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GABLES ASSISTED LIVING AT CHARLTON PLACE, TI	65 CHARLTON PLACE DEATSVILLE, AL 36022

(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 October 13, 2022, an unannounced licensure survey and complaint investigation was conducted for this 24 bed Assisted Living Facility (ALF) with a census of 12. There were four (4) complaints investigated during this survey. Intake ID: 20181007010 unsubstantiated Intake ID: 20181210009 substantiated with a deficiency cited Intake ID: 20190204002 substantiated but no deficiency cited Intake ID: 20190605017 unsubstantiated 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 risk or potential risk of harm to the residents and requires a plan of correction.	A 000		
A 402	420-5-4-.04 (3) Personnel. (3) Employee Screening. (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	A 402		

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contact shall not be permitted to have resident contact until free from such signs and symptoms.

(b) Not more than 30 days prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis.

(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.

(d) An assisted living facility shall not hire an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry.

This Rule is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure all employees had a physical examination (PE) certifying the employee was free of infectious diseases prior to resident contact. In addition, the facility failed to provide evidence all employees were evaluated for tuberculosis (TB) prior to resident contact.

Findings:

On October 13, 2022, the surveyor reviewed six (6) employee files with Employee Identifier (EI)#1, Administrator .

The following six (6) employees did not have a free from infectious disease PE on file, EI#1,

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Administrator, EI#2, Assistant Administrator, EI#7, Resident Care Aide (RCA), EI#8, RCA, EI#9, RCA, and EI#10, RCA. The following five (5) employees did not have a tuberculosis evaluation on file, EI#1, EI#2, EI#7, EI#9, and EI#10.

EI#1, explained to the surveyor the TB evaluations had been done for all employees at the time of hire, but did not have the supporting documentation available. EI#1 said a new process had been put into place and the infection control nurse would be monitoring the employees TB screenings and documentation. EI#1 also informed the surveyor the PE form was going to be revised to include a statement from the physician the employee was free from infectious diseases.

A 403 420-5-4-.04 (4) Personnel. A 403

(4) Personnel Records. An assisted living facility shall maintain a personnel record for each employee. This record shall contain:

(a) An application for employment which contains information regarding the employee's education, training, and experience.

(b) Verification of current certification or licensure, if applicable.

(c) Record of required physical examinations and vaccinations.

(d) Verification the facility has not hired an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry.

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A 403	Continued From page 3 (e) Date of hire. (f) Date of initial resident contact. (g) Date employment ceased. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain complete personnel records. Findings: On October 13, 2022, the surveyor reviewed the employee files with EI#1, Administrator. The date of initial resident contact was not documented for EI#1, EI#2, EI#7, EI#8, EI#9, and EI#10. EI#1, Administrator told the surveyor she (EI#1) would inform the Human Resource Manager, EI#11, to include this date in all employee files.	A 403		
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	A 405		

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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 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

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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 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 interview, the facility failed to provide staff with training in special needs of diabetic residents.

Findings:

The facility admitted and retained residents with diabetes mellitus. Resident Identifier (RI)#3, RI#4, and RI#6 were currently being treated for

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A 405	Continued From page 6 diabetes, however, the employee files did not have documented training for this special need. On October 13, 2022, EI#1 informed the surveyor this would be added to the initial training for all staff.	A 405		
A 508	420.5.4-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in an assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review. 1. Incidents which require investigation are: (i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as bruising, pain, or injury that is not consistent with actions necessary in providing day to day care to a resident or for which medical treatment was sought. (ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid, including but not limited to: a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office. (iii) The onset of wandering behavior by	A 508		

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any resident who is not fully cognitively intact.

(iv) Elopement by a resident.

(v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules.

(vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules.

(vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules.

(viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I of Alabama Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or Staphylococcus aureus).

(ix) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility.

(x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident.

