POC Accepted 1.9.25

chg Connie Cherry

PLAN OF CORRECTION

Facility Name: The Harbor at Hickory Hill Facility ID #: P0101

Survey Exit Date: 12/18/2024 Administrator: Allen Chambers

The following is the Plan of Correction for The Harbor at Hickory Hill regarding the Statement of Deficiencies dated December 18,2024. This 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.

1. **Deficiency Number: 420-5-20-.03 (e) Administration A 302.**
   - The facility failed to implement a written policy for the operation of small appliances in the facility. The surveyor observed the residents' mini refrigerators did not have thermometers.

2. **Corrective Action:**
   - A policy was developed and implemented on the operation of small appliances in the facility on 1/3/25.(SEE ATTACHMENT A).
   - An in-service was performed with the Administrator, the Administrator's Designee and the Maintenance Director on 1/6/25 by the Regional Director of Operations regarding the new policy on the operation of small appliances in the facility.

3. **Steps taken to identify other concerns:**
   - The Maintenance Director evaluated the mini refrigerators in all resident rooms and throughout the community on 12/19/24 for safe operation and addition of thermometers.

4. **Measures, systems or changes put in place to ensure this deficiency will not reoccur:**
   - On 12/31/24, the facility enhanced and modified the resident's Inventory Log, completed upon move-in to the community, to include a check-off for mini refrigerators with thermometer placement. (SEE ATTACHMENT B).
     - An in-service was performed with the Administrator and the Administrator's Designee on 12/31/24 by the Regional Director of Operations regarding the enhanced resident Inventory Log containing the check-off for mini refrigerators with thermometer placement.

5. **Monitoring of proposed corrective actions to ensure implementation:**
   - Copies of all resident Inventory Logs utilizing the newly enhanced form will be placed in the Plan of Correction binder for compliance review for a period of three months.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team.

1. **Deficiency Number: 420-5-20-.03 (2) (a) Administration A 303**
   - The facility failed to designate, in writing, an individual to act for the administrator during absences. A designee form which was presented to the surveyors was incomplete and did not contain the signature of the administrator.

2. **Corrective Action:**
   - In response to the deficiency cited, the Administrator/Designee form was signed by the Administrator on 12/31/24.(SEE ATTACHMENT C)

3. **Steps taken to identify other concerns.**
   - The Administrator/Designee form was signed by the Administrator on 12/31/24.

4. **Measures, systems, or changes put in place to ensure this deficiency will not reoccur:**
   - On 12/31/24, the Administrator/Designee form was modified to include a signature line for the Administrator as well as the Administrator's Designee to sign. The modified form was signed by the Administrator and the Administrator's Designee on 12/31/24.
   - An in-service was performed on 12/31/24 by the Regional Director of Clinical Services with the Regional Director of Operations with reeducation on the Administrator/Designee form requirements and the modified Administrator/Designee form.

5. **Monitoring of proposed corrective actions to ensure implementation.**
   - A signed copy of the current Administrator/Designee form will be placed in the Plan of Correction binder and will be reviewed by the Regional Director of Operations for compliance review for a period of three months.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team and the Governing Authority.

1. **Deficiency Number: 420-5-20-.04 (9) Personnel A 406**

   - Employee EI# 14 did not have current certification in cardiopulmonary resuscitation (CPR).

2. **Corrective Action**

   - EI# 14 is scheduled to take CPR class on 1/10/25.

3. **Steps taken to identify other concerns:**

   - An audit of all current employee files was completed on 12/31/24. All staff identified without current CPR certification will be placed on the roster for the CPR class being provided on 1/10/25.
   - All CPR certification information was placed into the community's employee electronic system to easily audit dates that certifications will expire or are missing as of 12/31/24.

4. **Measures, systems, or changes put in place to ensure this deficiency will not reoccur:**

   - An in-service was performed by the Regional Director of Operations on 12/31/24 with the Administrator, Administrator Designee, and the Business Office Manager regarding the requirement of all staff to have current CPR certification within and beyond 90 days of hire.
   - On 12/31/2024, An enhanced system was developed for the input of all current CPR certification expiration dates into the community's employee electronic system upon hire. An in-Service was performed 12/31/24 by the Regional Director of Operations with the Administrator, Designee, and Business Office Manager regarding this new system.
   - The Employee File Checklist has been modified to include a check-off for the license's expiration dates input. An in-Service was performed 12/31/24 by the Regional Director of Operations with the Administrator, Designee, and Business Office Manager regarding this new system. (SEE ATTACHMENT D)
   - A monthly CPR class will be scheduled as needed to accommodate any new hire and/or existing employee needs, this has been added to the monthly QA report.

5. **Monitoring of proposed corrective actions to ensure implementation**

   - The Administrator or Designee will sign off initially on all modified Employee File Checklists for existing staff as well as for all new hires for three months.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team and the Governing Authority.

