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SUMMARY STATEMENT OF DEFICIENCIES
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**0000 - Initial Comments**

AMENDED . . . . added information to tag Z814.
**********

The re-licensure survey was conducted on . . . . Alabama Oaks Assisted Living, license #37, had deficiencies at the time of the visit.

**0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC**

Based on record reviews and interview, the facility failed to ensure an updated health assessment (1823) was obtained for a change in health status for 1 of 2 sampled resident (#2) who received Hospice services.

Findings:

Record review for resident #2, admitted on , who was identified by the facility staff as receiving hospice services. Review of her most recent 1823 found it was dated . Review of the hospice interdisciplinary plan in her record found hospice services began on . . A new health assessment was not obtained when hospice services were started.

On at 3 PM, the administrator confirmed the findings.

Class III

**0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC**

Based on resident record review and interview, the facility failed to ensure the resident's healthcare provider and family were notified of significant changes in a resident's status for 2 of 3 sampled residents (#2, #6) and that medication was provided as ordered for 1 of 3 sampled residents (#3).

Findings:

1. Review of the record for resident # 2 (admitted . . . ) revealed documentation of . . in the observation notes on of a while sitting at the table and she sustained a " on her knee & forehead.". There was no documentation of any assessment of injury to the resident or that her healthcare provider or family were notified. There was no follow-up noted. The next note in her record

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was dated .

2. Review of the record for resident #6 (admitted ) revealed documentation of transport to the hospital on for coughing. She returned the following day. There was no documentation of any assessment of injury to the resident or that her healthcare provider or guardian were notified. There was no follow-up noted. The next note in her record was dated and documented the start of treatment "due to on arms and across chest." There was no documentation of any further treatment, cleaning procedures of her , bedding or clothing. No documentation of isolation to prevent the spread of the to others. There was no documentation of any assessment of injury to the resident or that her healthcare provider or family were notified. There was no follow-up noted.

On at 3:00 PM, the administrator stated they do always call, but they do not always document. She confirmed there was no documentation to show they had notified the health care provider and the family.

3. On at 12:00 PM, resident #3 explained that very early that morning there was a lot of commotion with another resident who was having distress, causing both to become soiled and the 2 staff working hard to get everything cleaned up before breakfast. Resident #3 said when she went to breakfast later she felt the pills given to her by staff A "smelled funny, like she hadn't washed her hands after the incident." Resident #3 said she took the little cup of pills and her toast to her , but didn't take any of them because "they smelled like poop." She said she threw her toast in the trash as well. Resident #3 stated no one came in to make sure she took her meds. They were still sitting on the nightstand during the interview just before lunchtime. When asked if she got her eye drops that morning, she said, "no, not today."

On at 12:00 PM, the assistant manager confirmed the meds were not given as ordered and stated this was not the proper procedure for assisting with medications and she will speak to the administrator and the staff member.

Class III

**0054 - Medication - Records - 58A-5.0185(5) FAC**

Based on resident record review and interview, the facility failed to ensure the resident's healthcare provider and family were notified of significant changes in a resident's status for 2 of 3 sampled residents (#2, #6) and that medication was provided as ordered for 1 of 3 sampled residents (#3).

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Findings:

1. Review of the record for resident # 2 (admitted ) revealed documentation of in the observation notes on of a while sitting at the table and she sustained a " on her knee & forehead." There was no documentation of any assessment of injury to the resident or that her healthcare provider or family were notified. There was no follow-up noted. The next note in her record was dated .

2. Review of the record for resident #6 (admitted ) revealed documentation of transport to the hospital on for coughing. She returned the following day. There was no documentation of any assessment of injury to the resident or that her healthcare provider or guardian were notified. There was no follow-up noted. The next note in her record was dated that documented the start of treatment "due to on arms and across chest." There was no documentation of any further treatment, cleaning procedures of her , bedding or clothing. No documentation of isolation to prevent the spread of the to others. There was no documentation of any assessment of injury to the resident or that her healthcare provider or family were notified. There was no follow-up noted.

On at 3:00 PM, the administrator stated they do always call, but they do not always document. She confirmed there was no documentation to show they had notified the health care provider and the family.

