

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D2603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/14/2019
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NAME OF PROVIDER OR SUPPLIER AUTUMN PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 5930 MAIN STREET MILLBROOK, AL 36054
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A 000	<p>Initial Comments</p> <p>On August 14, 2019 an unannounced licensure survey was conducted for this 16 bed Assisted Living Facility (ALF) with a census of 12.</p> <p>There was one complaint investigated during this survey. LC#256-2017 was unsubstantiated and no deficiencies were cited as a result of the complaint investigations.</p> <p>Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities. The deficiencies cited pose a potential risk of harm to the residents and require a plan of correction.</p>	A 000		
A 402	<p>420-5-4-.04 (3) Personnel.</p> <p>(3) Employee Screening.</p> <p>(a) Prior to any resident contact, such as but not limited to assistance with activities of daily living, newly employed personnel shall have a physical examination certifying that the employee is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to residents through normal staff to resident contact. Employees who develop signs or symptoms of infectious skin lesions or diseases that would be capable of transmission to residents through normal staff to resident contact shall not be permitted to have resident contact until free from such signs and symptoms.</p> <p>(b) Not more than 30 days prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis.</p>	A 402		

Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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A 402	<p>Continued From page 1</p> <p>(c) Vaccines. Assisted living facilities shall immunize employees in accordance with current recommended Centers for Disease Control and Prevention (CDC) guidelines (www.cdc.gov/vaccines). Any particular vaccination requirement may be waived or delayed by the State Health Officer in the event of a vaccine shortage.</p> <p>(d) An assisted living facility shall not hire an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure each employee was screened through the nurse aide abuse registry prior to being hired.</p> <p>Findings:</p> <p>Employee Identifier (EI)#4's date of hire was listed as May 1, 2018. EI#4's nurse aide screening was dated May 3, 2018, two (2) days after EI#4 was hired. The nurse aide abuse screening was not completed prior to the hire date as required. EI#1, Administrator, agreed the abuse screening was obtained two days after EI#4 was hired.</p>	A 402		
A 611	<p>420-5-4-.06 (4) (a) (b) Care of Residents.</p> <p>(4) Personal Care and Services. The facility shall provide care and services consistent with community standards.</p>	A 611		

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A 611	<p>Continued From page 2</p> <p>(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.</p> <p>(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.</p> <p>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:</p> <p>2. A listing of the resident's individual needs or problems that require intervention by the facility.</p> <p>3. A listing of interventions provided by the facility to address the resident's identified needs or problems.</p>	A 611		

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A 611	<p>Continued From page 3</p> <p>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.</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(iii) Hair. Resident's hair shall be kept clean, neat, and well groomed.</p> <p>(iv) Manicure. Fingernails and toenails shall be kept clean and trimmed.</p> <p>(v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed.</p> <p>(vi) Personal Safety. Residents shall be provided assistance with personal safety.</p> <p>6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes</p>	A 611		

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A 611	<p>Continued From page 4</p> <p>shall be documented.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain current and appropriate resident Care Plans (CP) for all residents.</p> <p>THIS IS A REPEAT DEFICIENCY FROM PREVIOUS SURVEY(S) CONDUCTED ON MARCH 8, 2017, OCTOBER 20, 2016 AND OCTOBER 31, 2013.</p> <p>Findings:</p> <p>Resident Identifier (RI)#1 was admitted to the facility on May 15, 2017 with diagnoses which included congestive heart failure, atrial fibrillation and had a history of a stroke. RI#1 was admitted to hospice services on August 29, 2018 with a terminal diagnosis of heart failure. Review of RI#1's medical exam and plan of care, dated March 28, 2018, revealed RI#1 required intervention with falls. Physical therapy was to be arranged. The CP was not updated to include hospice services and fall risk with interventions. The CP was not current and inadequate in addressing hospice services and fall prevention with interventions to assist the care staff in providing care for RI#1.</p> <p>RI#2 was admitted to the facility on December 27, 2016 with diagnoses which included chronic obstructive pulmonary disease, chronic respiratory failure and history of pneumonia. RI#2 had a physicians' order dated December 3, 2018 to self administer nebulized breathing treatments (ipratropium/albuterol solution 1 vial</p>	A 611		

