

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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NAME OF PROVIDER OR SUPPLIER PATHWAYS MEMORY CARE OF BIRMINGHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 285 WEST OXMOOR ROAD BIRMINGHAM, AL 35209
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>On December 8, 2021, an unannounced licensure survey and complaint investigation was conducted for this 32-bed Specialty Care Assisted Living Facility (SCALF) with a census of 26.</p> <p>There were two (2) complaints investigated during this survey. Complaint #20200415005 and Complaint #20211104008 were unsubstantiated. There were no deficiencies cited as a result of the complaint investigations.</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 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practices resulted in the potential for harm to all residents and require a plan of correction.</p>	A 000		
A 402	<p>420-5-20-.04 (3) Personnel.</p> <p>(3) Employee Screening.</p> <p>(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 contact shall not be permitted to have resident contact until free from such signs and symptoms.</p>	A 402		

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

Alabama Department of Public Health

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A 402	<p>Continued From page 1</p> <p>(b) Not more than 30 days prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis.</p> <p>(c) Vaccines. Specialty care 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.</p> <p>(d) A specialty care assisted living facility shall not hire an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to screen all employees for tuberculosis (TB) prior to providing resident care. In addition, the facility did not check the Alabama Department of Public Health Nurse Aide Abuse Registry prior to hiring all employees.</p> <p>Findings:</p> <p>On December 8, 2021, the employee files were reviewed with EI#6, Business Office Manager, for supporting documentation all staff had received the required screening as noted above. The deficiencies are listed below:</p> <p>TB Screening:</p> <p>Employee Identifier (EI)#2, Director of Nursing (DON) had a documented hire date and date of</p>	A 402		

Alabama Department of Public Health

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A 402	Continued From page 2 initial resident contact as September 20, 2021. However, the TB skin test was not read until September 23, 2021. Abuse Registry: EI#2, DON, date of hire was documented as September 20, 2021, but the abuse registry verification was dated September 23, 2021. EI#3, Licensed Practical Nurse (LPN), date of hire was documented as November 18, 2021, but the abuse registry verification was dated December 7, 2021.	A 402		
A 406	420-5-20-.04 (9) Personnel. (9) 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. An RN shall identify staff training needs and shall provide or arrange for needed training. 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 members receive training on the subject matter listed below: 1. State law and rules on specialty care assisted living facilities. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the	A 406		

Alabama Department of Public Health

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A 406	<p>Continued From page 3</p> <p>American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire.</p> <p>5. Identifying and reporting abuse, neglect, and exploitation.</p> <p>6. Basic first aid.</p> <p>7. Advance directives.</p> <p>8. Protecting resident confidentiality.</p> <p>9. Resident fire and environmental safety.</p> <p>(b) Prior to providing any resident care, all staff shall complete The Dementia Education and Training Act (DETA) Care Series Training developed by the Alabama Department of Mental Health or equivalent training approved by the State Health Officer. All licensed staff shall complete DETA Brain Series Training, The Pharmacological Management of Dementia, and the Dementia Assessment Series provided by the DETA Program or equivalent training approved by the State Health Officer prior to resident contact. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained.</p> <p>(c) All staff who have resident contact shall be able to demonstrate diversional methods and redirection. All staff shall be able to demonstrate an understanding of the implications of caring for residents with agnosia, amnesia, aphasia, and apraxia. All staff shall be able to demonstrate an understanding of the facility's fire</p>	A 406		

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A 406	<p>Continued From page 4</p> <p>and evacuation plan and all other policies regarding safety, including policies for preventing elopements, responding to elopements, and fall prevention.</p> <p>(d) Cardiopulmonary Resuscitation. A specialty care assisted living facility 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 CPR. All employees of a specialty care 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. A specialty care 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 the American Red Cross in CPR or AED utilization.</p> <p>(e) 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.</p> <p>(f) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above.</p>	A 406		

