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CC
2.27.25 Gregory C. Leitlin, RN, MSHAI

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//31/25. 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.

A401 420-5-20-.04 (1) (2) Personnel.

The facility failed to have sufficient staff on duty to meet the care and safety needs of all residents.

All residents had the potential to be affected.

Current employee staff schedule was audited to ensure ADPH required staffing ratios are met. Daily staffing ratios identified to be out of compliance were corrected on 02/01/25.

Re-education will be provided to the staffing coordinator regarding ADPH staffing requirements to ensure there is sufficient staff on duty to meet the care and safety needs of all residents by the Administrator no later than 03/13/2025.

Random audits will be conducted weekly by the Administrator or designee to ensure compliance with meeting staffing ratio requirements for six months. Areas of deficiencies identified will be corrected immediately.

Documentation of education and audits will be kept in the Resident Service Director's office.

A403 420-5-20-.04 (4) Personnel.

The facility had incomplete personnel records for employees.

All employee files had the potential to be affected.

Employee files for EI#2, EI#3, EI#4, EI#5, EI#6, and EI#7 will be reviewed to determine date of initial resident contact and dates identified will be documented in the employee file by 02/28/2025.

Audit to be completed to identify other employee files that may be missing documentation for initial resident contact date. Areas of deficiencies identified will be corrected by 03/13/2024.

Re-education will be provided to Human Resources Director regarding requirement for identifying and documentation each employee's initial resident contact date in his/her employee file by Administrator no later than 03/13/2025.

Random audits will be conducted weekly by the Administrator or designee through random employee file reviews for six months. The review will include documentation compliance of initial resident contact date. Areas of deficiencies identified will be corrected immediately.

Documentation of education and audits will be kept in the Resident Service Director's office.

A406 420-5-20-.04 (9) Personnel.

The facility failed to provide staff with appropriate training.

All employees had the potential to be affected.

EI#2, EI#6, EI#8, and EI#9 will complete the approve equivalent training to DETA by 02/28/25.

All employee training files will be audited by the Human Resources Director or designee for compliance of completing the DETA training or approved equivalent training by 03/13/25. Deficiencies identified will be corrected.

Re-education will be provided to the Human Resources Director regarding the requirement for an employee's completion of the DETA training or approved equivalent

training prior to resident contact. Re-education will be provided no later than 03/13/2025 by the Administrator or designee.

Random audits will be conducted weekly by the Administrator or designee through random employee file reviews for six months. The review will include documentation of completion of required training. Areas of deficiencies identified will be corrected immediately.

Documentation of education and audits will be kept in the Resident Service Director's office.

A504 420-5-20-.05 (3) (d) Records and Reports.

The facility failed to document the acknowledgment of Resident Rights as required.

All residents had the potential to be affected.

The acknowledgment documentation for Resident Rights for RI#2 and RI#5 will be completed no later than 03/13/25.

All current resident files will be reviewed to ensure presence of documented acknowledgment of Resident Rights. Deficiencies identified will be corrected by 03/13/25.

Re-education will be provided to the Resident Service Director regarding requirement to ensure all resident files have documented acknowledgment of Resident Rights. Re-education will be provided no later than 03/13/2025 by the Administrator or designee.

The Resident Service Director of designee will conduct monthly random audits to ensure compliance for six months. Areas of deficiencies identified will be corrected immediately.

Documentation of education and audits will be kept in the Resident Service Director's office.

A506 420-5-20-.05 (3) (f) Records and Reports.

Personal property of residents was not inventoried upon admission to the facility.

All residents had the potential to be affected.

The inventory of personal effects documentation for RI#2, RI#5, and RI#6 will be completed no later than 03/13/25.

All current resident files will be reviewed to ensure presence of documented inventory of personal effects. Deficiencies identified will be corrected by 03/13/25.

Re-education will be provided to the Resident Service Director regarding requirement to ensure all resident files have a documented inventory of personal effects. Re-education will be provided no later than 03/13/2025 by the Administrator or designee.

The Resident Service Director of designee will conduct monthly random audits to ensure compliance for six months. Areas of deficiencies identified will be corrected immediately.

Documentation of education and audits will be kept in the Resident Service Director's office.

A602 420-5-20-.06 (2) (a) (b) (c) Care of Residents.

Required information was not documented on residents' initial medical examination records.

All residents had the potential to be affected.

A request was made to RI#1 and RI#5's physician's to provide us with a new completed medical examination documentation later than 03/13/25.

All current resident files will be reviewed to ensure presence of a completed medical examination record. Deficiencies identified will be corrected by 03/13/25.

Re-education will be provided to the Resident Service Director regarding requirement to ensure all resident files have a completed medical examination document. Re-education will be provided no later than 03/13/2025 by the Administrator or designee.

The Resident Service Director or designee will review all medical examination documentation prior to admission or re-admission as well as conduct monthly random audits to ensure compliance for six months. Areas of deficiencies identified will be corrected immediately.

Documentation of education and audits will be kept in the Resident Service Director's office.

A604 420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents.

The facility Registered Nurse failed to provide adequate health supervision of two residents with weight loss.

All residents with significant weight loss had the potential to be affected.

Care plans for RI#1 and RI#2 will be updated to reflect interventions to address significant weight loss by 02/28/25.

Service plans for residents with significant weight loss will be reviewed to ensure weight loss interventions are in place. Deficiencies identified will be corrected by 03/13/25.

Re-education will be provided to the registered nurse regarding requirement to ensure that residents with significant weight loss has a service plan that includes interventions for significant weight loss. Re-education will be provided no later than 03/13/2025 by the Resident Service Director or designee.

