

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P-5903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/06/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LAKEVIEW ESTATES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 2634 VALLEYDALE ROAD BIRMINGHAM, AL 35244
---	---

(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 October 6, 2021, an unannounced licensure survey was conducted for this 76 bed Specialty Care Assisted Living Facility (SCALF) with a census of 41.</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 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practice resulted in the potential for harm to all residents and requires a plan of correction.</p>	A 000		
A 618	<p>420-5-20-.06 (7) Care of Residents.</p> <p>(7) Oxygen Therapy.</p> <p>(a) A resident of a specialty care assisted living facility that requires oxygen therapy shall have oxygen administered only by a physician, RN, or LPN.</p> <p>(b) Oxygen use including date, time, rate, and proper function of the equipment shall be documented on the medication administration or medication assistance record at least once per shift.</p> <p>1. If a resident receives oxygen therapy in a facility:</p> <p>2. All oxygen equipment, such as tubing, masks, and nasal cannula shall be maintained in a safe and sanitary condition.</p>	A 618		

Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P-5903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/06/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LAKEVIEW ESTATES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 2634 VALLEYDALE ROAD BIRMINGHAM, AL 35244
---	---

(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 618	<p>Continued From page 1</p> <p>3. All oxygen tanks shall be safely maintained and stored.</p> <p>4. The facility shall require safe use of oxygen therapy. No smoking and appropriate precautionary signs shall be posted.</p> <p>5. The facility shall ensure that each resident using oxygen therapy maintains an adequate supply of oxygen.</p> <p>Refer to National Fire Protection Association (NFPA) 99 for Oxygen Storage Requirements.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to document oxygen use every shift on the Medication Administration Record (MAR).</p> <p>Findings:</p> <p>Resident Identifier (RI)#7 was admitted to the facility on July 16, 2018 and had diagnoses which included congestive heart failure, chronic kidney disease, diabetes mellitus type II, chronic atrial fibrillation, dementia without behavioral disturbances, major depressive disorder and hypothyroidism. RI#7 had a physician's order for oxygen at 3 liters/minute via nasal cannula continuously and was observed during the survey using oxygen. Review of RI#7's MAR for the month of October 2021 revealed oxygen was listed on the MAR. However, there were no initials of the nurse on duty for the following dates to indicate the oxygen was in use and functioning properly: October 1, 2021 from 6:00 AM-2:00 PM; October 2, 2021 from 10:00 PM-6:00 AM;</p>	A 618		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P-5903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/06/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LAKEVIEW ESTATES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 2634 VALLEYDALE ROAD BIRMINGHAM, AL 35244
---	---

(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 618	<p>Continued From page 2</p> <p>October 3, 2021 from 10:00 PM-6:00 AM; October 4, 2021 from 10:00 PM-6:00 AM; October 5, 2021 from 10:00 PM-6:00 AM and from 2:00 PM-10:00 PM. Employee Identifier (EI)#3 and EI#4 agreed RI#7's oxygen use had not been documented as required.</p> <p>CONNIE CHERRY, REGISTERED NURSE</p>	A 618		