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A 406	<p>Continued From page 5</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to document the Pharmacological Management of Dementia training and the Dementia Assessment Series training for all licensed staff prior to providing resident care.</p> <p>Findings:</p> <p>On December 8, 2021, the employee files were reviewed for supporting documentation all licensed staff had received the required initial training as noted above. EI#3, LPN did not have documentation the required subject matters were covered during orientation. EI#3 informed the surveyor she did not recall having the Pharmacological Management of Dementia training and the Dementia Assessment Series during her orientation. EI#3 told the surveyor she (EI#3) would immediately do the training.</p>	A 406		
A 508	<p>420-5-20-.05 (3) (h) Records and Reports.</p> <p>(h) Incident Investigation. When an incident, as defined below, occurs in a specialty care 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> <p>1. Incidents which require investigation are:</p>	A 508		

Alabama Department of Public Health

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A 508	<p>Continued From page 6</p> <p>(i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as extensive 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 these rules, an outbreak is considered to be two or more affected people within 72 hours or less)</p>	A 508		

Alabama Department of Public Health

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A 508	<p>Continued From page 7</p> <p>of a contagious disease or condition including those listed in Appendix I to 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> <p>(iii) When the administrator was notified (date and time).</p>	A 508		

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A 508	<p>Continued From page 8</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> <p>(xvii) The investigative file includes the incident report itself, the incident investigation</p>	A 508		

Alabama Department of Public Health

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A 508	<p>Continued From page 9</p> <p>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.</p> <p>(ii) Elopement by a resident.</p> <p>(iii) Suspected, alleged, confessed, witnessed, or actual abuse, neglect, or exploitation of a resident or 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</p>	A 508		

Alabama Department of Public Health

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A 508	<p>Continued From page 10</p> <p>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 to Alabama Administrative Code Sec. 420-4-1-.04. shall also 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 three years.</p> <p>(x) Any indication of a malfunction of the sprinkler system, fire alarm system, or a door locking device.</p>	A 508		

Alabama Department of Public Health

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A 508	<p>Continued From page 11</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. (i) Vital Statistics Reports. A record shall be kept of all births, deaths, and stillbirths that occur within the specialty care assisted living facility. By the fifth day of each month, the administrator shall make a report of such births, deaths, and stillbirths for the preceding month on such forms as the State Board of Health shall provide to the county health officer, or in counties without a county health officer, to the State Registrar. This report shall be in addition to the official birth, death, and stillbirth certificates. If there are no births, deaths, or stillbirths in any 	A 508		

Alabama Department of Public Health

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A 508	<p>Continued From page 12</p> <p>month, a report shall be made stating that fact to the county health officer.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, a notifiable health condition was not reported and investigated as required.</p> <p>Findings:</p> <p>On December 8, 2021, the surveyor reviewed the facility's 24-Hour Report forms for the months of November and December 2021. On November 23, 2021, the documentation under Day Shift read "several residents with diarrhea and vomiting, standing order...for Immodium and Zofran, sanitized all rooms, several residents stayed in rooms throughout shift, push PO fluids, hydrate residents, gingerale from kitchen". Also, on the reports for November 22-24, 2021, six specific residents were listed as having nausea, vomiting and/or diarrhea. On December 7, 2021, EI#8 confirmed several residents and at least one employee exhibited these symptoms on or around these dates.</p> <p>On December 8, 2021, the surveyor asked EI#1 and EI#2 if the outbreak of gastrointestinal symptoms had been reported to the State. Neither were able to confirm that the outbreak had been reported or investigated as required.</p>	A 508		
A 602	<p>420-5-20-.06 (2) (a) (b) (c) Care of Residents.</p> <p>(2) Medical Examination Record.</p>	A 602		

