Theresa Kawika

Accepted 4/24/25

chg

PLAN OF CORRECTION

Facility Name: Proveer at Port City - SCALF Facility ID #: P4903

Survey Exit Date: 04/03/2025 Administrator: Jordyn Skinner

Deficiency Number: 420-5-20-.02 (2) The License

A 202

1. Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.

    - On March 27, 2025, all application and name change paperwork were submitted to the ADPH by the VP of Clinical Operations.
    - Upon receipt from the ADPH, EI#1 will hang the correct license with the name change of Kauhale Port City and remove the previously posted Proveer at Port City license.

2. Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems similar to those listed in each example. Include specific timetables and the title of staff responsible.

    - On 4/17/2025, the Senior Director of Clinical Operations visited the community and performed a community-wide evaluation to identify all forms, policies, contracts, assessments, and files that will need the appropriate Kauhale logo.
    - All items bearing previous names will be changed to Kauhale on or before June 1, 2025.

3. Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.

    - On or before June 1, 2025, all forms will be changed to Kauhale and will be utilized by the community, ongoing.
    - During routine visits, the VP of Clinical Operations, Sr. Director of Clinical Operations or Sr. Director of Operations will randomly review records to ensure that the Kauhale forms are being utilized, ongoing.

4. Explain how you will monitor your proposed corrective actions to ensure that they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.

- The Administrator will review forms and collateral to ensure that the Kauhale forms are being utilized, effective June 2025 x 3 months.
- During routine visits, the VP of Clinical Operations, Sr. Director of Clinical Operations or Sr. Director of Operations will randomly review records to ensure that the Kauhale forms are being utilized effective June 2025 x 3 months.

PLAN OF CORRECTION

Facility Name: Proveer at Port City – SCALF Facility ID #: P4903

Survey Exit Date: 04/03/2025 Administrator: Jordyn Skinner

Deficiency Number: 420-5-20-.01 (2) Personnel

A 401

1. Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.

   - On or before April 25th, 2025, the Executive Director and Memory Care Director, RN reviewed the monthly schedule with the overnight LPN and trained on the State Regulations for staffing requirements.

2. Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems similar to those listed in each example. Include specific timetables and the title of staff responsible.

   - On or before May 30, 2025, the Executive Director and/or Memory Care Director, RN will retrain all staff on the State Regulations for staffing requirements in the SCALF to ensure there are at least 3 associates in the SCALF on all 3 shifts/7 days per week.

3. Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.

   - Effective immediately, the Administrator and/or Memory Care Director will personally train all newly hired associates on the State Regulations on staffing requirements in the SCALF, ongoing.

4. Explain how you will monitor your proposed corrective actions to ensure that they are implemented and that the corrective actions adequately

address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.

- Effective immediately, the Administrator and/or Memory Care Director, RN will routinely audit that the SCALF staffing requirements are being met, X 3 months and randomly thereafter.
- During routine visits, the VP of Clinical Operations, Sr. Director of Clinical Operations or Sr. Director of Operations will review staffing schedules effective immediately X 3 months and randomly thereafter.

PLAN OF CORRECTION

Facility Name: Proveer at Port City – SCALF Facility ID #: P4903

Survey Exit Date: 04/03/2025 Administrator: Jordyn Skinner

Deficiency Number: 420-5-20-.04 (6)(7)(8) Personnel

A 405

1. Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.

   - On or before April 25th, 2025, the Memory Care Director, RN changed the schedule to ensure that at least one staff member with CPR certification was scheduled on each shift.
   - On April 22, 2024, the Administrator contacted the CPR Instructor to schedule a class to ensure all associates involving resident care receive current CPR certification.
   - On or before May 30, 2025, EI#1, EI#2, EI#6, and EI#7 found to be with an outdated CPR Certification will receive CPR certification and a current CPR Card will be placed in their respective personnel files.

2. Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems similar to those listed in each example. Include specific timetables and the title of staff responsible.
   - On April 23, 2025, the Memory Care Director, RN, reviewed the schedule and ensured that at least one CPR Certified Care Staff member was on the schedule for each shift.

3. Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in

your facility.

- Effective immediately, the Memory Care Director, RN, and/or Administrator will review the schedule prior to posting to ensure at least one associate who is CPR Certified is scheduled on each shift, ongoing.
- The Business Office Manager will maintain an active CPR List and will provide a copy, monthly, to the Memory Care Director, RN, to ensure that all care associates maintain current certification, ongoing.
- The Administrator and/or Business Office Manager will ensure all new hires are CPR certified within 90 days.

4. Explain how you will monitor your proposed corrective actions to ensure that they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.

   - The Administrator will review the CPR list against the schedule, monthly x 3 months and then randomly ongoing, to ensure that there is at least one associate that is CPR certified on each shift.
   - During routine visits, the VP of Clinical Operations, Sr. Director of Clinical Operations or Sr. Director of Operations, will perform random audits to verify that at least one CPR Certified Associate is scheduled on each shift.

PLAN OF CORRECTION

Facility Name: Proveer at Port City – SCALF Facility ID #: P4903

Survey Exit Date: 04/03/2025 Administrator: Jordyn Skinner

Deficiency Number: 420-5-20-.05 (3)(d) Records and Reports

A 504

1. Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.

   - On April 2, 2025, the dinnerware, stemware, and silverware were purchased to ensure that there are enough items to serve all residents.
   - Effective immediately, the Administrator and/or Memory Care Director, RN, will ensure that no paper or plastic products are used for food service during resident meals.

- On April 1, 2025, the Administrator had ketchup delivered to the Memory Care Dining Room for the residents to have condiments for their meal.
- Effective immediately, the Dining Services Director and/or Memory Care Director, RN, will ensure that the residents are provided with appropriate condiments with all meals.
- On April 3, 2025, EI#3 repaired the door at the time of the survey.
- Effective immediately, the Administrator and/or Memory Care Director, RN will ensure that the residents are offered water, tea, coffee and milk with all meals.

2. Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems similar to those listed in each example. Include specific timetables and the title of staff responsible.
    - N/A

3. Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.

    - Effective immediately, the Dining Services Director will ensure that no paper or plastic products are used for food service during resident meals and snacks ongoing.
    - Effective immediately, the Dining Services Director will ensure that the residents are provided with appropriate condiments with all meals ongoing.
    - Effective immediately, the Dining Services Director will ensure that the residents are offered water, tea, coffee and milk with all meals and snacks ongoing.

4. Explain how you will monitor your proposed corrective actions to ensure that they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.

    - Effective immediately, the Administrator and/or Memory Care Director, RN, will ensure that no paper or plastic products are used for food service during resident meals and snacks x 3 months and randomly thereafter.
    - Effective immediately, the Administrator and/or Memory Care Director, RN, will ensure that the residents are provided with appropriate condiments with all meals ongoing x 3 months and randomly thereafter.

- Effective immediately, the Administrator and/or Memory Care Director, RN, will ensure that the residents are offered water, tea, coffee and milk with all meals and snacks x 3 months and randomly thereafter.
- During routine visits, the VP of Clinical Operations or the Senior Director of Clinical Services will attend random meal service and snack times to ensure that appropriate stemware, dinnerware, silverware are being used x 3 months and randomly thereafter.
- During routine visits, the VP of Clinical Operations, Sr. Director of Clinical Operations or Sr. Director of Operations will attend random meal service and snack times to ensure that appropriate condiments are being offered x 3 months and randomly thereafter.
- During routine visits, the VP of Clinical Operations, Sr. Director of Clinical Operations or Sr. Director of Operations, will attend random meal service and snack times to ensure that residents are offered water, tea, coffee and milk during meals and snacks x 3 months and randomly thereafter.

PLAN OF CORRECTION

Facility Name: Proveer at Port City – SCALF Facility ID #: P4903

Survey Exit Date: 04/03/2025 Administrator: Jordyn Skinner

Deficiency Number: 420-5-20-.05 (3)(h) Records and Reports

A 508

1. Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.

