STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015120	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NHC HEALTHCARE, ANNISTON	2300 COLEMAN RD ANNISTON, AL 36207

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0919 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and review of the facility's policy titled CALL LIGHTS, the facility failed to ensure the resident call system was functioning on the 300 Hall from 7/20/2020 to 7/24/2020. During the 7:00 PM to 7:00 AM shift on 7/20/2020, a weather storm caused the system to not function. The staff in the facility during the storm failed to notify the facility's Administrator or Director of Maintenance at the time of the outage. The staff also failed to provide the residents who resided on the 300 Hall with an alternate means to call for assistance. The staff assigned to work the 300 Hall from 7/20/2020 to 7/23/2020, did not report the outage to the facility's Administrator or Director of Maintenance and they failed to follow-up with anyone to ensure the malfunctioning call system was being addressed. On 7/24/2020 around 8:30 AM, a staff member brought it to the attention of the Administrator and Director of Maintenance. The Director of Maintenance then rebooted the system and it was fully functioning in less than one minute. These failures affected all 10 residents who resided on the 300 Hall, one of four halls in the facility, and placed them in immediate jeopardy for serious injury, harm, death or impairment. According to a facility document dated 8/18/2020, and titled Census Detail by Level of Care for the time period 7/20/2020 to 7/24/2020, the facility had a total of 10 residents who resided on the 300 Hall. On 8/20/2020 at 1:08 PM, the Administrator, Corporate Vice President, and Assistant Regional Nurse were given a copy of the Immediate Jeopardy (IJ) template and notified of the finding of immediate jeopardy, past non-compliance in the area of Resident Call System, F919. Findings include: The facility's undated policy titled CALL LIGHTS documented PURPOSE: Center will provide each patient with a functioning call light . OBJECTIVE: A call light alerts the staff to respond to a patient's request for help . On 8/7/2020, the Alabama State Survey Agency received a complaint which alleged, the facility's call light system on the 300 Hall was struck during a storm on 7/20/2020 and no one reported the non-functioning call system to the facility's Administrator until 7/27/2020. Once the Administrator was notified, the Maintenance Director rebooted the system and it was functioning again. During an observation on 8/11/2020 beginning at 5:10 PM, all call lights on the 300 Hall were found to be functional; the lights illuminated over the resident's room door and were audible at the nurses' station. The facility's Daily Partner Time Collection Report for 7/20/2020 indicated Employee Identifier (EI) #1, a Licensed Practical Nurse (LPN) clocked in on 7/20/2020 at 6:58 PM and clocked out on 7/21/2020 at 7:00 AM. In an interview on 8/13/2020 at 7:10 AM, EI #1, an LPN was asked about the call lights not working in the facility. EI #1 replied, there was a storm and the call lights stopped working on Monday, 7/20/2020 during the third shift (11:00 PM to 7:00 AM). When asked what he did when he recognized the call system was not working, EI #1 stated he and the Certified Nursing Assistants (CNAs) conducted every 15 to 20 minutes rounds. According to EI #1, he reported to the oncoming nurse (later identified as EI #8, a LPN), that the call lights were not working, the staff had been making rounds and everyone was okay. EI #1 stated he didn't report it to anyone else and didn't record it in the maintenance log. EI #1 stated he figured maintenance would be in the facility in the morning and would fix it (call system). When asked how long the call system was not functioning, EI #1 stated he thought it was out until Friday (7/24/2020). When asked what he should have done when the call light system went out on the 300 Hall, EI #1 replied, he should have reported it on the maintenance log so that it could be addressed the next morning. In a follow-up telephone interview on 8/16/2020 at 8:54 AM, EI #1, a LPN, acknowledged he worked in the facility on 7/23/2020 during the 7:00 PM to 7:00 AM shift. When asked did he follow up with anyone on the call light system still being out, EI #1 stated he was told by EI #8 (LPN) that the call lights still were not working. EI #1 stated he thought someone was working on the system. The facility's Daily Partner Time Collection Report for 7/21/2020 indicated EI #8, a LPN clocked in on 7/21/2020 at 7:00 AM and clocked out at 6:44 PM. During a telephone interview on 8/13/2020 at 2:10 PM, EI #8 stated when she came on shift on 7/21/2020 a nurse reported to her the call light system was not working. EI #8 stated she was told a storm had come through and lightning struck the system. When asked if she reported to anyone that the call light system was not working, EI #8 stated she didn't report it to anyone because she thought it had