Alabama Department of Public Health

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A 602	<p>Continued From page 13</p> <p>(a) Initial Physical Examination. Not more than 30 days prior to admission of any resident to a specialty care assisted living facility, the resident or prospective resident shall be examined by a physician. For purposes of the initial physical examination, a physician currently licensed and 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. This examination is not required for a resident of a facility dually licensed as an assisted living facility and as a specialty care assisted living facility in those cases when the resident is transferred from the assisted living unit to the specialty care assisted living unit in the same 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:</p> <ol style="list-style-type: none"> 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. 4. Documentation of evaluation for tuberculosis within the previous 12 months. 	A 602		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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NAME OF PROVIDER OR SUPPLIER PATHWAYS MEMORY CARE OF BIRMINGHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 285 WEST OXMOOR ROAD BIRMINGHAM, AL 35209
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A 602	<p>Continued From page 14</p> <p>(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:</p> <ol style="list-style-type: none"> 1. The resident's weight and vital signs. 2. Changes in diagnoses. 3. Changes in condition. 4. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration). 5. Changes in treatment. <p>(c) Change of Condition Physical Examinations. Changes in the resident's condition that require a physician examination and result in a change in diagnoses, condition, 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 following:</p>	A 602		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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A 602	<p>Continued From page 15</p> <ol style="list-style-type: none"> 1. Changes in 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. <p>This Rule is not met as evidenced by: Based on record reviews and interviews, residents' Medical Examination Records were not completed as required.</p> <p>Findings:</p> <p>Review of residents' facility records on December 8, 2021 revealed the following information.</p> <p>Resident Identifier (RI)#4</p> <p>RI#4 was admitted to the facility on October 11, 2021 and had diagnoses which included dementia, hypertension, gastroesophageal reflux disease and dysphagia. RI#4's Initial Physical Examination, dated September 16, 2021, did not contain baseline weight and vital signs for RI#4.</p> <p>RI#5</p> <p>RI#5 was admitted to the facility on May 13, 2016 and had diagnoses which included dementia, benign neoplasm of the prostate, hyperlipidemia, Parkinson's disease, hypertension, osteoarthritis, anxiety, depression, insomnia, overactive</p>	A 602		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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NAME OF PROVIDER OR SUPPLIER PATHWAYS MEMORY CARE OF BIRMINGHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 285 WEST OXMOOR ROAD BIRMINGHAM, AL 35209
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A 602	<p>Continued From page 16</p> <p>bladder, convulsions and vitamin D deficiency. The most recent Annual Physical Examination for RI#5 was dated August 11, 2020. EI#3 confirmed an Annual Physical Examination had not been completed for the year 2021.</p> <p>RI#6</p> <p>RI#6 was admitted to the facility on February 9, 2021 and had diagnoses which included hypertension, hypothyroidism, schizoaffective disorder, chronic kidney disease, chronic obstructive pulmonary disease and mild persistent asthma. RI#6's Initial Physical Examination, dated February 9, 2021, did not contain baseline vital signs and weight for RI#6.</p> <p>EI#1 agreed these residents' Medical Examination Records had not been completed as required but stated the examinations and records would be completed promptly.</p>	A 602		
A 604	<p>420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents.</p> <p>(3) Health Supervision.</p> <p>(a) Initial Assessment. No more than 30 days prior to admission, the facility RN or care coordinator shall screen prospective residents for eligibility for admission into the specialty care assisted living facility. The screening shall include a clinical history, a mental status examination to include aphasia screening, a geriatric depression screen, a physical self-maintenance screen, and a behavior screen.</p> <p>Appendix A herein, contains the Physical Self Maintenance Scale (PSMS) form and the</p>	A 604		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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NAME OF PROVIDER OR SUPPLIER PATHWAYS MEMORY CARE OF BIRMINGHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 285 WEST OXMOOR ROAD BIRMINGHAM, AL 35209
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A 604	<p>Continued From page 17</p> <p>Behavior Screening form. These forms shall be completed to screen physical functioning and behaviors. The PSMS and Behavior Screen assessments shall be completed by the RN or care coordinator upon admission, annually, and when there is a change in the resident's status.</p> <p>The facility RN shall perform a comprehensive assessment of each prospective resident for facility eligibility. This assessment shall document identified care needs and serve as a baseline for the RN plan of care and future assessments.</p> <p>(b) Monthly Assessments. The RN shall assess each resident monthly and more often when necessary to identify changes in the resident's health status. The monthly assessment shall include a review of monthly weights, falls, incidents, elopements, behavioral symptoms, medications, changes in resident status, and appropriateness of the resident's plan of care.</p> <p>(c) Comprehensive Assessment. The facility RN shall perform a comprehensive assessment and communicate with the resident's attending physician and with the resident's sponsor or responsible family member when a decline in health status or behavior occurs, or if the resident develops any of the following problems:</p> <p>1. Weight loss:</p> <p>(i) Each month, the facility shall accurately weigh and record the weight of each resident.</p> <p>(ii) A significant weight loss is defined as</p>	A 604		

