

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D4519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2019
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NAME OF PROVIDER OR SUPPLIER COUNTRY COTTAGE HUNTSVILLE IVY	STREET ADDRESS, CITY, STATE, ZIP CODE 4200 CHRIS DRIVE HUNTSVILLE, AL 35802
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(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	<p>Initial Comments</p> <p>On December 4, 2019 an unannounced licensure survey was conducted for this 16 bed Assisted Living Facility (ALF) with a census of 9.</p> <p>There were no complaints investigated during this survey.</p> <p>A deficiency was 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 deficiency poses a potential risk of harm to the residents and requires a plan of correction.</p>	A 000		
A 601	<p>420-5-4-.06 (1) Care of Residents.</p> <p>(1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician.</p> <p>(a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her choice. If the resident is unable to designate an attending physician, or does not wish to designate an attending physician, the facility shall assist the resident in identifying an attending physician who will serve the resident. A resident shall be permitted to change the designation of his or her attending physician at any time. Whenever a resident requires medical attention, an attempt shall first be made to contact the resident's attending physician, except in medical emergencies requiring activation of the local EMS system (911 or another emergency call).</p> <p>(b) Back-up Physician Support. Each</p>	A 601		

Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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A 601	<p>Continued From page 1</p> <p>assisted living facility shall have an agreement with one or more duly licensed physicians to serve in those instances when a resident's own attending physician cannot be reached, and to provide temporary medical attention to any resident whose attending physician is temporarily not available. A nurse practitioner or physician's assistant shall not serve as the back-up physician in an assisted living facility.</p> <p>(c) All physician orders shall be written in accordance with community standards. If verbal orders are used, they are to be used infrequently. A physician verbal order shall only be accepted by an RN or LPN employed by the facility and authorized to do so by facility policy and procedures and state law. All verbal orders shall be reduced to writing on the physicians' order sheet by a licensed facility nurse and shall be dated and signed by the nurse receiving the order. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, or another practitioner who is responsible for the care of the resident and authorized to write orders by facility policy. All verbal orders must be authenticated within such time period as provided by facility policy, but in no case shall exceed 30 days following entry of the order.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow the physician's order for one resident's medication.</p> <p>Findings:</p>	A 601		

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A 601	<p>Continued From page 2</p> <p>On December 2, 2019 around 4:00 PM, the surveyor observed Employee Identifier (EI)#6 provide medication assistance to Resident Identifier (RI)#1. RI#1 was admitted to the facility on August 12, 2019 and had diagnoses which included paroxysmal atrial fibrillation, hypertension and history of pacemaker placement. RI#1 had a physician's order for Rhythmol (a medication to treat and prevent serious irregular heart rhythms) 225 milligrams three times daily. The medication was scheduled to be taken at 6:00 AM, 12:00 noon and 4:00 PM. Although a sealed and labeled package was present for the Rhythmol, no medication was in the sealed package. Upon further investigation by the facility, the medication had not been sent from the pharmacy as ordered and RI#1 had missed doses of the Rhythmol since November 30, 2019. The missed doses were circled on RI#1's Medication Administration Record (MAR), indicating they were not given due to unavailable. However, the pharmacy had not been contacted to order the missing doses and RI#1's physician had not been notified of the missed doses. An immediate plan of correction was requested by the surveyor and RI#1 resumed taking the Rhythmol on the evening of December 2, 2019.</p> <p>CONNIE CHERRY, REGISTERED NURSE</p>	A 601		