3. On at 12:00 PM, resident #3 explained that very early that morning there was a lot of commotion with another resident who was having distress, causing both to become soiled and the 2 staff were working hard to get everything cleaned up before breakfast. Resident #3 said when she went to breakfast later she felt the pills given to her by staff A "smelled funny, as if she hadn't washed her hands after the incident." Resident #3 said she took the little cup of pills and her toast to her , but did not take any of them because "they smelled like poop." She said she threw her toast in the trash as well. Resident #3 stated no one came in to make sure she took her meds. They were still sitting on the nightstand during the interview just before lunchtime. When asked if she got her eye drops that morning, she said, "no, not today."

On at 12:00 PM, the assistant manager confirmed the meds were not given as ordered and stated this was not the proper procedure for assisting with medications and she will speak to the administrator and the staff member.

Class III

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.
Based on observation, medication observation record (MOR) review and interview, the facility failed to maintain an accurate log of medications provided to 1 of 2 residents sampled (#3)

Findings:

Observation during a resident interview found a small cup with 5 pills in it sitting on the nightstand next to resident #3's bed.

On . ... . at 12:00 PM, resident #3 explained that very early that morning there was a lot of commotion with another resident who was having distress, causing both to become soiled and the 2 staff were working hard to get everything cleaned up before breakfast. Resident #3 said when she went to breakfast later she felt the pills given to her by staff A "smelled funny, as if she hadn't washed her hands after the incident." Resident #3 said she took the little cup of pills and her toast to her . . , but did not take any of them because "they smelled like poop." She said she threw her toast in the trash. Resident #3 stated no one came in to make sure she took her meds. They were still sitting on the nightstand during the interview just before lunchtime. When asked if she got her eye drops that morning, she said, "no, not today."

Review of the MOR for resident #3 revealed the following medications were signed as being given on at 7:00 AM.
One-A-Day Women's Tablet, take one tablet by mouth every day- 7AM (found in the cup)
, , , 5mg tablet, take one tablet by mouth every morning- 7AM (found in the cup)
. , , 20 mg tablet, take one tablet by mouth every day- 7AM (found in the cup)
. . , 100 mg tablet, take one tablet by mouth every day- 7AM (found in the cup)
Levothryoxine 50mcg tablet, take one tablet by mouth every morning on an empty stomach- 7AM, 30 minutes before breakfast or other meds (found in the cup with all the other pills, to be taken at the same time)

. . . 1%-0.2% eye drops, instill 1 drop into both eyes three times a day- signed for 7:00 AM and 7:00 PM on (resident stated these were not given at 7:00 AM on ).

On at 12:10 PM, the assistant manager was shown the cup of pills in resident #3's . She said, "This should never happen." She reviewed the MOR for resident #3 and confirmed the medications had been signed as given on at 7:00 AM by staff A.

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Class III

**0078 - Staffing Standards - Staff - 58A-5.019(2) FAC**

Based on personnel record review and interview the facility failed to obtain an annual statement from the health care provider for 1 of 4 sampled staff (B) documenting freedom from ( ) annually.

Findings:

Personnel Record review for Staff B (caregiver, hired ), revealed no current annual documentation to confirm she was free from .

On at 12:10 PM, the assistant manager stated they believed the chest x-rays were good for 2 years and confirmed that the documentation was not in the record.

Class III

**0079 - Staffing Standards - Levels - 58A-5.019(3) FAC**

Based on observation, staff schedule review and interview, the facility failed to maintain written staff schedule that reflected its 24-hour staffing pattern.

Findings:

Observations on arrival at the facility found staff E, a caregiver hired , working in the main house with staff A. Staff G was working with the 4 residents that reside in the small cottage. Staff E stated she came to work at 5:00 AM that morning and was working until 9:30 AM.

Observation at 8:10 AM of the staff schedule posted on the kitchen bulletin board revealed Staff E handwritten in for with a start time of 5am and end time of 9:30 AM. Staff A was also on the schedule from 9 PM until 9 AM . Staff A and staff G started work at 9pm on and ended their shifts at 9 AM on .