Alabama Department of Public Health

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NAME OF PROVIDER OR SUPPLIER PATHWAYS MEMORY CARE OF BIRMINGHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 285 WEST OXMOOR ROAD BIRMINGHAM, AL 35209
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A 604	<p>Continued From page 18</p> <p>a five percent or greater weight loss in a period of one month or less, or a seven and a half percent or greater weight loss in a period of 3 months or less, or a 10 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.</p> <p>2. Falls (two or more falls within a 30 day period).</p> <p>3. Elopement.</p> <p>4. Any sign and symptom of adverse drug reaction, interaction or over sedation, or circumstances which contraindicate medications that have been prescribed for the resident.</p> <p>5. Unmanageable, combative, or potentially harmful behavior(s).</p> <p>6. Any accident with injury.</p> <p>(d) Focused Assessments. The RN or LPN shall conduct focused assessments when necessary to identify changes in resident status.</p> <p>(e) Any change in resident status requires immediate documentation and implementation of interventions or reassessment of existing interventions.</p> <p>This Rule is not met as evidenced by:</p>	A 604		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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NAME OF PROVIDER OR SUPPLIER PATHWAYS MEMORY CARE OF BIRMINGHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 285 WEST OXMOOR ROAD BIRMINGHAM, AL 35209
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A 604	<p>Continued From page 19</p> <p>Based on observations, interviews and record reviews, the facility failed to provide required health supervision of residents.</p> <p>Findings:</p> <p>Review of residents' facility records on December 8, 2021 revealed the following information.</p> <p>RI#1</p> <p>RI#1 was admitted to the facility on September 8, 2021 and had diagnoses which included fronto-temporal dementia with behaviors, hypertension, unilateral nephrectomy, insomnia, psychosis, overactive bladder, anxiety and depression. No clinical history was documented for RI#1. No mental status examination, aphasia screening and geriatric depression screen were documented for RI#1 until October 26, 2021. No PSMS, behavior screen and comprehensive assessment were documented for RI#1 until October 10, 2021. There was no documentation RI#1 was screened for admission and there was no documentation of a PSMS and behavior screen upon RI#1's admission to the facility.</p> <p>RI#3</p> <p>RI#3 was admitted to the facility on December 17, 2020 and had diagnoses which included Alzheimer's disease, diabetes mellitus II, hyperlipidemia, scoliosis/chronic back pain, osteoarthritis multiple sites, urge incontinence and unsteady gait. No PSMS and behavior screen were documented for RI#3 upon admission. No monthly assessments were documented for RI#3 in the months of January, February, March and April 2021.</p>	A 604		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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A 604	<p>Continued From page 20</p> <p>RI#4</p> <p>RI#4 had resided at the facility since October 11, 2021. Refer to deficiency 602 for additional information on RI#4. No clinical history was documented for RI#4. No PSMS and behavior screen were documented for RI#4 upon admission to the facility. RI#4 was found on the floor on October 23, 2021 and was physically aggressive toward staff on October 18 and 26, 2021. No comprehensive assessment and behavior screen were documented when these significant changes occurred. A PSMS was completed for RI#4 on October 23, 2021 but there was no PSMS documented when the other significant changes occurred.</p> <p>RI#9</p> <p>RI#9 was admitted to the facility on December 3, 2021 and had diagnoses which included transischemic attacks, arthritis, chronic renal insufficiency, dementia and hypothyroidism. No PSMS and behavior screen were documented for RI#9 upon admission to the facility.</p> <p>RI#11</p> <p>RI#11 was admitted to the facility on January 30, 2020 and had diagnoses which included anemia, hypothyroidism, vitamin D deficiency, metabolic encephalopathy, chronic diastolic congestive heart failure, essential hypertension, dementia with behavioral disturbance, atherosclerotic heart disease and sequelae of cerebral infarct. In December 2021, RI#11 sustained a significant weight loss of 7.5 per cent for three months (120 pounds in September 2021 and 111 pounds in December 2021). A Comprehensive Nursing Assessment form was completed for RI#11 by</p>	A 604		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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A 604	<p>Continued From page 21</p> <p>El#7 on December 2, 2021. The comprehensive assessment documented under "Recent weight change: no". No comprehensive assessment, PSMS and behavior screen were completed to address the significant weight loss. There was also no documentation that RI#11's sponsor and physician were notified of the significant weight loss. In addition, implementation of interventions to prevent further weight loss was not documented. RI#11 also sustained falls at the facility on October 31, 2021 and again on November 12, 2021 (two falls within a 30 day period). No comprehensive assessment, PSMS and behavior screen were completed when this significant change occurred.</p> <p>The above deficient practices in health supervision were discussed with EI#1 and EI#2 on December 8, 2021 and EI#1 assured the surveyors the practices would be corrected.</p>	A 604		
A 611	<p>420-5-20-.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. The RN shall develop written plans of care for each resident prior to or at the time of admission. The plans of care shall be based on resident's assessments, diagnoses, and recommendations of the resident's physician. The plan of care shall be developed in</p>	A 611		