   - The previous Administrator is no longer at the community, as of February 28, 2025.
   - On or before May 30, 2025, the Administrator and/or Memory Care Director, RN, will retrain all staff on the Incident Reporting Policy and Procedures.

2. Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems similar to those listed in each example. Include specific timetables and the title of staff responsible.

   - On or before June 1, 2025, the Administrator and/or Memory Care Director will review all Incident Reports to ensure that there are no

additional IR that will need to be investigated and reported to the ADPH.

- On or before June 1, 2025, the Administrator will ensure that all Incidents have an investigation completed.

3. Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.

    - Effective immediately, all incidents that are State Reportable will be reported to the Administrator, the Memory Care Director, RN, the VP of Clinical Operations and the Senior Director of Clinical Services.
    - Effective immediately, the Administrator will report all State Reportable incidents to the ADPH within 24 hours of any incident that requires medical attention.
    - Effective immediately, the Administrator will complete an investigation on all incidents and maintain in a confidential investigative file.

4. Explain how you will monitor your proposed corrective actions to ensure that they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.

    - During routine visits, the VP of Clinical Operations, Sr. Director of Clinical Operations or Sr. Director of Operations will verify that all State Reportable incidents are in the binder with confirmation that they have been reported, ongoing.
    - During routine visits, the VP of Clinical Operations, Sr. Director of Clinical Operations or Sr. Director of Operations will very that all incidents have a confidential investigation on file, ongoing.

PLAN OF CORRECTION

Facility Name: Proveer at Port City – SCALF Facility ID #: P4903

Survey Exit Date: 04/03/2_ A025dministrator: Jordyn Skinner

Deficiency Number: 420-5-20-.06 (2)(a)(b)(c) Care of Residents

A 602

1. Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.

    - Previous Administrator is no longer employed at the community, as of February 28, 2025.
    - On April 7, 2025, the Administrator retrained the Memory Care Director, RN, on the ADPH requirement that all residents are to have a Physician Medical Examination prior to moving into the community.
    - On April 4, 2025, the Administrator and/or the Memory Care Director, RN, reviewed RI#3's Medical Record to ensure that the resident has a current medical examination on file.

2. Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems similar to those listed in each example. Include specific timetables and the title of staff responsible.

    - On or before May 30, 2025, the Administrator and/or the Memory Care Director reviewed all residents Medical Records to ensure that there are no other residents with Medical Examinations that were not completed before the resident moved into the community.

3. Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.

    - Effective immediately, the Memory Care Director, RN, will ensure that all residents will have a Medical Examination within 30 days of the resident's physical move-in, ongoing.

4. Explain how you will monitor your proposed corrective actions to ensure that they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.

    - Effective immediately, the Administrator will review all residents Medical Examination prior to the resident physically moving into the community, x 3 months and randomly thereafter.
    - During routine visits, the VP of Clinical Operations, Sr. Director of Clinical Operations or Sr. Director of Operations, will review the new move in Medical Records to ensure that the Medical Examination was

completed prior to the resident's physical move-in, randomly, ongoing.

PLAN OF CORRECTION

Facility Name: Proveer at Port City – SCALF Facility ID #: P4903

Survey Exit Date: 04/03/2025 Administrator: Jordyn Skinner

Deficiency Number: 420-5-20-.06 (4)(a)(b)(c) Care of Residents

A 611

1. Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.

   - On April 8, 2025, EI#2 updated RI#1, #2, #3, #4 to address any significant medical diagnosis and medications.

2. Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems similar to those listed in each example. Include specific timetables and the title of staff responsible.

   - On or before April 25, 2025, EI#2 will review all other residents' care plans and address any missing conditions, diagnoses and medications.

3. Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.

   - Effective immediately, the Memory Care Director, RN, will ensure that all Care Plans moving forward will contain all medical conditions, diagnoses and medications.
   - Effective immediately, the Memory Care Director, RN, will begin using the Care Plan Addendum template to capture all pertinent medical information.