(xi) An unplanned occurrence that results

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A 508	Continued From page 8 in media attention. (xii) A medication error, overdose, or over sedation. (xiii) Ingestion by a resident of a toxic substance that requires medical attention. (xiv) Any indication of malfunction of the sprinkler system, or fire alarm system. 2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following: (i) Names of all residents involved. (ii) Names of all staff involved including person in charge at the time of the incident. (iii) When the administrator was notified (date and time). (iv) Circumstances under which the incident occurred. (v) When the incident occurred (date and time). (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken. (viii) The extent and description of injury, if any, to the affected resident or residents. (ix) Immediate treatment rendered.	A 508		

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(x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified.

(xi) Names, telephone numbers, and addresses of witnesses.

(xii) Date and time relatives or sponsor were notified.

(xiii) Out-of-facility treatment.

(xiv) Follow-up care.

(xv) Outcome resolution.

(xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future.

(xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation.

(xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request.

(xix) The entire investigative file and documentation of all corrective action taken shall be retained for a period of not less than 3 years after the resident is discharged or dies.

(xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff.

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3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident:

(i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention as defined in these rules.

(ii) Elopement by a resident.

(iii) Suspected, alleged, confessed, or witnessed abuse, neglect, or exploitation of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file.

(iv) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility.

(v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident.

(vi) An unplanned occurrence that results in media attention.

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(vii) Any medication error, overdose, or over sedation. The incident shall be immediately reported to the attending physician, facility medical director, or back-up physician.

(viii) Ingestion by a resident of a toxic substance that requires medical attention.

(ix) Notifiable diseases and health conditions listed in Appendix I of the Alabama Administrative Code Sec. 420-4-1-.04. shall be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1-.04. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than 3 years.

(x) Any indication of malfunction of the sprinkler system, or fire alarm system.

4. The report to the Department's Online Incident Reporting System shall include the following:

(i) Facility name and direct phone number.

(ii) Time and date of the report.

(iii) Reporter's name.

(iv) Name of resident(s), staff, or visitor(s) involved in the incident.

(v) Names of staff on duty at the time of the incident.

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A 508	Continued From page 12 (vi) Date and time of the incident. (vii) A brief description of the incident. (viii) Any injury or injuries to resident(s). (ix) Action taken by the facility in response to the incident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report an outbreak of a contagious disease to the Department's Online Incident Reporting System (OIRS) within 24 hours of the diagnosis (Code 420-4-1-.04). Findings: A review of the OIRS on October 11, 2022, by the surveyor revealed no positive cases of COVID-19 had been reported by the facility. During the survey the surveyor learned there had been an outbreak of COVID at the facility during August 2022. EI#1, Administrator, explained there were six (6) positive cases that had been reported to the COVID-19 National Healthcare Safety Network (NHSN). However, the facility did not report the outbreak to the ALF OIRS within 24 hours of the positive test results. The surveyor reviewed the disease reporting requirements with EI#1 and she (EI#1) verbalized understanding and agreed to comply in the future.	A 508		

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A 601	420-5-4-.06 (1) Care of Residents.	A 601		

(1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician.

(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).

(b) Back-up Physician Support. Each 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.

(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

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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.

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure that all resident care was under the direction of a physician.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON OCTOBER 10, 2018.

Findings:

RI#3 was admitted to the facility on September 5, 2022, with diagnoses to include, chronic hypoxemia and obstructive sleep apnea. On October 12, 2022, at 2:00 PM, the surveyor observed RI#3 receiving three (3) liters of oxygen via a concentrator in her/his room. RI#3 told the surveyor she/he wears the oxygen most of the time. A review of RI#3's record revealed there was not a physician's order for RI#3 to receive oxygen therapy.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLES ASSISTED LIVING AT CHARLTON PLACE, TI	**65 CHARLTON PLACE DEATSVILLE, AL 36022**

(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 601	Continued From page 15 EI#2, Assistant Administrator, agreed there was not an order for oxygen therapy and contacted the physician. Later that afternoon an order was received via fax to administer oxygen 2-4 LPM on exertion.	A 601		
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.	A 602		

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A 602	Continued From page 16 4. Documentation of evaluation for 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	A 602		

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A 602	Continued From page 17 following: 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 record reviews and interviews, the facility failed to obtain all the required baseline information on the Initial Medical Examination. The facility also failed to obtain documentation of evaluation of tuberculosis prior to admission. In addition, not all residents had an Annual Physical Examination completed. Findings: Initial Medical Examination: RI#3 was admitted to the facility on September 5, 2022, and the initial medical examination was dated August 15, 2022. The physician failed to document RI#3's baseline temperature and weight. Tuberculosis Evaluation: RI#3 did not have documentation of evalaution for tuberculosis within the previous 12 months prior to admission (9/5/22). RI#3 told the surveyor she/he had a chest x-ray in the hospital not long	A 602		

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before coming to the facility. EI#2 said she (EI#2) had previously requested the family to obtain a copy of the chest x-ray but documentation was not provided during the survey.