Alabama Department of Public Health

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A 611	<p>Continued From page 22</p> <p>cooperation with the resident, if appropriate, and the sponsor. The RN shall identify resident care problem areas and formulate written interventions to address those problems. The RN shall evaluate the implementation of the interventions and the resident's response to the interventions and modify the plan of care as necessary.</p> <p>1. The plan shall at all times reflect the current condition of the resident. All entries on the plan of care shall be accurately dated. 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> <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 a specialty care assisted living facility 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</p>	A 611		

Alabama Department of Public Health

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A 611	<p>Continued From page 23</p> <p>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. Residents' 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> <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, interviews and record reviews, the facility Registered Nurse (RN) failed to develop appropriate care plans to address the current care needs of the residents.</p> <p>Findings:</p> <p>Review of residents' facility care plans on December 8, 2021 revealed the following information.</p>	A 611		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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A 611	<p>Continued From page 24</p> <p>RI#3</p> <p>RI#3 had resided at the facility since December 17, 2020. Refer to deficiency 604 for additional information on RI#3. RI#3 developed a wound to the left foot on June 11, 2021 at the facility and had received home health services for wound care to the foot since June 14, 2021. The wound and home health services were not addressed on RI#3's facility care plan.</p> <p>RI#11</p> <p>RI#11 had resided at the facility since January 30, 2020. Refer to deficiency 604 for additional information on RI#11. On January 30, 2020 a physician's order was written for RI#11 which read "Oxygen at 3 liters per minute continuous with portability". RI#11's facility care plan, dated January 30, 2020, read "...Oxygen to be on at all times at 4 liters per minute...". The intervention for oxygen on RI#11's care plan did not accurately reflect the physician's orders. In addition, RI#11 sustained a significant weight loss of 7.5 per cent for three months in December 2021. A care need of "Underweight" was listed on RI#11's facility care plan with an intervention of "...any signs of weight loss. We will contact the Dietitian...". However, the significant weight loss was not identified as a current care need with appropriate interventions to prevent further weight loss.</p> <p>When the above issues were discussed on December 8, 2021, EI#1 and EI#2 acknowledged the care plans were not current and accurate.</p>	A 611		
A 617	<p>420-5-20-.06 (6) Care of Residents.</p> <p>(6) Disposal of Medications.</p>	A 617		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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A 617	<p>Continued From page 25</p> <p>(a) 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, et. seq. Under no circumstances shall expired, discontinued, or unused medications be stored or housed in the facility beyond 30 days.</p> <p>(b) 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.</p> <p>(c) When medications are destroyed on the premises of the specialty care assisted living facility, a record shall be made and retained for at least three years. This record shall include: the name of the specialty care 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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews,</p>	A 617		