On at 9:45 AM, the assistant manager stated that staff E was just "dropping something off and did not work today." When informed that staff E had already told the surveyor that she was working since 5AM and she was observed working with the residents since 8 AM, the assistant manager hesitated, and then said, "She was not supposed to work; she's not on the schedule." The assistant

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manager and the surveyor went to view the schedule again, which now had white out obscuring the entry for staff E from the morning of .
When asked who put the white out on the schedule, at 9:50 AM on , the assistant manager confirmed that she did it. She restated that staff E was not supposed to have worked.

On at 3:00 PM, the administrator confirmed that staff E had worked that morning and that the assistant manager had forgotten to inform staff E not to work. The administrator stated the assistant manager informed her that she used white out on the schedule that morning.

Class III

**0081 - Training - Staff In-Service - 58A-5.0191(2-3) FAC**

Based on personnel record reviews and interview, the facility failed to ensure that 1 of 4 sampled staff (B) received the required in-service training within 30 days of hire.

Finding:

Personnel Record review for Staff B (caregiver, hired ), revealed no certificates documenting training in 1) incident reporting and 2) safe food handling, as required within 30 days of hire.

On at 1:30 PM, the assistant manager confirmed the findings.

Class III

**0083 - Training - First Aid and - 58A-5.0191(5) FAC**

Based on personnel record review, staff schedule review and interview, the facility failed to ensure that staff working alone had current training and certification in First Aid (C).

Findings:

Review of the staff schedule found staff C, caregiver hired , was scheduled to work alone with the residents from 9pm until 9am, .

Review of the personnel record for staff C did not reveal any current or expired certification in First Aid.

On at 1:30 PM, the assistant manager confirmed the finding and said one of the other staff

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would work tonight.

Class III

**0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC**

Based on personnel record reviews and interview, the facility failed to ensure that 3 of 4 sampled staff (A, B & C) received the required training and updates regarding Assisting with self-administration of medications.

Finding:

1. Personnel Record review for Staff A (caregiver, hired ), revealed a certificate dated with a description of "Medication Technician Training Class, six hour certification." There were no certificates indicating completion of a 4 or 6-hour initial class in assisting with self-administration of medications.

2. Personnel Record review for Staff B (caregiver, hired ), revealed a certificate dated with a description of "Medication Technician Training Class, 2 hour update." There were no certificates indicating completion of the required annual 2-hour update class in assisting with self-administration of medications.

3. Personnel Record review for Staff C (caregiver, hired ), revealed a certificate dated with a description of "Medication Technician Training Class, 2 hour update." There were no certificates indicating completion of the required annual 2-hour update class in assisting with self-administration of medications.

On at 1:30 PM, the assistant manager confirmed the findings.

Class III

**0090 - Training - - 58A-5.0191(11) FAC**

Based on personnel record reviews and interview, the facility failed to ensure that 2 of 4 sampled staff (B & C) received the required training in the facility's policies and procedures ( ) within 30 days of hire.

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Findings:

Personnel Record review for Staff B (caregiver, hired ), revealed no certificate for training.

Personnel Record review for Staff C (caregiver, hired ), revealed a certificate for training that was dated , but was not provided by this facility.

On at 1:30 PM, the assistant manager confirmed the findings.

Class III

**0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC**

Based on observation, dining record review and interview, the facility failed to maintain 6 months of substitutions made to the dietician approved menu, as required by 58A-5.020(2) FAC.

Findings:

Observation at 8:10 AM on of the substitution log posted on the kitchen bulletin board revealed the last substitution was documented on .

Observation at 11:45 AM while observing lunch preparation revealed a new page of substitutions was now posted over top of the previous log. The page previously observed to end at , now had substitutions for dates in , and 2018. The new top page had several substitutions for , , including a substitution for the day of the survey, , for the lunch dessert.

When asked about the substitutions, at 11:45 AM on , the assistant manager showed me the log on the bulletin board. When informed that the surveyor had already seen the log earlier that day, she confirmed that she had added the additional items and the new page that morning.

