

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D1703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEIGHBORHOOD AT SHEFFIELD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COX BLVD SHEFFIELD, AL 35660
---	--

(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 June 15, 2022, an unannounced licensure survey and complaint investigations were conducted for this 56 bed Assisted Living Facility (ALF) with a census of 38.</p> <p>There were four (4) complaints investigated during this survey.</p> <p>Intake ID: 20200709007 was substantiated with deficiencies cited. Intake ID: 20220104007 was unsubstantiated with no deficiencies cited. Intake ID: 20210609002 and Intake ID: 20200910008 were substantiated, but no deficiencies were cited.</p> <p>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.</p>	A 000		
A 508	<p>420.5.4-.05 (3) (h) Records and Reports.</p> <p>(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.</p>	A 508		

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: D1703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEIGHBORHOOD AT SHEFFIELD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COX BLVD SHEFFIELD, AL 35660
---	--

(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 508	<p>Continued From page 1</p> <p>1. Incidents which require investigation are:</p> <p>(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.</p> <p>(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.</p> <p>(iii) The onset of wandering behavior by any resident who is not fully cognitively intact.</p> <p>(iv) Elopement by a resident.</p> <p>(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.</p> <p>(vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules.</p> <p>(vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules.</p> <p>(viii) An outbreak (for purposes of</p>	A 508		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D1703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEIGHBORHOOD AT SHEFFIELD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COX BLVD SHEFFIELD, AL 35660
---	--

(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 508	<p>Continued From page 2</p> <p>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).</p> <p>(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.</p> <p>(x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident.</p> <p>(xi) An unplanned occurrence that results in media attention.</p> <p>(xii) A medication error, overdose, or over sedation.</p> <p>(xiii) Ingestion by a resident of a toxic substance that requires medical attention.</p> <p>(xiv) Any indication of malfunction of the sprinkler system, or fire alarm system.</p> <p>2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following:</p> <p>(i) Names of all residents involved.</p> <p>(ii) Names of all staff involved including person in charge at the time of the incident.</p>	A 508		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D1703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEIGHBORHOOD AT SHEFFIELD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COX BLVD SHEFFIELD, AL 35660
---	--

(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 508	<p>Continued From page 3</p> <p>(iii) When the administrator was notified (date and time).</p> <p>(iv) Circumstances under which the incident occurred.</p> <p>(v) When the incident occurred (date and time).</p> <p>(vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn).</p> <p>(vii) Immediate actions taken.</p> <p>(viii) The extent and description of injury, if any, to the affected resident or residents.</p> <p>(ix) Immediate treatment rendered.</p> <p>(x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified.</p> <p>(xi) Names, telephone numbers, and addresses of witnesses.</p> <p>(xii) Date and time relatives or sponsor were notified.</p> <p>(xiii) Out-of-facility treatment.</p> <p>(xiv) Follow-up care.</p> <p>(xv) Outcome resolution.</p> <p>(xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future.</p>	A 508		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D1703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEIGHBORHOOD AT SHEFFIELD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COX BLVD SHEFFIELD, AL 35660
---	--

(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 508	<p>Continued From page 4</p> <p>(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.</p> <p>(xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request.</p> <p>(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.</p> <p>(xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff.</p> <p>3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident:</p> <p>(i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention as defined in these rules.</p> <p>(ii) Elopement by a resident.</p> <p>(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</p>	A 508		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D1703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEIGHBORHOOD AT SHEFFIELD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COX BLVD SHEFFIELD, AL 35660
---	--

(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 508	<p>Continued From page 5</p> <p>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.</p> <p>(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.</p> <p>(v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident.</p> <p>(vi) An unplanned occurrence that results in media attention.</p> <p>(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.</p> <p>(viii) Ingestion by a resident of a toxic substance that requires medical attention.</p> <p>(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.</p> <p>(x) Any indication of malfunction of the</p>	A 508		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D1703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEIGHBORHOOD AT SHEFFIELD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COX BLVD SHEFFIELD, AL 35660
---	--

(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 508	<p>Continued From page 6</p> <p>sprinkler system, or fire alarm system.</p> <p>4. The report to the Department's Online Incident Reporting System shall include the following:</p> <ul style="list-style-type: none"> (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. (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. <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to report an incident to the Department's Online Incident Reporting System (OIRS) as required,</p>	A 508		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D1703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEIGHBORHOOD AT SHEFFIELD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COX BLVD SHEFFIELD, AL 35660
---	--

