4 was being discharged in two weeks due to decline in cognition. EI#1 had not given RI#4 a 30-day discharge notice upon the surveyor entering the facility on July 31, 2024. EI#1 states that the facility doesn't usually issue a 30 day notice instead EI#1 and the resident's family agree on a discharge date. The surveyor conducted an interview with EI#4 on August 1, 2024, at approximately 1:26 PM. EI#4 stated that RI#4 was not appropriate to be in an ALF due to confusion. Also, EI#4 stated that RI#4 had a decline in status over the past six months. EI#4 stated RI#4 would also be in the other ALF building looking for his/her room. RI#4 would be in other residents' rooms at night standing over them. In addition, RI#4 would ask EI#4 several times after medication administration when EI#4 is going to give RI#4 his/her medications. According to Resident Care Communication Logs dated from June 9-July 29, 2024, there was documented incidents ranging from RI#4 standing over other residents in the middle of the night, asking for medication after he/she had	A 606		

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A 606	Continued From page 5 already taken them, and 11PM-7AM shift RI#4 came down the hall fully dressed thinking it was lunch time. Per resident transfer/discharge form dated June 11, 2024, EI#1 had spoken with RI#4's family about RI#4's cognitive decline causing sundowners and they decided to transfer RI#4 to a higher level of care. RI#5 was admitted to the facility on July 13, 2018, with a diagnosis which includes benign essential hypertension, hypothyroidism, dementia, hyperlipidemia, and osteoarthritis. The surveyor asked EI#1 during an interview on July 31, 2024, about RI#5. EI#1 was aware of the cognitive decline for RI#5. During a facility tour on July 31, 2024, at approximately 3:35 PM, the surveyor observed RI#5 in his/her room with a sitter. RI#5 could not tell the surveyor his/her last name and gave an incorrect name. The surveyor asked RI#5 where he/she was living, and RI#5 indicated "Knoxville". RI#5 could not tell the surveyor the date, time, or year, and had inappropriate responses to all questions that the surveyor asked. During a medication awareness test conducted on August 1, 2024, at 11:45 AM RI#5 did recognize his/her name and time noted on the medication pack. During an interview with EI#4 on August 1, 2024, at approximately 2:32 PM, EI#4 stated that RI#5 was confused and had been having a decline in cognition over the last eight months. During another interview the same day EI#5 stated RI#5 was really confused. Per resident transfer/discharge plan communication note, EI#1 spoke with RI#5's family about starting to look for the next level of care for RI#5. The communication note was dated for June 27, 2024. During an interview on August 1, 2024, EI#1 and	A 606		

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A 606	Continued From page 6 EI#3 agreed that RI#3, RI#4, and RI#5 were not appropriate for an ALF and needed placement in a higher level of care facility.	A 606		
A 613	420-5-4-.06 (5) (a) (b) (c) (d) (e) Care of Residents. (5) Medications. (a) Medications as defined in these rules, may be administered to a resident of an assisted living facility only after the drugs have been prescribed specifically for the resident by an individual currently licensed to prescribe medications in Alabama. A currently licensed physician in good standing with the Medical Licensure Commission of any state may prescribe medications to a resident of an assisted living facility only during the initial physical examination. (b) A physician order is required for a resident to manage and have custody of his or her own medications. (c) A resident may have custody of and manage over the counter topical medications with the written approval of a physician. A physician order is not required for over the counter topical medications that are self-administered by residents and approved by the physician for resident possession. (d) Nothing in these rules shall preclude a facility from using a licensed nurse employed by the facility or nursing agency to administer medication to any resident. An RN or LPN shall administer medications to residents in the assisted living facility only in accordance with	A 613		

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A 613	Continued From page 7 physician orders and the Nurse Practice Act. (e) A resident who is incapable of recognizing his or her name, or understanding the facility unit dose medication system, or does not have the ability to protect himself or herself from a medication error shall require medication administration. Medication administration shall be provided only by a physician or by an RN or LPN. If the resident cannot understand or be trained to understand the unit dose medication system used by the facility or cannot protect himself or herself from medication errors by facility staff, the resident will be appropriately discharged. This Rule is not met as evidenced by: Based on observations, resident records and interviews, the facility failed to ensure residents who were unable to protect themselves from a medication error received medication administration by licensed staff. In addition, the facility failed to create a medication identification system for the visually impaired. Findings: Protection From Medication Errors Review of resident records, on July 31 and August 1, 2024, as well as interviews with facility staff, on July 31 and August 1, 2024, revealed the following information. RI#3 has resided at the facility since December 2, 2019. Three out of three staff members interviewed (EI#1, EI#4, and EI#5) reported that RI#3 was frequently confused and required escorts from a sitter to and from the dining room for each meal. EI#1 stated that RI#3 wouldn't be	A 613		

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A 613	Continued From page 8	A 613		

able to pass a medication awareness test. RI#3 also had a decline in his/her eyesight. There wasn't any identification system in place to assist RI#3 with medication identification. Review of the July Medication Administration Record (MAR) revealed RI#3 was receiving medication assistance from unlicensed staff members. Refer to deficiency 605 for more information on RI#3.

RI#4 has resided at the facility since December 18, 2023. Three out of three staff members interviewed (EI#1, EI#4, and EI#5) reported RI#4 was frequently confused. EI#1 was aware of RI#4's cognitive decline and had spoken with family about a higher level of care. EI#1 stated RI#4 was being discharged in two weeks due to cognitive decline. However, record review revealed no 30 day discharge notice had been issued. According to EI#4 (Resident Attendant), RI#4 would ask EI#4 several times after medication administration was completed when EI#4 was going to give RI#4 his/her medications. Review of the July 2024 MAR revealed unlicensed staff administered medication to RI#4. Refer to deficiency 605 for more information on RI#4.