Alabama Department of Public Health

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A 617	<p>Continued From page 26</p> <p>disposition of a resident's medications upon discharge was not documented as required.</p> <p>Findings:</p> <p>Review of RI#12's facility record on December 8, 2021 revealed the following information. RI#12 was admitted to the facility on August 24, 2021 and had diagnoses which included diabetes mellitus II, hyperlipidemia, dementia, major depressive disorder, anxiety disorder, encephalopathy, hypertensive heart disease, atherosclerotic heart disease, atrial fibrillation and osteoarthritis. RI#12 was discharged from the facility on November 5, 2021. A Medication Disposition Record of Discharged or Transferred Residents was completed for RI#12 by EI#8 on November 5, 2021. The form documented Gabapentin was released to RI#12 upon discharge and also read "See Attachment". Attached to the form was a list of RI#12's medication orders, dated November 5, 2021. The list did not contain the prescription numbers, the pharmacy and the amount of each medication that was released to RI#12. In addition, RI#12 did not sign a statement that those medications had been received.</p> <p>On December 8, 2021, EI#1 agreed the medication disposition form was incomplete.</p>	A 617		
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>	A 618		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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NAME OF PROVIDER OR SUPPLIER PATHWAYS MEMORY CARE OF BIRMINGHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 285 WEST OXMOOR ROAD BIRMINGHAM, AL 35209
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 618	<p>Continued From page 27</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> <ol style="list-style-type: none"> 1. If a resident receives oxygen therapy in a facility: 2. All oxygen equipment, such as tubing, masks, and nasal cannula shall be maintained in a safe and sanitary condition. 3. All oxygen tanks shall be safely maintained and stored. 4. The facility shall require safe use of oxygen therapy. No smoking and appropriate precautionary signs shall be posted. 5. The facility shall ensure that each resident using oxygen therapy maintains an adequate supply of oxygen. <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 a resident's oxygen use as required.</p> <p>Findings:</p> <p>RI#11 had resided at the facility since January 30, 2020 and was observed using oxygen continuously during the survey. Refer to deficiencies 604 and 611 for additional</p>	A 618		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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A 618	Continued From page 28 information on RI#11. A physician's order for RI#11 to receive oxygen at 3 liters per minute continuously was written on January 30, 2020. However, RI#11's Medication Administration Record (MAR) for the month of December 2021 was reviewed on December 8, 2021, and only listed "Oxygen" with no frequency or flow rate. The only documentation under "Oxygen" on RI#11's MAR was an oxygen saturation level each shift. There was no documentation of the date, time, rate and proper function of the equipment at least once per shift. On December 8, 2021, EI#1 and EI#2 agreed RI#11's oxygen use was not documented as required.	A 618		
A 621	420-5-20-.06 (9) (b) Care of Residents. (b) Retention. 1. A specialty care assisted living facility shall not allow any resident to return to the specialty care assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the specialty care assisted living facility is licensed to provide or the facility is capable of providing. 2. A specialty care assisted living facility shall not retain a resident that has a PSMS score greater than 23 or a score of five in feeding, dressing, grooming, bathing or a score of four or five in physical ambulation. 3. A specialty care 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.	A 621		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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NAME OF PROVIDER OR SUPPLIER PATHWAYS MEMORY CARE OF BIRMINGHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 285 WEST OXMOOR ROAD BIRMINGHAM, AL 35209
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A 621	<p>Continued From page 29</p> <p>4. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in a specialty care assisted living facility.</p> <p>5. A specialty care assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless:</p> <p>(i) The individual is capable of performing and does perform all tasks related to his or her own care; OR</p> <p>(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 facility staff and does direct facility staff 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.</p> <p>6. If a resident of a specialty care assisted living facility is diagnosed with a terminal illness 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</p>	A 621		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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NAME OF PROVIDER OR SUPPLIER PATHWAYS MEMORY CARE OF BIRMINGHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 285 WEST OXMOOR ROAD BIRMINGHAM, AL 35209
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A 621	<p>Continued From page 30</p> <p>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 specialty care assisted living facilities.</p> <p>The facility would in all cases remain 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.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility retained residents who did not meet the criteria for a SCALF.</p> <p>Findings:</p> <p>RI#2</p> <p>RI#2 was admitted to the facility on December 21, 2015 and had diagnoses which included dementia, hypertension, degenerative joint disease, legally blind, anxiety, diabetes mellitus, acute hypokalemia, hypomagnesia and metabolic encephalopathy. RI#2 was admitted to the hospital on November 25, 2021 and remained hospitalized at the time of the survey. Review of RI#2's facility record on December 8, 2021 revealed RI#2 had a total score of 28 (above the maximum allowed level of 23 for a SCALF) on a PSMS completed by EI#2 on October 26, 2021. This was a significant decline from RI#2's previous PSMS on October 10, 2021 which</p>	A 621		

