

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D3771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/28/2019
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NAME OF PROVIDER OR SUPPLIER RIVER HIGHLANDS	STREET ADDRESS, CITY, STATE, ZIP CODE 1851 DATA DRIVE HOOVER, AL 35244
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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 March 28, 2019 an unannounced licensure survey was conducted for this 101 bed Assisted Living Facility (ALF) with a census of 58.</p> <p>There was one complaint investigated during this survey. Complaint ID#20190401002 was not substantiated and no deficiencies were cited as a result of the complaint investigation.</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 potential risk of harm to the residents and require a plan of correction.</p>	A 000		
A 509	<p>420-5-4-.05 (3)(c) Records and Reports</p> <p>Medical Examination Record. Not more than thirty days prior to admission of any resident to an assisted living facility, the resident or prospective resident shall be examined by a physician, who shall report his or her findings in writing to the facility. In addition to any information otherwise required by the facility's policies and procedures, and in addition to any other information the physician believes is pertinent, the medical 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. A statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact. 	A 509		

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

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A 509	<p>Continued From page 1</p> <p>3. Medication presently prescribed (name, dosage, and strength of drug, frequency of administration).</p> <p>4. A physician order is required for a resident to manage and have custody of his or her own medications.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to obtain a physicians' order for a resident to maintain custody of their medication(s).</p> <p>Findings:</p> <p>During observation of medication assistance, the surveyor observed a bottle of medication (Pepcid) on a table next to Resident Identifier (RI)#4. When asked if there were other medications in the room, RI#4 stated yes there were other medications kept in a bedside table in the bedroom. Along with Employee Identifier (EI)#6, the surveyor observed a bottle of eye drops, two bottles of extra strength Tylenol, and two bottles of nasal spray inside the drawer of the bedside table. EI#2, Director of Nursing, stated RI#4 did not have a physicians' order to maintain medications at bedside and immediately removed the medications from the room.</p>	A 509		

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A 617	Continued From page 2	A 617		
A 617	<p>420-5-4-.06(4)(b)(c)(d) Care of Residents</p> <p>(b) For purposes of this section, "aware of his or her medications" shall mean either of the following:</p> <ol style="list-style-type: none"> 1. The resident can maintain possession and control of his or her medications, and self-administer medications, without creating an unreasonable risk to health and safety; or 2. The resident has a reasonable lay person's understanding of the unit dose packaging system in use by the facility such that the resident could likely protect himself or herself from medication errors if unit dose packages are brought to the resident by facility staff. The resident shall have the opportunity to demonstrate his or her ability to correctly utilize the unit dose package system at every opportunity for medication use. <p>(c) A resident who is not aware of his or her medications is deemed to be severely cognitively impaired. Severely cognitively impaired is defined as a resident being incapable of recognizing his or her name, or if he or she does not understand and cannot be trained to understand the unit dose medication system in use by the facility, or if the resident likely cannot protect himself or herself from medication errors by the facility staff.</p> <p>(d) An assisted living facility resident who is aware of his or her medications as defined above may be assisted with the self-administration of medication by any assisted living facility staff, including staff members who hold no professional licensure. Assistance with self-administration of medication includes the following practices:</p>	A 617		

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A 617	<p>Continued From page 3</p> <ol style="list-style-type: none"> 1. Reminding a resident who is aware of his or her medications as defined above that it is time to take a medication or medications, where such medications have been prescribed for a specific time of day, a specific number of times per day, specific intervals of time, or for a specific time in relation to mealtimes or other activities such as arising from bed or retiring to bed. 2. Physically assisting a resident who is aware of his or her medications as defined above by opening or helping to open a container holding oral medications. 3. Offering liquids to a resident who is aware of his or her medications as defined above to assist that resident in ingesting oral medications. 4. Physically bringing a container of oral medications to a resident who is aware of his or her medications as defined above. <p>This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure visually impaired residents were provided a unique identifier to protect themselves from medication errors.</p> <p>Findings:</p> <p>During observation of medication assistance on March 26, 2019 the surveyor observed EI#5, Resident Assistant (RA), assist RI#7 with medications. RI#7 was visually impaired and had a velcro circle on medication cards for name identification. When asked if there were other visually impaired residents requiring identifiers on their medication card, EI#5 stated RI#8 was</p>	A 617		

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A 617	<p>Continued From page 4</p> <p>visually impaired and required the velcro identifier as well. The surveyor observed RI#8's medication cards which had velcro circles attached. EI#5 agreed the two residents should have unique and different identifiers for their medication cards. EI#2, Director of Nursing, later told the surveyor the name identifiers were corrected and each resident had different identifiers.</p> <p>SUSAN OVERTON, REGISTERED NURSE</p>	A 617		