Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D3904	A. BUILDING: ______ B. WING ______	03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEESTONE OF FLORENCE	**201 NORTH CEDAR STREET FLORENCE, AL 35630**

(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 March 17, 2021, an unannounced licensure survey and complaint investigation was conducted for this 43 bed Assisted Living Facility (ALF) with a census of 28. There was one complaint investigated during this survey. Complaint #20210308006 was investigated and portions of the complaint were substantiated. Deficiencies were 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. The deficiencies cited pose a potential risk of harm to the residents and require a plan of correction.	A 000		
A 401	420-5-4-.04 (1) (2) Personnel. Personnel. (1) An assisted living facility shall ensure personnel are employed and on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. (a) An assisted living facility shall be staffed at all times by at least one individual who has a current certification in cardiopulmonary resuscitation (CPR). (b) An assisted living facility must be staffed to ensure the safe evacuation of all residents in the event of a fire or emergency. (2) Employee Schedule. An assisted	A 401		

Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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living facility shall post a schedule of employees indicating names and days and hours scheduled to work. This schedule shall be retained in the facility for 6 months after use.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure adequate personnel were on duty at all times to meet the safety needs of all residents and to ensure safe evacuation of all residents in the event of a fire or emergency.

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

Findings:

The Alabama Department of Public Health received a complaint which included an allegation that only one staff member was on duty at night at the facility. This portion of the complaint was substantiated during the onsite survey and this deficiency was cited due to care needs of a resident which required two staff members to ensure safety of the resident.

Resident Identifier (RI)#6 was admitted to the facility on November 7, 2018 and had diagnoses which included chronic atrial fibrillation, weakness, hyponatremia, and hypo-osmolality. Review of RI#6's facility care plan revealed the following information. RI#6 was admitted to the hospital on December 21, 2020 due to COVID-19, influenza type A and influenza type B. After recovering from those infections, RI#6 was admitted to a rehabilitation facility where he/she refused therapy and developed pneumonia, resulting in re-admission to the hospital. RI#6's

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diagnoses also included acute respiratory failure with hypoxia and pericardial effusion. Following this hospital admission, RI#6 was again admitted to a rehabilitation facility where he/she again refused to participate in therapy and repeatedly stated he/she did not want to get better.

According to the facility care plan, at the time of his/her return to the facility, RI#6 was very weak and frail, was unable to ambulate or transfer without assistance, had decreased appetite and required full assistance with activities of daily living. RI#6 also had an indwelling urinary catheter and used oxygen continuously.

On the afternoon of March 16, 2021, the surveyor spoke with RI#6 in RI#6's room. RI#6 was very weak, made no attempt to get up alone and verbalized frustration that he/she was unable to walk. RI#6 spoke very softly and answered questions briefly. RI#6 repeatedly said "I'm just so weak".

Later that same afternoon, the surveyor requested to observe staff transfer RI#6. Two staff members went to RI#6's room to complete the transfer. The surveyor observed Employee Identifier (EI)#2 and EI#7 transfer RI#6 from the chair to the wheelchair. Each staff member placed an arm under RI#6's arm and lifted RI#6 from the chair, then turned RI#6 to sit in the wheelchair. During the transfer RI#6's feet were sliding on the floor, making the transfer more difficult. RI#6 did not assist with the transfer. Once seated in the wheelchair, RI#6 immediately requested to be transferred back to the chair and was transferred to the chair by EI#2 and EI#7. RI#6 again did not assist with the transfer.

During interviews with all facility staff on March 16

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A 401	Continued From page 3 and March 17, 2021, the surveyor was repeatedly informed RI#6 required two people to safely transfer. Staff reported RI#6's family members would sometimes assist with transferring RI#6. Staff also reported RI#6 could, at times, stand or transfer with one staff member but could not consistently and safely transfer with only one person assisting. Review of the facility's employee schedule revealed only one staff member worked at the facility between the hours of 10:00 PM and 6:15 AM. A second staff member was not available to assist with transferring RI#6, placing RI#6 at risk of harm in the event of a fire or emergency at the facility. During an interview on the afternoon of March 17, 2021, EI#1 agreed there was a possibility RI#6 could not safely be moved from the facility in the event of a fire or emergency. A sitter was placed with RI#6 on the night of March 16, 2021 and RI#6 was discharged from the facility to a skilled nursing facility on March 17, 2021.	A 401		
A 617	420-5-4-.06 (8) Care of Residents. (8) Disposal of Medications. 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	A 617		

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beyond 30 days.

