STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015127	A. BUILDING _____ B. WING _____	05/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSHIRE HEALTHCARE CENTER	4320 JUDITH LANE HUNTSVILLE, AL 35805

(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) COMPLETION DATE
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of a policy tilted "Abuse Policy" the facility failed to ensure an allegation of verbal abuse was reported to the State Agency within 2 hours. This affected one of five abuse records reviewed during the survey and Resident Identifier (RI)	F 609	"This Plan of Correction in response to the statement of deficiencies demonstrates our good faith and desire to continue to improve the Quality of Care and Services. The answers do not, however, constitute an admission that the citations are accurate in any respect."	5/22/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/31/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 609	Continued From page 1 #165 and RI #25. Findings Include: Review of a policy tilted "Abuse Policy", with an effective date of June 2018, documented: "...Reporting... 1. Any allegation of abuse within two hours..." On 5/20/19 at 12:00 p.m., the surveyor reviewed an online incident report involving an allegation of verbal abuse concerning RI #165 and RI #25. The facility became aware of the incident on 8/14/18 at 6:00 p.m. and did not report the incident until 8/15/18 at 6:18 p.m. On 5/20/19 at 12:42 p.m., an interview was completed with Employee Identifier (EI) #1, Registered Nurse (RN)/Director of Nursing (DON). EI # 1 stated the allegation of abuse concerning RI #165 and RI #25 occurred on 8/14/18 and was reported to the State Agency on 8/15/18. When asked when the allegation should have been reported to the State Agency, EI #1 stated she thought it was 24 hours, but it should have been reported within 2 hours.	F 609	"This Plan of Correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements." F-0609 RI#165 and RI#25 suffered no adverse effects due to this deficient practice. E#1 was educated on the Abuse Policy with emphasis placed on timely reporting to the State Agency. This in-service was done on 5/21/2019, by the Administrator. All managers were educated on the Abuse policy with emphasis on timely reporting to the State Agency. The in-service was conducted by the Administrator on 5/22/2019. All new hired managers will be in-serviced on the abuse policy with emphasis placed on timely reporting to the State Agency on hire and PRN. The Administrator/Designee will ensure that all allegation of abuse will be reported to the State Agency within 2 hours, effective 5/22/19. Any identified concerns will be addressed immediately and reviewed in our Quality Assurance and Performance Improvement Meeting (QAPI) x 3 months following our initial reviews. Documentation of monitoring will be kept in the Director of Nursing Services' Office. The Administrator/Designee will immediately,	

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F 609	Continued From page 2	F 609	beginning 5/22/19, monitor continued compliance of all allegations of Abuse being reported to the state agency within 2-hours of notification, by reviewing daily and/or per allegation of abuse, effective 5/22/19. The Administrator is responsible for overall compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		6/22/19

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F 880	Continued From page 3 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of a facility document titled, "SKILL	F 880	F0880 RI #10 suffered no negative outcome as a	

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F 880	Continued From page 4 7-1 Hand Hygiene", the facility failed to ensure a licensed nurse washed their hands after removing gloves and prior to administering Resident Identifier (RI) #10's eye drop medication. Further, the licensed nurse left RI #10's room after administering medications and returned to the medication cart without first washing hands. This affected one of two residents observed during medication administration pass receiving an eye drop medication and one of four nurses observed during medication administration pass. Findings Include: Review of a facility document titled "SKILL 7-1 Hand Hygiene", undated, revealed the following: "... The most important and basic technique in preventing and controlling transmission of infection is hand hygiene. ... 3... a. Before and after having direct contact with patients. ... c. After contact with body fluids or excretions, mucous membranes... e. When moving from a contaminated body site to a clean body site during patient care... g. After removing gloves..." RI #10 was admitted to the facility on 3/25/15 and readmitted on 12/14/15. On 5/19/19 at 8:34 a.m., Employee Identifier (EI) #2, Licensed Practical Nurse (LPN), was observed administering medications to RI #10. After giving RI #10's medications by mouth, EI #2 did not wash hands prior to putting on gloves to administer RI #10's eye drops. EI #2 then left RI #10's room and returned to the medication cart to sign the medications off on the Medication	F 880	result of this deficient practice. EI #2 was educated on hand hygiene during eye drop medication administration by the Director of Clinical Education on 5/19/2019. Nurses were in-serviced on hand hygiene during eye drop medication administration on 5/19/2019 and 5/28/2019 by the Director of Clinical Education. All new Nurses will be in-serviced on Hand Hygiene during eye drop medication administration on hire and PRN. The Director of Clinical Education/Designee will perform random check offs on hand hygiene during eye drop medication administration twice weekly on varied shifts X 4 Weeks, bi-weekly X 1 month and monthly X 1 beginning 5/22/2019. Any identified concerns will be addressed immediately and reviewed in our Quality Assurance and Performance Improvement Meeting (QAPI) X 3 months following our initial reviews. Documentation of monitoring will be kept in the Director of Nursing Services' office. The Administrator is responsible for overall compliance.	

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F 880	Continued From page 5 Administration Record, without first washing hands. On 5/19/19 at 3:39 p.m., EI #2, LPN, was interviewed. When asked what was done after administering RI #10's medications by mouth, EI #2 said he put on gloves without washing hands. EI #2 further stated after he administered RI #10's eye drops, he removed gloves and returned to the medication cart without washing hands. When asked what should have been done, EI #2 said wash hands before putting on gloves and after removing them for infection control reasons. EI #3, the Infection Control Preventionist, was interviewed on 5/19/19 at 3:45 p.m.. When asked what the facility's policy was on hand hygiene during medication administration, including by mouth medications and eye drops. EI #3 said wash hands, dry hands, and put on gloves. EI #3 said if a nurse did not wash hands after removing gloves, the concern would be infection control and it could cause an infection to a resident. ANGELA PARKER, SOCIAL WORKER ALICE HADAWAY, REGISTERED NURSE GLORIA PORTER, REGISTERED NURSE DEBORAH CAMPBELL, REGISTERED NURSE	F 880		