Annual Physical Examination:

RI#2 had been a resident at the facility since November 22, 2014. RI#2 had not been examined annually by a physician. There was a Medical Examination (not dated) on file with a fax date of May 24, 2021. EI#2 confirmed a physical exam was due but had not been completed for RI#2.

A 604 | A 604

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

(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

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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 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 reviews and interviews, the facility failed to complete monthly assessments for all residents, document identified changes in resident status, assess the resident's ability to safely self administer medications with assistance, and weigh and record the weight of each resident monthly.

Findings:

Monthly Assessments:

On October 12, 2022, at 10:20 AM during an interview EI#2 informed the surveyor she (EI#2) did not document her (EI#2) monthly

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assessments. EI#2 explained she (EI#2) visited each resident around the middle of the month to ask about their medicines and weigh them. EI#2 also told the surveyor she (EI#2) did not assess any of the residents during the months of July 2022, or August 2022. Later in the morning the surveyor discussed the concerns with EI#1. EI#1 told the survyor her (EI#1) expectation was for EI#2 to document her (EI#2) assessments monthly and to inform her (EI#1) when monthly assessments were not done. EI#1 told the surveyor she (EI#1) would immediately retrain EI#2.

Monthly Medication Awareness:

During an interview with EI#2 on October 12, 2022, the surveyor inquired how the residents were assessed monthly to determine their ability to safely self administer their medications with assistance from staff. EI#2 informed the surveyor she (EI#2) did not assess the residents ability to protect himself or herself from a medication error. The surveyor reviewed the process with EI#1 and EI#2 and they agreed to comply.

Monthly Weights:

During review of the monthly weights for 2022, (January - September) the surveyor found that none of the residents had weights recorded for the months of July 2022 and August 2022. EI#2 said she (EI#2) could not remember why she (EI#2) did not check the resident's weights in July 2022, but she (EI#2) was sick in August 2022.

On October 13, 2022, EI#1 and EI#2 verbalized understanding of the rules and stated they would immediately comply with proper health supervision of the residents.

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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 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.	A 611		

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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 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.

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A 611	Continued From page 23 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 reviews and interview, the facility failed to update ALF Care Plans with appropriate interventions to address current care needs for all residents. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON OCTOBER 10, 2018. Findings: Resident Identifier (RI) RI#2 had been residing at the facility since November 22, 2014, with diagnoses to include hypothyroidism, hyperlipidemia, and osteoporosis. On May 4, 2020, RI#2 was seen by the nurse practitioner (NP) after a fall sustaining a skin tear to the left upper extremity. RI#2's care plan was not updated to address this fall and interventions were not in place for the care staff to assist with fall prevention. The staff asked the NP see RI#2 on April 20, 2021, due to her/his low vision. The NP wrote in the Progress Note the low vision was due to macular degeneration and glaucoma. A Medical Examination with a fax date of May 24, 2021, included macular degeneration as a diagnosis. The care plan did not mention this new diagnoses or include safety interventions due	A 611		