1. **Deficiency Number: 420-5-20-.05 (3) (d) Records and Reports A 504**

    - The facility failed to maintain a safe and decent environment for residents, staff, and the public. The surveyor observed a door that was unlocked across from room 1, containing electrical switches for the generator along with EI# 6's computer.

2. **Corrective Action:**

    - The door across from room 1 was immediately locked upon identification on 12/17/24.
    - All office set-up was removed from the room on 12/19/24.

3. **Steps taken to identify other concerns:**

    - All other doors to secured areas assessed on 12/31/24. No further deficiencies were identified.

4. **Measures, systems, or changes put in place to ensure this deficiency will not reoccur:**

    - On 1/3/2025, automatic locks were purchased and installed on all rooms that require securing to ensure automatic locking with closure.
    - An enhanced system was implemented utilizing the electronic TELS Maintenance System to establish monthly checks on secured doors.

5. **Monitoring of proposed corrective actions to ensure implementation:**

    - The enhanced system implemented utilizing the TELS Maintenance System will be monitored by the Administrator/Designee monthly for 3 months.
    - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team and the Governing Authority.

1. **Deficiency Number: 420-5-20-.06 (1) Care of Residents A 601**

   - RI# 6 did not have a physician's order to crush medication.

2. **Corrective Action:**

   - Upon identification an order was requested to crush medications for RI# 6 on 12/19/24. All clinical staff were instructed to not crush medications until an order was obtained. An order was obtained on 1/3/2025 for RI #6.

3. **Steps taken to identify other concerns:**

   - An audit was conducted on resident files of residents with a possible need for crushed medications on 12/31/24, no further deficiencies were identified.

4. **Measures, systems, or changes put in place to ensure this deficiency will not reoccur:**

   - On 12/19/2024, the Regional Director of Clinical Services reeducated the Unit Coordinator on the importance of obtaining all applicable orders to crush medications for any resident prior to crushing medications.
   - On 1/6/2025, an in-service was conducted by the Administrator's Designee and the Unit Coordinator with all nursing staff that they may not crush medications unless the order is on the EMAR and is documented with every medication pass.
   - On 1/6/2025, an enhanced system implemented to include a modification to the RN monthly assessment form to include a verification of all new orders in the residents electronic MAR. (SEE ATTACHMENT E)

5. **Monitoring of proposed corrective actions to ensure implementation:**

   - Administrator or Designee to sign off on RN monthly assessments for three months to verify that crushed medications has been overviewed.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team and the Governing Authority.

1. **Deficiency Number: 420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents A 604**

   - RI# 7 did not have a PSMS and Behavior Screen completed prior to or upon admission. RI# 5 did not have a PSMS and Behavior Screen completed prior to admission.

2. **Corrective Action**

   - A PSMS and Behavior Screen were completed for RI# 7 on 1/2/25.
   - A PSMS and Behavior Screen were completed for RI# 5 on 1/2/25.

3. **Steps taken to identify other concerns**

   - An audit was conducted on resident files on 1/2/25 to identify any resident without a PSMS and Behavior Screen completed prior to and upon admission. Residents with missing PSMS and Behavior Screens were addressed and all appropriate screening completed.

4. **Measures, systems, or changes put in place to ensure this deficiency will not reoccur:**

   - An enhanced system was implemented to include the Administrator/Designee's review and sign-off on the Chart Order Checklist, which lists all specific preadmission screening tools, upon every new resident admission. The Chart Order Checklist has been modified to include a signature space for the Administrator/Designee. (SEE ATTACHMENT F).
   - On 12/31/2024, an in-service was performed with the Administrator and the Administrator's Designee by the Regional Director of Operations regarding the enhanced Chart Order Checklist.

5. **Monitoring of proposed corrective actions to ensure implementation**

   - Administrator or Designee to sign off on the Chart Order Checklist for newly admitted residents and place it in the Plan of Correction binder for three months.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team and the Governing Authority.

1. **Deficiency Number: 420-5-20-.06 (6) Care of Residents A 617**

   - The disposition of a resident's medications was not properly documented upon discharge of the resident from the facility.
   - A Medication Destruction Log was documented for disposition of RI# 10's medications on 10/15/24. The log did not contain the name of the pharmacy.

2. **Corrective Action:**

   - The name of the pharmacy was documented on the Medication Destruction Log for disposition of RI# 10's medications on 12/31/24.

3. **Steps taken to identify other concerns:**

   - An audit was completed on 1/2/25 of all current resident files to ensure that Medication Destruction Logs for disposition of medications were all completed with the name of the pharmacy. Concerns identified were addressed.