RI#5 has resided in the facility since July 13, 2018. Three out of three staff members interviewed (EI#1, EI#4, and EI#5) reported RI#5 was frequently confused and required a sitter escort to and from the dining room for each meal. EI#1 was aware of RI#5's cognitive decline, but had failed to issue a 30 day notice. RI#5 could not tell the surveyor his/her last name and gave an incorrect name. RI#5 could not tell the surveyor the date, time, or year, and had inappropriate responses to all questions the surveyor asked. Review of the July MAR revealed unlicensed staff administered medication to RI#5. Refer to

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A 613	Continued From page 9 deficiency 605 for more information on RI#5. On August 1, 2024, EI#1 stated licensed staff were being provided to administer medications to all three residents. Unit Dose Medication Identification System RI#3 has resided at the facility since December 2, 2019. During an interview with EI#4 on August 1, 2024, at approximately 1:26 PM, EI#4 stated RI#3's eyesight had gotten worse and RI#3 could not read medication labels anymore. In addition, EI#4 stated since the facility changed to a different pharmacy company the special identification system could not be utilized due to packaging. The facility did not provide RI#3 with a way to identify his/her medicines, therefore, RI#3 could not protect themselves from a medication error by staff.	A 613		
A 614	420-5-4-.06 (5)(f)(g)(6)(7)(a)-(i) Care of Residents. (f) A resident may self-manage his or her medications. For the purposes of these rules, self-manage shall mean the resident is capable of maintaining possession and control of his or her medications, who does maintain possession and control of his or her medications, and self-administers his or her medications without creating an unreasonable risk to health and safety. (g) A resident that cannot self-manage his or her own medication without creating an unreasonable risk to health and safety may be assisted with self-administration of medication by any assisted living facility staff, including staff members who hold no professional licensure	A 614		

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A 614	Continued From page 10 provided: 1. The resident can and does identify his or her name on the medication package and has a reasonable understanding of the unit dose packaging system in use by the facility such that the resident could protect himself or herself from medication errors when unit dose packages are brought to the resident by facility staff. The resident shall have the opportunity to demonstrate his or her ability to correctly utilize the unit dose package system at every opportunity for medication use. (6) Assistance with self-administration of medication includes the following practices: (a) Reminding a resident that it is time to take a medication or medications, where such medications have been prescribed for a specific time of day, a specific number of times per day, specific intervals of time, or for a specific time in relation to mealtimes or other activities such as arising from bed or retiring to bed. (b) Physically assisting a resident by opening or helping to open a container holding medications. (c) Offering liquids to a resident to assist that resident in ingesting oral medications. (d) Physically bringing a container of medication to a resident. (7) Assistance with self-administration of medications shall under no circumstances include any of the following practices:	A 614		

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A 614	Continued From page 11 (a) Medication administration as defined in these rules. (b) Determining the amount of medication to be given. If a medication is not available in unit dose packaging, unlicensed facility staff may measure the prescribed amount of medication only under the direction and control of the resident, provided that the resident is capable of determining the amount of medication to be given. (c) Giving a resident injections of any kind. (d) Telling or reminding a resident that it is time to take a PRN, or as needed medication. (e) Placing medications in a feeding tube. (f) Giving enemas or suppositories. (g) Crushing or splitting medications, provided that a physician has ordered a specific medication to be crushed or split and the resident is capable of self-managing his or her own medication or the resident is capable of medication self-administration with assistance and would be capable of crushing or splitting his or her own medications but for limitations of mobility or dexterity, may be assisted with crushing or splitting medications by unlicensed staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and	A 614		

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A 614	Continued From page 12 procedure to ensure safe practices by facility staff. (h) Mixing medications with food or liquids, provided that a physician has ordered a medication to be mixed with food or liquid and the resident is capable of self-managing his or her own medications or the resident is capable of medication self-administration with assistance and would be capable of mixing his or her own medications with food or liquid but for limitations of mobility or dexterity, may be assisted with mixing medications with food or liquid by unlicensed staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. (i) Assisting with self-administration of eye drops, eardrops, nose drops, inhalers, nebulizers, or topical medications, provided that a resident who is capable of self-managing his or her own medication or a resident who is capable of medication self-administration with assistance and who would be capable of self-administration of his or her own medications but for limitations of mobility or dexterity, may be assisted with eye drops, ear drops, nose drops, inhalers, nebulizers, or topical medications by unlicensed facility staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff.	A 614		

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A 614	Continued From page 13 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a resident who was visually impaired and assisted with medications by staff, was able to utilize the unit dose packaging system. RI#3 was admitted to the facility on December 2, 2019. A medication awareness test was performed on August 1, 2024, at approximately 1:55 PM. EI#2 performed the medication awareness test and RI#3 was presented with two medication packs. The medication awareness test included one pack with RI#3's name and the other pack had a different name. RI#3 couldn't read the name on the pack that wasn't his/hers but was able to read the pack with his/her name on it. RI#3 was asked multiple times to identify the name on the pack that wasn't his/hers. RI#3 finally got agitated due to not being able to read it. RI#3 stated, "I will just pretend". During an interview afterwards, EI#2 stated "RI#3 just couldn't do it". Refer to deficiency 606 for more information on RI#3. TROY BLACK, REGISTERED NURSE	A 614		