Alabama Department of Public Health

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A 621	<p>Continued From page 31</p> <p>showed a total score of 19. The PSMS for RI#2 on October 26, 2021 also revealed the following scores which were above the level allowed in a SCALF: 5 in Feeding (does not feed self at all and resists efforts of others to feed him/her); 5 in Dressing (completely unable to dress self and resists efforts of others to help); 5 in Grooming (actively negates all efforts of others to maintain grooming); 4 in Physical Ambulation (sits unsupported in chair or wheelchair, but cannot propel self without help); 5 in Bathing (does not try to wash self, and resists efforts to keep him/her clean). The Monthly Assessment for RI#2, documented by EI#2 on October 29, 2021, read under Health Changes "general decline".</p> <p>When questioned about the high PSMS score on December 8, 2021, EI#1 stated the facility had been discussing need for a higher level of care with RI#2's sponsor but a 30-day discharge notice had not been issued. EI#1 further stated RI#2 would not be returning to the facility from the hospital.</p> <p>RI#3</p> <p>RI#3 had resided at the facility since December 17, 2020 and was currently receiving home health services for a wound to the left foot. Refer to deficiencies 604 and 611 for additional information on RI#3. RI#3's home health and facility records repeatedly documented impaired decision making and forgetfulness. Review of home health records on December 8, 2021 revealed RI#3 had received home health services since June 14, 2021 for wound care to the left foot and the wound was first identified on June 11, 2021. RI#3 had received skilled wound care at the facility for almost six months at the time of the survey which exceeded the 90 days of skilled</p>	A 621		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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NAME OF PROVIDER OR SUPPLIER PATHWAYS MEMORY CARE OF BIRMINGHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 285 WEST OXMOOR ROAD BIRMINGHAM, AL 35209
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A 621	Continued From page 32 nursing care which is allowed in a SCALF. EI#1 stated the facility would immediately issue a 30-day discharge notice to RI#3's sponsor.	A 621		
A1001	420-5-20-.10 (1) Sanitation and Housekeeping. (1) Sanitation. (a) Water Supply. 1. If at all possible, all water shall be obtained from a public water supply. If it is impossible to connect to a public water system, the private water supply shall meet the approval of the local County Health Department. 2. Water under pressure of not less than 15 pounds per square inch shall be piped within the building to all sinks, toilets, lavatories, tubs, showers, and other fixtures requiring water. Tubs, showers, sinks, lavatories, and other fixtures used by residents shall have hot water supplied. Hot water accessible to residents shall in no case exceed 110 degrees Fahrenheit. (b) Disposal of Liquid and Human Wastes. 1. There shall be installed within the building a properly designed waste disposal system, connecting to all fixtures to which water under pressure is piped. 2. All liquid and human waste, including floor wash water and liquid waste from refrigerators, shall be disposed through trapped drains into a public sewer in localities where such system is available.	A1001		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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A1001	<p>Continued From page 33</p> <p>3. In localities where a public sanitary sewer is not available, liquid and human waste shall be disposed through trapped drains into a sewage disposal system approved by the local County Health Department. The sewage disposal system shall be of a size and capacity based on the number of residents and personnel housed and employed in the institution. Where the sewage disposal system is installed at an existing facility prior to granting of a license, it shall be inspected and approved by the local County Health Department.</p> <p>(c) Premises. The premises shall be kept neat and clean. The property shall be free of rubbish, weeds, ponded water, or other conditions, which may create a health, safety, or sanitation hazard.</p> <p>(d) Control of Insects, Rodents, and other Pests. Each facility shall be kept free of ants, flies, roaches, rodents, and other pests. Proper and lawful methods for their eradication or control shall be used. Droppings shall be evidence of infestation by pests.</p> <p>(e) Toilet Room Cleanliness. Floors, walls, ceilings, and fixtures of all toilet rooms shall be kept clean and free of objectionable odors. These rooms shall be kept free of an accumulation of rubbish, cleaning supplies, toiletry articles. The use of a common towel and common bar soap is prohibited.</p> <p>(f) Garbage Disposal.</p> <p>1. Garbage must be kept in water-tight suitable containers with tight-fitting covers.</p>	A1001		