(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 508	Continued From page 7 Findings: Resident Identifier, (RI)#4 was admitted to the facility on January 30, 2020, and had diagnoses which included diabetes, chronic obstructive pulmonary disease (COPD), and benign prostatic hypertrophy (BPH). The morning of June 13, 2022, the surveyor observed RI#4 had a large bandage wrapped around his/her left hand. Employee Identifier (EI)#2, Wellness Director (WD) informed the surveyor RI#4 had a fall on May 30, 2022, and he/she sustained a laceration that required 22 stitches. The surveyor asked EI#1, Administrator, if the incident had been reported to the OIRS. EI#1 explained EI#2 was responsible for submitting the incident report to the state after she (EI#1) completes the investigation. However, a review of the OIRS by the surveyor on June 13, 2022, revealed the incident had not been reported. On June 15, 2022, EI#1 informed the surveyor there had been a miscommunication between her (EI#1) and EI#2 and the incident had not been reported within 24 hours. EI#1 submitted a late report to the OIRS on June 14, 2022.	A 508		
A 601	420-5-4-.06 (1) Care of Residents. (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	A 601		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D1703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEIGHBORHOOD AT SHEFFIELD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COX BLVD SHEFFIELD, AL 35660
---	--

(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	<p>Continued From page 8</p> <p>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 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>	A 601		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D1703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEIGHBORHOOD AT SHEFFIELD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COX BLVD SHEFFIELD, AL 35660
---	--

(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	<p>Continued From page 9</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility nurses failed to follow physicians' orders for residents' medications.</p> <p>Findings:</p> <p>On June 15, 2022, the surveyor observed EI#10, Licensed Practical Nurse (LPN), assist the residents with their morning medications. The following deficiencies were observed:</p> <p>RI#6 at 7:25 AM, did not have Lantus 40 units available for the morning dose as ordered. RI#6 had a significant medical history of uncontrolled diabetes. See deficiency 611 for additional information. Review of the finger-stick blood sugars (FSBS) for the month of June 2022 ranged from 149 mg/dl to 487 mg/dl.</p> <p>RI#1 at 8:18 AM was not given medications as ordered. RI#1 was to receive levothyroxine (Synthroid) every morning on an empty stomach 15 minutes before breakfast for treatment of hypothyroidism. RI#1 was also to receive pantoprazole (Protonix) before 7:59 AM (early morning) due to a history of gastrointestinal bleeding. RI#1 told the surveyor she/he had already eaten breakfast and her/his medications were two (2) hours late.</p> <p>The above deficiencies were discussed with EI#10, EI#1 and EI#3 on June 15, 2022. All acknowledged this was unacceptable. EI#1 said the nurses would immediately receive mandatory re-training.</p>	A 601		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D1703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEIGHBORHOOD AT SHEFFIELD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COX BLVD SHEFFIELD, AL 35660
---	--

(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 611	<p>420-5-4-.06 (4) (a) (b) Care of Residents.</p> <p>(4) Personal Care and Services. The facility shall provide care and services consistent with community standards.</p> <p>(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.</p> <p>(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.</p> <p>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:</p> <p>2. A listing of the resident's individual needs or problems that require intervention by the facility.</p>	A 611		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D1703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEIGHBORHOOD AT SHEFFIELD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COX BLVD SHEFFIELD, AL 35660
---	--

(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 611	<p>Continued From page 11</p> <p>3. A listing of interventions provided by the facility to address the resident's identified needs or problems.</p> <p>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.</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(iii) Hair. Resident's hair shall be kept clean, neat, and well groomed.</p> <p>(iv) Manicure. Fingernails and toenails shall be kept clean and trimmed.</p> <p>(v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed.</p> <p>(vi) Personal Safety. Residents shall be provided assistance with personal safety.</p>	A 611		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D1703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEIGHBORHOOD AT SHEFFIELD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COX BLVD SHEFFIELD, AL 35660
---	--

