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Plan of Correction

Accepted 03/06/25 0757 AM
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Specialty Care Assisted Living

Facility: St Martin's in the Pines P3706

The following is the Plan of Correction for Diversicare St. Martin's in the Pines regarding the Statement of Deficiencies dated 1//14/25. The Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.

Plan of Correction for Deficiency Related to Rule 420-5-20-.03(2)(c) – Department Notification

1. **Corrective Action Taken for Affected Issue:**
    - On 12/30/2024 the facility submitted the required written notification to the Alabama Department of Health regarding the change in administrator via postal mail and again on 2/3/2025 via email.
    - A confirmation of submission was obtained and placed in the facility's administrative records.
2. **Systemic Changes to Prevent Recurrence:**
    - The facility's leadership team has been reminded of the regulatory requirement to notify the Alabama Department of Health within 45 days of any administrator change.
    - The administrator will ensure that any future changes are promptly reported by setting a reminder upon notice of an administrator change and confirming submission with the appropriate staff.
3. **Training and Education:**
    - The current administrator and other key staff involved in regulatory reporting have received training on the requirement for timely notification of administrator changes.

- Training covered the specific timelines outlined in Alabama Administrative Code 420-5-20-.03(2)(c) and was completed on 2/03/2025.
- Attendance was documented, and records of training will be maintained.

4. **Monitoring and Ongoing Compliance:**
   - The facility will track reporting deadlines related to administrator changes using an administrative checklist that is reviewed monthly for six months.
   - The administrator (or designee) will conduct quarterly audits of facility records to verify compliance with notification requirements for six months.
   - Compliance findings will be discussed in administrative meetings, and any necessary corrective actions will be taken.
   - Audits will be kept in the Administrator's office

Completion Date for Full Compliance: 2/5/25

Plan of Correction for A1101 420-5-20-.11 (1) Fire and Safety

1. Corrective Action Taken for Affected Residents:

- The facility immediately conducted a fire drill on 1/2/2025 upon identification of the deficiency to ensure compliance with fire safety regulations.
- Staff participated in the drill, and documentation was completed and filed per regulatory requirements.

2. Measures to Prevent Recurrence:

- A Fire Drill Compliance Log has been created and will be maintained by the Maintenance Director to track monthly fire drills and ensure timely execution for six months.
- The Maintenance Director and Administrator will jointly review fire drill schedules and compliance monthly for six months.
- Maintenance Director has been re-educated on fire drill requirements, including the necessity for monthly drills and quarterly shift-based drills.

3. Systemic Changes to Ensure Future Compliance:

- The fire alarm system will be used to initiate all drills, as required.

- The Maintenance Director will submit completed fire drill reports to the Administrator within 24 hours of each drill for six months.
- Fire drill effectiveness will be evaluated monthly for six months, and written observations will be maintained for at least three years.

4. Monitoring and Quality Assurance:

- The Administrator will conduct a monthly audit for six months of fire drill records to verify compliance and effectiveness.
- Any missed drills or identified issues will be reported during monthly safety committee meetings, with immediate corrective actions implemented.
- Compliance with fire drill regulations will be reviewed during the facility's quarterly Quality Assurance and Performance Improvement (QAPI) meetings for six months.
- Fire Drill Compliance Log will be kept in the Administrators office.

Completion Date: 2/5/25

Responsible Party: **Administrator and Maintenance Director**

Plan of Correction for A1206 420-5-20-.12 (8) Physical Environment

Deficiency: The facility failed to provide a functioning central control panel for remotely unlocking all exit doors and did not conduct monthly checks to ensure delayed-egress exit doors functioned properly.

1. Corrective Action for Affected Areas

- **Immediate Repairs:** The facility has contacted the fire alarm system vendor to restore full functionality of the central control panel for unlocking all exit doors. The system will be tested and verified operational on 12/23/24.
- **Door Functionality Check:** All delayed-egress exit doors have been inspected, and door 4 SNL and the common area egress door have been repaired and tested for proper function.

2. Systemic Changes to Prevent Recurrence

  - The facility will complete monthly testing and documentation of all delayed-egress doors for six months.

- Immediate reporting and resolution of malfunctioning doors will be completed when necessary.
- Clear identification of emergency button.

- **Staff Training:** All staff, will be re-trained by 1/13/24 on:
  - Locating and using the emergency release button for unlocking exit doors.

3. Monitoring and Quality Assurance

- **Monthly Inspections:** The maintenance director or designee will conduct and document monthly door function tests for six months. These will be reviewed by the administrator and kept on file for state review.
- **Quarterly Fire Drills:** Fire drills will be conducted at least quarterly, including testing exit door functionality under emergency conditions. Documentation will be maintained for compliance verification.

4. Compliance Oversight

- **Administrative Review:** The executive director and administrator will audit the emergency door system records monthly for six months to ensure compliance.
- Audits will be kept in the Administrators office

Completion Date: 2/5/25
Responsible Party: **Administrator & Maintenance Director**

Administrator Signature: DBeck *Date:* 2/26/25