4. Explain how you will monitor your proposed corrective actions to ensure that they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.

   - Effective immediately, the Administrator will audit all resident care plans, weekly x 3 months and randomly thereafter.

- During routine visits, the VP of Clinical Operations and/or the Senior Director of Clinical Compliance will randomly review resident care plans, ongoing.

PLAN OF CORRECTION

Facility Name: Proveer at Port City – SCALF Facility ID #: P4903

Survey Exit Date: 04/03/2025 Administrator: Jordyn Skinner

Deficiency Number: 420-5-20-.07 (3) Food Service

A 703

1. Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.

   - On April 1, 2025, the Administrator had ketchup delivered to the Memory Care Dining Room for the residents to have condiments for their meal.
   - Effective immediately, the Dining Services Director and/or Memory Care Director, RN, will ensure that the residents are provided with appropriate condiments with all meals.
   - Effective immediately, the Dining Services Director and/or Memory Care Director will ensure that residents' food is palatable and that buns are fresh.

2. Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems similar to those listed in each example. Include specific timetables and the title of staff responsible.

   - On April 23, 2025, the Administrator ensured that condiments were brought to all residents to ensure that food was not dry.

3. Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.
   - Effective immediately, the Dining Services Director will ensure that the residents are provided with appropriate condiments with all meals ongoing.

4. Explain how you will monitor your proposed corrective actions to ensure that they are implemented and that the corrective actions adequately

address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.

- Effective immediately, the Administrator and/or Memory Care Director, RN, will ensure that the residents are provided with appropriate condiments with all meals ongoing x 3 months and randomly thereafter.
- Effective immediately, the Administrator and/or Memory Care Director, RN, will ensure that the residents are served fresh and palatable meals, ongoing x 3 months and randomly thereafter.
- During routine visits, the VP of Clinical Operations, Sr. Director of Clinical Operations or Sr. Director of Operations will attend random meal service and snack times to ensure that appropriate condiments are being offered x 3 months and randomly thereafter.

PLAN OF CORRECTION

Facility Name: Proveer at Port City – SCALF Facility ID #: P4903

Survey Exit Date: 04/03/2025 Administrator: Jordyn Skinner

Deficiency Number: 420-5-20-.06 (4)(a)(b)(c) Care of Residents

A 1102

1. Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.

    - EI#3 is no longer employed at the community, as of April 4, 2025.
    - On April 2, 2025, housekeeping cleaned R#1, R#2, R#3 and R#4's refrigerators.
    - On or before May 30, 2025, the Maintenance Director will clean and extract all common areas, hallways, and resident apartment carpeting in the Memory Care.
    - On April 7, 2025, the Administrator allowed associates access to the supplies that are needed daily for resident needs and care.
    - On April 16th, 2025, the Memory Care Director, RN, ordered the correct and enough gloves necessary for the care and needs of the residents.
    - On April 23, 2024, the Maintenance Director replaced the lock on the Chemical Storage Cabinet.
    - On April 8th, 2025, the Administrator provided retraining the housekeeping staff on effective cleaning protocols.

2. Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems like those listed in each example. Include specific timetables and the title of staff responsible.

   - On April 4th, 2025, housekeeping inspected and cleaned all other residents' refrigerators.
   - On April 4th, 2025, the Administrator and Memory Care Director, RN, inspected all other residents' apartments for cleanliness,
   - On April 7th, 2025, the Administrator and Memory Care Director, RN, inventoried all supplies to determine if any supplies needed to be ordered, outside of gloves. No other supplies were identified to be low.

3. Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.

   - Effective immediately, the Memory Care Director, RN, will implement a weekly resident housekeeping schedule to ensure appropriate sanitation and cleanliness.
   - Effective immediately, the Memory Care Director, RN, will ensure that the staff have 24/7 access to the supplies that are necessary to meet the needs of the residents.
   - Effective immediately, the Administrator will implement a common area cleaning and extraction schedule to ensure that the community is clean.
   - Effective immediately, the Memory Care Director and/or Administrator will ensure that the chemical supply cabinet is locked and functioning properly.