already been reported. EI #8 was asked what was provided to the residents to alert the staff when care was needed. EI #8 replied, nothing that she knew of. When asked what should have been done, EI #8 answered, it should have been reported to maintenance or the Supervisor and bells be given to the residents. EI #8 stated the purpose of the call light system was to help the residents be able to call for help if they need assistance. According to the Daily Partner Time Collection Report, EI #8, a LPN worked in the facility on 7/22/2020 from 7:00 AM to 6:49 PM and on 7/23/2020 from 7:00 AM to 7:05 PM. In a follow-up interview on 8/15/2020 at 5:35 PM, EI #8, a LPN, was asked why she didn't follow-up on the status of the call light system not functioning. EI #8 stated she thought it was already reported. When asked why she didn't ask someone when the system would be fixed, EI #8 replied, she didn't know. In a telephone interview on 8/13/2020 at 3:40 PM, EI #9, a Certified Nursing Assistant (CNA) was asked how did she become aware the call light system was not working. EI #9 answered that she was working the night it went out. EI #9 stated there was a storm that started during the second shift (3:00 PM to 11:00 PM) that caused the call lights to not work. EI #9 stated the residents were not given any other devices to alert the staff of care needs; that she and other staff constantly checked on the residents. According to EI #9, the only resident that complained was Resident Identifier (RI) #2 and all he/she wanted to know was when the call lights would be working again. When asked how long the call light system was nonfunctional, EI #9 stated for about three to four days. EI #9 stated she didn't question anyone as to why the call lights were not working. On 8/11/2020 at 6:00 PM, RI #2 said a storm knocked the call system out but could not recall how long it remained out. RI #2 stated someone came to check on him/her at least every hour but was not sure how long that lasted. According to the Daily Partner Time Collection Report, EI #10, an LPN worked in the facility during the 7:00 PM to 7:00 AM shift on 7/20/2020, 7/21/2020, and 7/22/2020. During an interview on 8/13/2020 at 4:35 PM, EI #10, an LPN was asked how she became aware of the call light system not working. EI #10 stated she was working on the 400 Hall the night the storm hit and a resident, RI #2, informed her that he/she needed some ice and water and that the call lights were out. When asked if she questioned anyone as to why the call lights were not working, EI #10 stated she did not and thought it was just RI #2's call light that was not working. In an interview on 8/13/2020 at 11:25 AM, EI #2, a CNA was asked how she became aware the call light system was not working. EI #2 stated she worked on 7/21/2020 and was told there has been a storm on 7/20/2020, lightning struck the system and it was out. When asked what call lights were not working, EI #2 stated it was just the 300 Hall. EI #2 was asked if any residents complained about the call lights not working and she replied, RI #3. According to EI #2, RI #3 told her that the staff needed to get the darn lights back working. RI #3 could be heard beating on the walls to let the staff know he/she needed to go the bathroom. EI #2 stated she thought the problem was being taken care of and she didn't know it would drag out as long as it did. When asked how many days the call lights were out, EI #2 said about two to three days. In an interview on 8/11/2020 at 5:38 PM, RI #3 was asked about the call light system. RI #3 stated a while back it was out for a long time. RI #3 couldn't recall

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0919 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) how long the system was not working. According to RI #3, lightning had struck one of the circuits. While the call lights were not working, the staff checked on the residents about every 10 minutes. In a follow-up interview on 8/12/2020 at 10:55 AM, RI #3 stated the call lights were out for approximately three days. On 8/12/2020 at 11:15 AM, a random audit of the facility's call light system throughout the building was completed. All call lights were found to be functional. On 8/13/2020 at 9:30 AM, a telephone interview was conducted with RI #1, a resident who resided on the 300 Hall. RI #1 was asked if he/she was aware the call light system was not working. RI #1 replied, yes, it went out on Monday (7/20/2020) during the storm. RI #1 explained that one of the CNAs passed his/her room and said the call lights were out. When asked what he/she was provided as an alternate means to alert the staff of help needed, RI #1 said he/she was to call out or yell in hopes of getting someone's attention. RI #1 acknowledged there was a telephone in the room; however, the telephone was not always within reach and he/she was not provided a telephone number to call. On 8/13/2020 at 12:23 PM, an interview was conducted with EI #12, a first shift (7:00 AM to 3:00 PM) CNA. EI #12 stated when she came into work on 7/21/2020, she was notified