Alabama Department of Public Health

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A1001	<p>Continued From page 34</p> <p>Garbage containers must be emptied at frequent intervals and shall be thoroughly cleaned and aired before using again.</p> <p>2. Garbage and waste shall be disposed of in accordance with local and state regulations.</p> <p>(g) Control of Odors. The facility shall be free of objectionable odors.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility was not free of objectionable odors.</p> <p>Findings:</p> <p>RI#1 had resided at the facility since September 8, 2021. Refer to deficiency 604 for additional information on RI#1. RI#1 had a diagnosis of overactive bladder and was incontinent of urine. On the morning of December 7, 2021, the surveyor and EI#3 toured residents' rooms in the facility. A strong urine odor was present in RI#1's room and bathroom. On December 8, 2021, at two different times, the surveyor noted RI#1 ambulating about the facility. A strong urine odor was noted when the surveyor was in close proximity to RI#1 in the hallway. Review of RI#1's facility record on December 8, 2021 revealed RI#1 had resided at another SCALF prior to admission to the facility. A Physician Visit Form, dated August 18, 2021, from the previous SCALF read "Eval for higher level of care...Pt. is urinating whenever (he/she) is standing. Room smells of urine...Incontinence of urine. Pt. not appropriate for here if (he/she) can't control bathroom habits. Health hazard to other residents".</p>	A1001		

Alabama Department of Public Health

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A1001	Continued From page 35 On December 8, 2021, EI#1 stated the facility would work with RI#1 and sponsor to develop a plan to control the odors.	A1001		
A1101	420-5-20-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All specialty care 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. 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 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		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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A1101	<p>Continued From page 36</p> <p>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. 2. Adequately protects against inappropriate access. 3. Complies with the requirements of the currently adopted Life Safety Code. <p>(f) Fire Alarm and Sprinkler System.</p> <ol style="list-style-type: none"> 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		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P3722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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A1101	<p>Continued From page 37</p> <p>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> <p>This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to properly document monthly fire drills.</p> <p>Findings:</p> <p>The surveyor reviewed the 2020 and 2021 Monthly Fire Drill reports with EI#4, Maintenance Director. The fire drills were being conducted jointly for the ALF (D3777) and SCALF (P3722), which are located in the same building. However, there was no documentation of the observations for each individual facility (ALF and SCALF) to include the effectiveness of the fire drill plan. The surveyors reviewed the SBOH requirement rules for ALF/SCALF that each separate facility must have observations of the fire drill plan effectiveness monthly, even when one alarm is pulled for the entire building. EI#4 verbalized understanding and provided the proper documentation for the fire drill conducted on December 7, 2021 at 1:44 PM.</p>	A1101		