(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 611	<p>Continued From page 12</p> <p>6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to update all Resident Care Plans (RCP) to include the appropriate interventions. In addition, the facility failed to provide care consistent with safe community standards.</p> <p>Findings:</p> <p>Resident Care Plans:</p> <p>RI#6 was admitted to the facility on February 24, 2022. The Report of Resident Physical Examination was dated February 22, 2022, and listed the following diagnoses, breast cancer, hypertension, hyperlipidemia, diabetes mellitus (DM), GERD, hypothyroidism, neuropathy, sleep apnea, and morbid obesity. The physician ordered a diet of no concentrated sweets and no added salt upon admission. On May 18, 2022, RI#6 visited the physician and documented, "Blood sugars still very high." The physician changed the diet order to strict diabetic and to eliminate fruit juices and desserts. The RCP was not updated by EI#2 with this new diet order. On June 15, 2022, EI#3, Regional Director of Operations (RDO), informed the surveyor the RCP would be updated immediately.</p>	A 611		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D1703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEIGHBORHOOD AT SHEFFIELD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COX BLVD SHEFFIELD, AL 35660
---	--

(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 611	<p>Continued From page 13</p> <p>Community Standards:</p> <p>THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.</p> <p>Findings:</p> <p>The ADPH had received a complaint the nurses were dropping off medications in cups in the resident's rooms (Intake ID: 20200709007). During interviews with staff the surveyor was told they (staff) had seen medications left in the resident's room on all shifts. On June 15, 2022 at 9:00 AM, the surveyor entered RI#5's room and observed her/him unsupervised with medications in her/his hand. RI#5 told the surveyor EI#10 had left her/his medications because she/he needed some time in the bathroom. RI#5 told the surveyor this was not the first time it had happened. EI#10 quickly entered the room and said she (EI#10) had just stepped out for a minute. EI#10 told the surveyor she (EI#10) knew this was not allowed, but this was how EI#2, WD, had trained her (EI#10) when she (EI##10) starting working two (2) months ago.</p> <p>EI#3, RDO, told the surveyor the staff should never leave medications in a room for a resident to take later. EI#3 said a mandatory training for the nurses would be held on June 16, 2022.</p>	A 611		
A1101	<p>420-5-4-.11 (1) Fire and Safety</p> <p>(1) General.</p> <p>(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</p>	A1101		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D1703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEIGHBORHOOD AT SHEFFIELD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COX BLVD SHEFFIELD, AL 35660
---	--

(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
A1101	<p>Continued From page 14</p> <p>smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place.</p> <p>(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.</p> <p>(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 wheelchairs.</p> <p>(d) Roller latches are prohibited on doors separating corridors from adjacent spaces.</p> <p>(e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that:</p> <ol style="list-style-type: none"> 1. Minimizes leaks and spills. 	A1101		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D1703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/15/2022
--	--	--	---

NAME OF PROVIDER OR SUPPLIER NEIGHBORHOOD AT SHEFFIELD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COX BLVD SHEFFIELD, AL 35660
---	--

(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
A1101	<p>Continued From page 15</p> <p>2. Adequately protects against inappropriate access.</p> <p>3. Complies with the requirements of the currently adopted Life Safety Code.</p> <p>(f) Fire Alarm and Sprinkler System.</p> <p>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).</p> <p>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 next duty day, and shall be corrected expeditiously.</p> <p>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.</p>	A1101		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D1703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEIGHBORHOOD AT SHEFFIELD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COX BLVD SHEFFIELD, AL 35660
---	--

(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
A1101	<p>Continued From page 16</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the fire alarm system and sprinkler system were not inspected semiannually for compliance with the respective codes.</p> <p>Findings:</p> <p>The facility's fire and safety documentation was reviewed on June 14, 2022, with EI#12, Maintenance Director. There were no inspection reports for the fire alarm system for 2020 and 2021. The sprinkler system was not inspected in 2020 and only inspected once in 2021 (Nov. 2, 2021).</p> <p>EI#12, stated he (EI#12) had been the Maintenance Director (MD) since March 2022, and the previous MD did not leave any documentation. EI#1 said after the MD left the facility the inspection reports could not be found. EI#1 said she (EI#1) had requested the prior fire alarm company to fax the 2020 and 2021 reports to her (EI#1), but they failed to do so.</p> <p>DEBRA FREEMAN, REGISTERED NURSE</p>	A1101		