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.

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.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to properly document medication destruction following discharge of a resident.

Findings:

RI#11 was admitted to the facility on December 30, 2017 and had diagnoses which included primary generalized osteoarthritis, fractured left femur, hypertensive heart disease with heart failure, hypothyroidism, insomnia and dementia. RI#11 passed away at the facility on February 8,

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A 617	Continued From page 5 2021. Review of RI#11's facility record revealed RI#11's medications were destroyed by the facility on February 10, 2021 following RI#11's death. Two Medication Disposition Forms were completed by EI#2 to document destruction of RI#11's medications. The Medication Disposition Forms did not contain the name of the assisted living facility, the pharmacy, the prescription number and the amount of each medication. EI#1 reviewed the Medication Disposition Forms on March 17, 2021 and agreed they did not contain all required information.	A 617		
A 621	420-5-4-.06 (11) (b) Care of Residents. (b) Retention 1. An assisted living facility shall not allow any resident to return to the assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the facility is licensed to provide or the facility is capable of providing. 2. An assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility. 3. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in an assisted living facility. 4. An assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days	A 621		

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A 621	Continued From page 6 unless: (i) The individual is capable of performing and does perform all tasks related to his or her own care; OR (ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity BUT the individual has sufficient cognitive ability to direct his or her own care AND the individual is able to direct others and does direct others to provide the physical assistance needed to complete such tasks, AND the facility staff is capable of providing such assistance and does provide such assistance. 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. 5. If a resident of an assisted living facility is diagnosed with a terminal illness other than dementia and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90 days. If the facility is unable or becomes unable to meet the needs of a resident receiving hospice care, or if a resident receiving hospice care requires care beyond what the facility may lawfully provide pursuant to this section, then the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for assisted living facilities. The facility would in all cases remain	A 621		

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responsible for ensuring the appropriate delivery of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident.

6. All skilled services provided in the facility, such as but not limited to wound care or insertion of a urinary catheter, shall be provided by the staff of properly licensed or certified agencies. Skilled services shall not be delegated to facility staff.

7. Residents that develop acute infectious pulmonary disease, such as active tuberculosis, or other diseases capable of transmission to other individuals through normal person-to-person contact shall be immediately transferred to an appropriate level of care until certified by a physician to be free of a contagious condition.

8. No assisted living facility shall be operated in whole or in part in a manner that prevents free and unhindered egress from the facility by any of its residents.

9. An assisted living facility shall not retain any resident who cannot safely reside in the facility unless his or her egress from the facility is restricted.

This Rule is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to ensure a resident could direct his/her own care.

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

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A 621	Continued From page 8 Findings: The Alabama Department of Public Health received a complaint which included an allegation that residents of the facility were unable to direct their own care. The surveyor substantiated this portion of the complaint during the onsite survey. RI#6 returned to the facility on February 23, 2021 following multiple hospital and rehabilitation admissions due to COVID-19 and pneumonia. Refer to deficiency 401 for additional information on RI#6. RI#6 returned to the facility with an indwelling urinary catheter to manage urinary retention. RI#6 was extremely weak and required maximum assistance to transfer. RI#6 was dependent on staff for assistance with all care and was physically unable to care for the catheter without assistance. Documentation on RI#6's facility care plan, dated February 24, 2021, stated RI#6 was able to direct his/her own care of the catheter and any concerns with the catheter should be directed to home health. During interviews on March 16 and 17, 2021, facility staff reported home health was responsible for all care of RI#6's catheter including emptying the urinary drainage bag. On March 17, 2021, EI#2 was asked how often home health visited the facility and EI#2 replied every other day. On the afternoon of March 16, 2021, the surveyor asked RI#6 about the catheter including how and when the bag was to be emptied. RI#6 stated he/she did not know and further stated those tasks were completed by the staff and home health. RI#6 was currently unable or unwilling to direct all care of the catheter. CONNIE CHERRY, REGISTERED NURSE	A 621		