4. **Measures, systems, or changes put in place to ensure this deficiency will not reoccur:**

   - Enhanced system implemented to include an adapted Medication Destruction Log with the preferred pharmacy information auto filled as well as a designated area for residents who choose to use a different pharmacy. This area will be highlighted. (SEE ATTACHMENT G).
   - The Resident Services Director or Designee to sign off on Medication Destruction Logs prior to filing them in the resident's chart.
   - An in-service was performed with the Unit Coordinator on 12/31/24 by the Regional Director of Clinical Services regarding the enhanced Medication Destruction Log.

5. **Monitoring of proposed corrective actions to ensure implementation**

   - Administrator or Designee to sign off on the Medication Destruction Logs reviewed by the Resident Services Director or Designee and place it in the Plan of Correction binder for three months.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team and the Governing Authority.

1. **Deficiency Number: 420-5-20-.06 (7) Care of Residents A 618**

   - The facility failed to provide an appropriate precautionary sign for oxygen.
   - The facility failed to ensure that oxygen was listed on the medication administration record (MAR).
   - RI# 3's room did not have any precautionary sign posted.
   - RI# 3 did not have oxygen listed on the MAR as ordered by the hospice medical director.

2. **Corrective Action:**

   - A precautionary oxygen sign was placed on RI# 3's apartment door on 12/18/24.
   - Oxygen orders are listed on the MAR on 12/18/2024.

3. **Steps taken to identify other concerns:**

   - An audit was completed on 1/2/25 of all current resident files. No further deficiencies noted.

4. **Measures, systems, or changes put in place to ensure this deficiency will not reoccur:**

   - On 1/3/2025 the current "Environmental Safety Audit Tool" for staff was enhanced to include an audit of "oxygen in use" that will be performed monthly by the community Housekeeping Department and turned into the community Maintenance Director for review and corrections, if needed. (SEE ATTACHMENT H)
   - On 1/6/2025, an in-service was conducted by the Administrator's Designee to re-educate all nurses on the community's policy that all oxygen orders will be verified and documented on the MAR to include date, time, rate, and proper function of the equipment as well as the placement of precautionary oxygen signs on resident apartment doors when oxygen is ordered.

5. **Monitoring of proposed corrective actions to ensure implementation**

   - Resident Services Director or Designee to sign off on any new oxygen orders, verifying they are placed correctly on the MAR and with precautionary signage on resident apartment doors, and place it in the Plan of Correction binder for three months.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team and the Governing Authority.

1. **Deficiency Number: 420-5-20-.07 (2) Food Service A 702**
   - The facility failed to provide thermometers in mini refrigerators.
   - The surveyor observed that the dishwasher temperature gauge never exceeded 94 degrees.

2. **Corrective Action:**
   - A policy was developed and implemented on the operation of small appliances in the facility on 1/3/25. (SEE ATTACHMENT A).
   - Refrigerator thermometers were placed on all mini refrigerators throughout the community on 12/19/24 by the Maintenance Director.
   - Maintenance Director evaluated the dishwasher temperature gauge on 12/17/24 and determined that Gordon's Food Service, the community's vendor for kitchen repairs, would need to evaluate and make needed repairs. Gordon's Food Service made a service call to the community on 12/23/24 and determined the thermostat to the dishwasher needed to be replaced. A new thermostat was installed on 12/23/24 and no further concerns were noted with the dishwasher temperature gauge.

3. **Steps taken to identify other concerns:**
   - In response to the deficiency cited, the Maintenance Director evaluated the mini refrigerators in all resident rooms and throughout the community on 12/19/24 for the placement of thermometers. It was confirmed that all mini refrigerators did not have thermometers in place. This was corrected 12/19/24.
   - A new thermostat was installed on 12/23/24 by Gordon's Food Service and no further concerns were noted with the dishwasher.

4. **Measures, systems or changes put in place to ensure this deficiency will not reoccur:**
   - An in-service was performed with the Administrator and the Administrator's Designee and the Maintenance Director on 1/6/25 by the Regional Director of Operations regarding the new policy on the operation of small appliances in the facility.
   - On 12/31/24, the facility enhanced and modified the resident's Inventory Log, completed upon move-in the community, to include a check-off for mini refrigerators with thermometer placement. (SEE ATTACHMENT B). An in-service was performed with the Administrator and the Administrator's Designee on 12/31/24 by the Regional Director of Operations regarding the enhanced resident Inventory Log containing the check-off for mini refrigerators with thermometer placement.
   - Gordon's Food Service is contracted to perform monthly visits to evaluate the proper functioning of kitchen equipment. An enhanced system has been implemented utilizing the TELS Maintenance System to establish monthly checks to ensure Gordon's Food Service has completed their monthly visit and evaluation for properly functioning equipment.