The Resident Service Director or designee will conduct monthly random audits to ensure compliance. Audits will be conducted for six months. Areas of deficiencies identified will be corrected immediately.

Documentation of education and audits will be kept in the Resident Service Director's office.

A611 420-5-20-.06 (4) (a) (b) Care of Residents.

The care plans were not updated to reflect the current conditions of two residents and did not include appropriate interventions.

All residents with significant weight loss had the potential to be affected.

Care plans for RI#1 and RI#2 will be updated to reflect appropriate interventions to address significant weight loss by 02/28/25.

Service plans for residents with significant weight loss will be reviewed to ensure appropriate weight loss interventions are in place. Deficiencies identified will be corrected by 03/13/25.

Re-education will be provided to the registered nurse regarding requirement to ensure that residents with significant weight loss has a service plan that includes interventions for significant weight loss. Re-education will be provided no later than 03/13/2025 by the Resident Service Director or designee.

The Resident Service Director or designee will conduct monthly random audits to ensure compliance. Audits will be conducted for six months. Areas of deficiencies identified will be corrected immediately.

Documentation of education and audits will be kept in the Resident Service Director's office.

A618 420-5-20-.06 (7) Care of Residents.

Based on observation, interview and record review, oxygen therapy was not documented on the medication administration record as required.

All residents had the potential to be affected.

All current residents, including RI#4, with orders for oxygen therapy will have oxygen listed on their MARs to including the date, time, rate, and proper function of the equipment by 02/28/25.

Re-education will be provided to the nurses regarding requirement to document oxygen therapy in use including the date, time, rate, and the proper function of the equipment. Re-education will be provided no later than 03/13/2025 by the Resident Service Director or designee.

The Resident Service Director or designee will conduct monthly random audits to ensure compliance. Audits will be conducted for six months. Areas of deficiencies identified will be corrected immediately.

Documentation of education and audits will be kept in the Resident Service Director's office.

A804 420-5-20-.08 (4) Physical Facilities

The facility failed to have food service equipment that was clean and free of grease and dirt.

All residents and employees had the potential to be affected.

The kitchen oven ranges identified were cleaned on 01/28/25.

The employee break room refrigerator and freezer were cleaned on 01/28/25, temperature logs put in place, paper towels and soap dispenser replenished by the adjacent sink on 01/28/25.

All kitchen oven ranges and break rooms will be monitored for cleanliness daily and cleaned as appropriate.

Re-education will be provided to all staff regarding maintaining cleanliness of the employee break room. Re-education will be provided to the kitchen staff regarding cleaning standards for oven ranges. Re-education will be provided no later than 03/13/2025 by the Administrator or designee.

The Administrator or designee will conduct monthly random audits to ensure compliance. Areas of deficiencies identified will be corrected immediately. Audits will be documented for six months.

Documentation of education and audits will be kept in the Resident Service Director's office.

A901 420-5-20-.09 (1) (2) Laundry.

The facility failed to keep adequate, effective, and clean lint traps in use on all dryers.

All laundry rooms had the potential to be affected.

Lint was cleaned and removed from identified laundry room on 01/28/25.

Re-education will be provided to the clinical and housekeeping department regarding the requirement to keep the laundry rooms free from lint. Re-education will be provided no later than 03/13/2025 by the Administrator or designee.

Random audits will be conducted weekly by the Administrator or designee through random rounds. The review will include documentation of completion of required training. Audits will be conducted for six months. Areas of deficiencies identified will be corrected immediately.

Documentation of education and audits will be kept in the Resident Service Director's office.

A1002 420-5-20-.10 (2) Sanitation and Housekeeping.

The resident's toilet room (Spa) and soiled utility room were not clean and in good repair.

All spa rooms had the potential to be affected.

Spa rooms and soiled utilities rooms were cleaned and repaired on 01/29/25.

Re-education will be provided to the clinical and housekeeping department regarding the requirement to keep the spa rooms and soiled utility rooms clean and in good repair. Re-education will be provided no later than 03/13/2025 by the Administrator or designee.

Random audits will be conducted weekly by the Administrator or designee through random rounds. The review will include documentation of completion of required training. Audits will be done for six months. Areas of deficiencies identified will be corrected immediately.

Documentation of education and audits will be kept in the Resident Service Director's office.

A1101 420-5-20-.11 (1) Fire and Safety

The facility failed to perform fire drills for the 2023 year and for the period of June 2024 through to December 2024.

All residents had the potential to be affected.

Fire drill conducted on day shift on January 30, 2025.

Fire drills will be conducted monthly alternating on each shift and documented as required by the ADPH ALF regulations.

All staff will be re-educated regarding the requirement to ensure chemicals are secured when not in use. Re-education will be provided by the Administrator or designee no later than 03/13/25.

The Administrator or designee will conduct random audits to ensure compliance monthly. Audits will be conducted for six months.

Documentation of education and audits will be kept in the Resident Services Director's office.

A1203 420-5-20-.12 (5) Physical Environment

The facility failed to ensure walls were of sound construction with an acceptable surface, clean and in good repair.

All residents had the potential to be affected.

Items identified needing repair in room 861, 865, 866, 867, 868, and hallway first floor storage room will be evaluated by the Director of Maintenance to identify extent of damage and develop a plan of repair by 02/28/25.

Fire drills will be conducted monthly alternating on each shift and documented as required by the ADPH ALF regulations.

All staff will be re-educated regarding the requirement to ensure chemicals are secured when not in use. Re-education will be provided by the Administrator or designee no later than 03/13/25.

The Administrator or designee will conduct random audits to ensure compliance monthly. Audits will be conducted for six months.

Documentation of education and audits will be kept in the Resident Services Director's office.

Administrator signature: _____ ***Date:*** 2/25/25