4. Explain how you will monitor your proposed corrective actions to ensure that they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.

   - Effective immediately, the Administrator will do a daily walk through the Memory Care community to ensure that carpets, common areas, hallways, resident apartments are clean and that supplies are available to the associates, x 1 month and then weekly thereafter.
   - Effective immediately, the Administrator will do a daily walk through the Memory Care community to ensure that the clinical supply cabinet is locked and functioning properly x 1 month and then weekly thereafter.
   - During routine visits, the VP of Clinical Operations and/or the Senior Director of Clinical Operations will randomly visit the Memory Care

community to ensure cleanliness and supply availability for the associates, ongoing.

- During routine visits, the VP of Clinical Operations, Sr. Director of Clinical Operations or Sr. Director of Operations will randomly visit the Memory Care community to ensure that the chemical supply cabinet is locked and functioning properly, ongoing.

PLAN OF CORRECTION

Facility Name: Proveer at Port City– SCALF Facility ID #: D49003

Survey Exit Date: 04/03/2025 Administrator: Jordyn Skinner

Deficiency Number: 420-5-4-.11(1) Fire Safety

A 1101

1. Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.

   - E#3 is no longer employed at the community, as of April 4th, 2025.
   - The Administrator retrained the new Maintenance Director on Fire Safety Training and required monthly Fire Drills with one/shift each quarter
   - On or before May 30, 2025, the Administrator and/or Maintenance Director will retrain all staff on the proper Fire and Safety Training.
   - On or before April 29th, 2025, the Maintenance Director will perform a Fire Drill on 1st shift with the Administrator present.

2. Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems similar to those listed in each example. Include specific timetables and the title of staff responsible.

   - N/A

3. Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.

   - Effective immediately, the Administrator and/or Maintenance Director will provide Fire Safety and Fire Drill training with all new hires ongoing.

- Effective immediately, the Administrator will ensure that the Maintenance Director is holding a monthly fire drill, with one per shift each quarter, ongoing.

4. Explain how you will monitor your proposed corrective actions to ensure that they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.

   - Effective immediately, the Administrator will review all Fire Drill Logs for completion and compliance monthly x 3 months and randomly thereafter.
   - During routine visits, VP of Clinical Compliance and/or Senior Regional Director of Clinical Operations will randomly check for documented fire drill logs, ongoing.

PLAN OF CORRECTION

Facility Name: Proveer at Port City– SCALF Facility ID #: D49003

Survey Exit Date: 04/03/2025 Administrator: Jordyn Skinner

Deficiency Number: 420-5-20-.12(1) Physical Environment

A 1201

1. Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.

   - E#3 is no longer employed at the community, as of April 4th, 2025.
   - E#3 repaired the door system at the time of the survey on 4/1/2025.

2. Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems similar to those listed in each example. Include specific timetables and the title of staff responsible.

   - N/A

3. Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.

   - Effective immediately, the Maintenance Director and/or Memory Care Director will ensure that the door is functioning properly, ongoing.

4. Explain how you will monitor your proposed corrective actions to ensure that they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.

    - Effective immediately, the Administrator will perform daily Memory Care walk through to ensure that the doors are functioning properly, X 1 month and randomly thereafter.
    - During routine visits, VP of Clinical Operations, Sr. Director of Clinical Operations or Sr. Director of Operations will randomly check that the Memory Care doors are functioning properly, and ongoing.

NOTE: All Plan of Correction documentation will be in a binder, organized and filed by the Administrator. This binder will be stored in the Administrator's office.

Should any corrective action be determined as ineffective, the Administrator and Governing Authority shall make immediate revisions and submit an amended Plan of Correction to the Alabama State Board of Health.

Administrator Signature Jordyn Skinner ***Date*** 4/24/25

Prepared by:
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Kauhale Health
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