Class III

**0160 - Records - Facility - 58A-5.024(1) FAC**

Based on observation, facility record review and interview, the facility failed to ensure an annual report of fire safety inspections by the local authority or the State Fire Marshal was maintained on file pursuant to Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C.

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Findings:

Tour of the facility on at 8:05 AM did not reveal a copy of the facility's fire inspection.

Request to review the facility records revealed a fire inspection with violations dated . The report documented 4 violations to be fixed by .

In an interview with the manager on at 10:30 AM, she confirmed the revisit by the fire inspector had not been done.

Class III

**0162 - Records - Resident - 58A-5.024(3) FAC**

Based on resident record review and interview, the facility failed to maintain documented weights for 2 of 2 sampled residents at least semi-annually (#2 & #6) for residents who received assistance with Activity of Daily Living (ADL).

Findings:

1. Review of the record for resident #2 revealed he was admitted on . The most current Health Assessment (1823), dated documented a weight of 122 lbs. Her diagnoses included , chronic kidney , Parkinson's and . Weights were documented on the admission health assessment (140 lbs.) and in by the facility (145 lbs.). No weights were recorded by the facility since 2015.

2. Review of the record for resident #6 revealed she was admitted on . The initial Health Assessment (1823) documented a weight of 144 lbs. Her diagnoses included Parkinson's , and . A weight of 160 lbs. was documented on a hospital discharge 1823 dated , and a weight of 150 lbs. was documented on another hospital discharge 1823 dated . No weights were documented from admission to present by the facility.

On at 1:00 PM, the administrator stated that the nurse practitioner weighed every resident and probably had the information. The administrator confirmed she did not maintain a weight record for the residents.

Class III

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**0181 - Emergency Plan Approval - 58A-5.026(2) FAC**

Based on review of the facility's Comprehensive Emergency Management Plan (CEMP) and interview, the facility failed to have documentation the CEMP was approved by the local emergency management agency according to 58A-5.026(2)(c) (1) FAC.

Findings:

Upon request to review the facility's CEMP, the administrator provided an approval letter dated from the County Office of Emergency Management.

On at 10:00 AM, the manager stated the new plan was submitted. She stated she did not know when it was submitted or have acknowledgement from the County that the plan was received. The facility did not have an approval letter for 2018.

Class III

**Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS**

Based on Observation, Agency Clearinghouse Review and Interview, the facility failed to register and maintain the employment status of employees within the Agency's Background Screening Clearinghouse for 1 of 4 sampled staff employees (Staff A).

Findings:

Review of the Agency's Background Screening website revealed staff A, caregiver hired , was not listed on the facility's roster.

Further review of the record found staff A had a level 2 background screen with an eligible date of .

In an interview with the administrator on at 3:00 PM, she stated she thought she had included everyone.

Unclassified

**Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS**

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Based on observation, record review and interview, the facility failed to ensure that all staff working with residents had a current eligibility background status and did not have any disqualifying offenses . (E)

Findings:

Observations on arrival at the facility found staff E, caregiver hired , and working with staff A. Staff E stated there were currently 11 residents in the main house and identified each resident, most of whom were sitting on the large front porch at 8:00 AM. Staff E stated she came to work at 5:00 AM that morning and was working until 9:30 AM.

Observation at 8:10 AM of the staff schedule posted on the kitchen bulletin board revealed Staff E handwritten in for with a start time of 5am and end time of 9:30 AM. Staff A was also on the schedule from 9 PM until 9 AM .

On at 9:45 AM, the assistant manager stated that staff E was just "dropping something off and did not work today." When informed that staff E had already told the surveyor that she was working since 5AM and she was observed working with the residents since 8 AM, the assistant manager hesitated, and then said, "She was not supposed to work." Since staff, E was cited for lacking a current background screen at the sister facility on , she was not to work until a new screening was obtained. When asked to see the screening results, the assistant manager stated staff E was going to get the screening today ( ). The assistant manager confirmed that staff E had worked with the residents before obtaining a new screening.

On at 3:00 PM, the administrator confirmed that staff E had not yet obtained a new screening and stated that the assistant manager forgot to inform staff E not to work .

Unclassified.