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A 611	<p>Continued From page 5</p> <p>four times daily). The surveyor observed the nebulizer machine at bedside in RI#2's room. The CP, dated November 13, 2018, did not list these respiratory diagnoses and did not address self-administering of breathing treatments by RI#2. The CP was not updated and did not address all of RI#2's problems and needs, therefore there were no interventions in place for care staff to follow to provide appropriate and necessary care required for RI#2.</p> <p>RI#3 was admitted to the facility on April 3, 2019 with diagnoses which included angina pectoris, diabetes mellitus, heart failure, major depressive disorder and anxiety. Review of RI#3's CP revealed these pertinent diagnoses were not addressed on the CP, therefore there were no interventions in place for the care staff to follow in providing care and addressing needs for RI#3.</p> <p>RI#4 was admitted to the facility on February 2, 2018 with diagnoses which included type II diabetes mellitus (non-insulin dependent) and was admitted to hospice services on November 12, 2018 with a terminal diagnosis of heart disease and congestive heart failure. The CP did not address management of diabetes and the services provided by hospice, therefore no interventions were in place for the care staff to follow.</p> <p>The surveyor reviewed the CP expectations with EI#1 who verbalized understanding and agreed to update the CP accordingly.</p>	A 611		
A 617	<p>420-5-4-.06 (8) Care of Residents.</p> <p>(8) Disposal of Medications.</p>	A 617		

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A 617	<p>Continued From page 6</p> <p>1. Controlled substances and legend drugs dispensed to residents, that are expired or unused because the medication is discontinued or because the resident dies, shall be destroyed within 30 days. Unused legend drugs that are not expired may be donated to a charitable clinic pursuant to Alabama Administrative Code, Chapter 420-11-11. Under no circumstances should expired, discontinued, or unused medications be stored or housed in the facility beyond 30 days.</p> <p>2. Medications of residents who are discharged or transferred to another facility shall be returned to the residents. The responsible party will sign a statement that these medications have been received. The statement shall list the pharmacy, prescription number, date, resident's name and strength of the medication, and the amount. This statement shall be maintained in a file for at least three years.</p> <p>3. When medications are destroyed on the premises of the assisted living facility, a record shall be made and retained for at least 3 years. This record shall include: the name of the assisted living facility, the method of disposal, the pharmacy, the prescription number, the name of the resident, the name, strength, and dosage of the medication, and the amount and the reason for the disposal. This record shall be signed and dated by the individual performing the destruction and by at least one witness.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to complete medication disposition forms</p>	A 617		

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A 617	Continued From page 7 as required. Findings: RI#5 was admitted to the facility on April 11, 2016 and discharged from the facility on August 4, 2018. The Medication Release Form for RI#5, which was completed on August 4, 2018, documented release of RI#5's medication to RI#5's sponsor. However, the form did not contain documentation of the pharmacy name and the strength of the medication as required. EI#1 agreed the documentation was incomplete.	A 617		
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 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	A1101		

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A1101	<p>Continued From page 8</p> <p>effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years.</p> <p>(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.</p> <p>(d) Roller latches are prohibited on doors separating corridors from adjacent spaces.</p> <p>(e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that:</p> <ol style="list-style-type: none"> 1. Minimizes leaks and spills. 2. Adequately protects against inappropriate access. 3. Complies with the requirements of the currently adopted Life Safety Code. <p>(f) Fire Alarm and Sprinkler System.</p> <ol style="list-style-type: none"> 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 	A1101		

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A1101	<p>Continued From page 9</p> <p>that corridor smoke detection shall not be deleted when its use is dictated by other requirements).</p> <p>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.</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to have the fire alarm system inspected semiannually as required.</p> <p>Findings:</p> <p>Review of the facility's fire alarm system inspections on August 14, 2019, revealed there was no documentation of inspections for the year of 2018. EI#1 stated the inspections had been done but could not provide the documentation. An inspection of the fire alarm system had been inspected on March 3, 2019.</p> <p>SUSAN OVERTON, REGISTERED NURSE</p>	A1101		

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