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A 611	Continued From page 24 to impaired vision. A podiatry exam was completed on July 18, 2022, and RI#2 was found to have peripheral vascular disease. According to the report "The staff was advised to visually inspect the patient's feet and to report any problems ASAP." This was not addressed on the care plan. On August 9, 2022, RI#2 tested positive for COVID-19 and was seen by the NP for nasal congestion and fatigue. The care plan was not updated to include this change in condition. RI#3 was a recent admission to the facility on September 5, 2022, with diagnoses to include chronic hypoxemia, coronary artery disease, obstructive sleep apnea (OSA), osteoarthritis and Type 2 diabetes. The diabetes was mentioned on the care plan, but there were no interventions in place to recognize complications related to diabetes. The care plan did not list any of the other significant diagnoses related to heart disease or respiratory distress with interventions to observe for or report. The care plan listed oxygen as a need but it did not give the amount of liters per minute that was to be administered. RI#5 was admitted to the facility on April 12, 2022, with diagnoses to include congestive heart failure, (CHF), chronic kidney disease, muscle weakness, hypertension, atrial fibrillation, and restless leg syndrome. The only diagnoses listed on the care plan was CHF and hypertension, but there were no interventions provided for the staff. On May 24, 2022, RI#5 was treated for a urinary tract infection (UTI). The care plan did not provide any signs or symptoms to monitor in the event of another UTI or preventive measures. RI#5 was seen by the NP on July 10, 2022, for significant symptoms of depression and anxiety. The care plan did not address this new diagnosis with	A 611		

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A 611	Continued From page 25 appropriate interventions. On July 19, 2022, RI#5 had a follow-up exam with the NP due to edema of her/his lower extremities. The care plan was not updated to include this problem or list interventions to help prevent edema of the lower extremities. On October 13, 2022, the survyor discussed the care plan expectations with EI#1 and EI#2. They both verbalized understanding and agreed to comply.	A 611		
A 612	420-5-4-.06 (4) (c) (d) (e) (f) Care of Residents (c) The facility shall offer appropriate activity programs to each resident, maintaining supplies and equipment as necessary to implement the activity programs. Every day the facility shall provide activities appropriate to each resident. (d) Pets residing at the facility or used in activity programs shall be in good health and shall have current vaccinations as required by law. Vaccination certificates, or copies of vaccination certificates, shall be kept on file at the facility to demonstrate compliance with this requirement. (e) Mail, Telegrams, and Other Communications. 1. Incoming mail, telegrams, and other written communications addressed to the resident shall be delivered to the resident unopened. Outgoing mail shall be promptly delivered to regular postal channels upon receipt from the resident. Residents shall be permitted to place and receive telephone calls at the facility in	A 612		

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complete privacy.

2. Personnel of the facility shall assist residents with communications, such as writing letters or assisting with writing letters, or reading mail out loud if requested to do so.

(f) Appointments. Residents shall be assisted in making and keeping appointments.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to provide activities appropriate to each resident every day.

THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

Findings:

The Alabama Department of Public Health received a complaint there was a calendar, but no activities offered for the residents. On October 11, 2022 at 1:25 PM, the surveyor heard RI#2 ask EI#2 if anything was going on this afternoon and EI#2 replied no.

On October 12, 2022, the surveyor reviewed the current calendar with EI#6, Activity Coordinator. EI#6 informed the surveyor she (EI#6) was just hired (9/27/22) for the activity position and only worked on Wednesday, Thursday, and Friday. EI#6 acknowledged there were no activities offered on Saturday, Sunday, Monday or Tuesday. The surveyor reviewed the rule with EI#6 and she (EI#6) said she (EI#6) would immediately make arrangements for activities to

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A 612	Continued From page 27 be made available for the residents on her days off.	A 612		
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 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	A1101		

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A1101	Continued From page 28 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. 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	A1101		

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	D0108	A. BUILDING: ______ B. WING ______	10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLES ASSISTED LIVING AT CHARLTON PLACE, TI	65 CHARLTON PLACE DEATSVILLE, AL 36022

(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
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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.

This Rule is not met as evidenced by:
Based on observation, record reviews, and interviews, the facility failed to provide written observations of the effectiveness of the fire drills for each unit located in the building.

Findings:

On October 12, 2022, the surveyor reviewed the 2020, 2021, and 2022, Fire and Safety documentation with EI#4, Maintenance Director. The surveyor was informed the ALF fire drills are conducted simultaneously with the Long Term Care (LTC) unit. However, the facility was not writing the observation of the effectiveness of the fire drills for the ALF unit on a Monthly Fire Drill Report. EI#4 stated he (EI#4) would immediately start documenting his (EI#4) monthly observations and file those reports in a separate binder.

DEBRA FREEMAN, REGISTERED NURSE