by a third shift staff that a storm had come through and the call light system was not working because it had been struck by lightning. EI #12 stated to her knowledge, only the call lights on the 300 Hall were affected. EI #12 stated she assumed the issue had been reported. On 8/14/2020 at 8:51 AM, an interview was conducted with EI #13, a 7:00 PM to 7:00 AM shift LPN who works on the 300 Hall. EI #13 stated she came in one afternoon and noticed the call lights were not working. EI #13 also stated that a CNA informed her the call lights were not working and had been out since the storm. EI #13 stated the residents were checked every 30 minutes to hour to see if they needed anything. EI #13 stated she assumed it had already been reported to maintenance. According to the Daily Partner Time Collection Report, EI #13 worked in the facility during the 7:00 PM to 7:00 AM shift on 7/21/2020, 7/22/2020 and 7/24/2020. In a follow-up interview on 8/15/2020 at 3:35 PM, EI #13, a LPN was asked why she did not follow-up on the status of the non-functioning call lights when she worked in the facility on 7/21/2020 and 7/22/2020. EI #13 replied, she thought they knew and there was a reason why it was not fixed yet. EI #13 stated she works at night and thought the day shift staff had notified maintenance or the Administrator. During an interview on 8/19/2020 at 1:03 PM and 1:05 PM, respectively with RI #6 and RI #7, both residents acknowledged they were aware of the call light system was not working and was told to call out/holler for help. Both residents stated they had no unmet needs as the result of the call lights not working. In an interview on 8/13/2020 at 6:10 PM, EI #3, an LPN acknowledged that she immediately notified the Administrator on 7/24/2020 after becoming aware that RI #1's call light was not working. According to EI #3, the Administrator then notified maintenance and the residents were given a bells to alert the staff if they needed assistance, During an interview on 8/14/2020 at 4:45 PM, EI #5, the Administrator was asked how she became aware the call light system on the 300 Hall was not functioning. EI #5 replied, EI #3 notified her via text message on Friday (7/24/2020) morning around 8:30 AM. When asked how long the call lights were out, EI #5 stated there was a storm on Monday, 7/20/2020 and apparently that was when the call lights stopped working. EI #5 stated she called the nursing staff about the call lights. According to EI #5, EI #10 reported she was as aware because a resident had asked for ice and water and EI #1 said the storm caused the call lights to go out on Monday, 7/20/2020. EI #1 then reported it to EI #8. EI #5 stated, everybody assumed that everybody knew and assumed it was being fixed. In a follow-up interview on 8/15/2020 at 6:45 PM, EI #5, the Administrator stated after she became aware the call lights on the 300 Hall were not working, she notified EI #4, the Director of Maintenance. According to EI #5, EI #4 was not aware and begun working to fix the system. During an interview on 8/14/2020 at 9:30 AM, EI #4, the Director of Maintenance acknowledged that he found out on Friday, 7/24/2020 that the call light system on the 300 Hall was not working due to a storm that came through on Monday, 7/20/2020. When asked what was done to address the problem, EI #4 stated he reset the call light system and it was functional within about a minute. EI #4 was asked what his understanding was as to how long the call light system was not working. EI #4 replied, from Monday 7/20/2020 to Friday, 7/24/2020. EI #4 stated after he reset the system, he checked all the call lights throughout the entire facility. ********** After the facility's Administrator became aware of the non-functioning call light system on the 300 Hall, the following corrective actions were implemented: On 7/24/2020, all residents on the 300 Hall were provided with a bell or [MEDICATION NAME]. All residents who resided on the 300 Hall were interviewed and no concerns were voiced. The Director of Maintenance, EI #4, was notified on 7/24/2020. EI #4 reset the call light system and it was again functional. EI #4 also conducted a facility-wide audit of all the call lights in the facility and none were found to be not working. EI #4 implemented a twice per week monitoring of the facility's call light system. Staff education was provided on 7/27/2020 regarding the facility's back-up call light system process, to include notification of appropriate personnel. 1:1 staff education was provided to EI #1 and EI #8 regarding the procedure to follow when there is a call light outage. Twice per week monitoring of the facility's call light was implemented. The above corrective actions were reviewed by the facility's Quality Assurance committee. ********** After review of the facility's corrective actions, observations, resident and staff interviews, the facility implemented corrective actions from 7/24/2020 to 7/27/2020, thus immediate jeopardy past non-compliance was cited. This deficiency was cited as a result of complaint/report number AL 761.