5. **Monitoring of proposed corrective actions to ensure implementation:**
   - Copies of all resident Inventory Logs utilizing the newly enhanced form will be placed in the Plan of Correction binder for compliance review for a period of three months.
   - Administrator/Designee to print the report of completed tasks from the TELS Maintenance System monthly and the report will be placed in the Plan of Correction binder for compliance review for a period of three months.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team.

1. **Deficiency Number: 420-5-20-.07 (3) Food Service A 703**

   - The facility failed to post a weekly menu and meal times as required.

2. **Corrective Action:**

   - Upon identification, menu and meal times were immediately posted in the food service area on 12/17/24.
   - Dietary Manager, EI# 6, was disciplined regarding not maintaining the posting of weekly menus and meal times.

3. **Steps taken to identify other concerns:**

   - Menu and meal times were posted in the food service area on 12/17/24 in designated framed menu holders.

4. **Measures, systems, or changes put in place to ensure this deficiency will not reoccur:**

   - The community's daily stand-up agenda has been modified to include daily verification of menu and meal time postings. (SEE ATTACHMENT I).
   - In-service conducted on 1/6/25 by the Regional Director of Operations with the Administrator's Designee regarding the modification of the daily stand-up agenda.
   - In-Service conducted on 1/6/25 by the Administrator's Designee to educate the new Dietary Manager on the requirement of weekly menu and meal time postings in the food service area.

5. **Monitoring of proposed corrective actions to ensure implementation**

   - The Administrator/Designee to verify weekly menu and meal time postings in the food service area weekly for six weeks.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team and the Governing Authority.

1. **Deficiency Number: 420-5-20-.12 (5) Physical Environment A 1203**

   - Resident room 2 – the transition from carpet to vinyl floor was missing a transition strip and the carpet was frayed. (Multiple rooms)
   - Resident room 4 – the bathroom floor was not secured and coming up
   - Resident room 6 – bathroom baseboards needed repair.
   - Resident room 11 – bathroom floor was not secured and coming up
   - Resident room 14 – bathroom floor was not secured and coming up along with a black substance noted on the baseboards
   - Resident room 28 – bathroom floor was not secured and coming up.

2. **Corrective Action:**

   - Resident rooms 2 – Corrected by Director of Maintenance on 12/27/24.
   - Resident rooms 4, 11, and 28 – It was identified that the current flooring has been discontinued. New flooring has been selected and scheduled for installation the week of 1/6/25.
   - Resident room 6 – Corrected by Director of Maintenance 1/6/25.
   - Resident room 14 – It was identified that the current flooring has been discontinued. New flooring has been selected and scheduled for installation the week of 1/6/25. The black substance noted on the baseboards was removed by the Director of Maintenance on 12/23/24.

3. **Steps taken to identify other concerns:**

   - Director of Maintenance evaluated all resident rooms and bathrooms. All rooms identified are scheduled for repairs and/or installation to be completed by 1/10/25.

4. **Measures, systems, or changes put in place to ensure this deficiency will not reoccur:**

   - An enhanced system has been implemented utilizing the TELS Maintenance System to establish monthly checks to ensure that all resident apartment flooring and transition areas as well as bathroom flooring and baseboards are maintained in good and safe condition.

5. **Monitoring of proposed corrective actions to ensure implementation**

   - The Administrator/Designee to print out monthly checks from the TELS Maintenance System verifying their completion monthly for three months for compliance review.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team and the Governing Authority.

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: _____ *Date:* 1/6/25

Prepared by Allen Chambers, Administrator

The Harbor at Hickory Hill, 334-561-5111

ATTACHMENT A

The Harbor at Hickory Hill
A Premier Memory Care Center

Policy: Memory Care Units Small Appliance Usage

1. Prohibited Appliances

- Appliances with Heating Elements:
    - Toasters, toaster ovens, hot plates, space heaters, and irons are usually not allowed to prevent fire hazards or burns.
- Kitchen Appliances:
    - Microwaves, stoves, and other cooking devices are generally restricted in resident rooms but may be available in supervised common areas.
- Electric Blankets/Heating Pads: Prohibited to avoid overheating or accidental misuse.

2. Allowed Appliances

- Mini-Fridges:
    - Staff will monitor contents and temperature regulation monthly to prevent spoilage or hazardous consumption.
- Medical Devices:
    - Devices such as oxygen concentrators, CPAP machines, or nebulizers are allowed but must be approved.

3. Facility-Provided Appliances

- Appliances like microwaves, kettles, or toasters are often available in supervised common areas for resident use under staff oversight.

ATTACHMENT B

The Harbor
at Hickory Hill
A Premier Memory Care Center

RESIDENT: _____APT#_____

ITEM NUMBER	ITEM DESCRIPTION	LOCATION	QUANTITY

Refrigerator: Yes ( ) No( ) Thermometer provided by Facility: ( ) By Initials: ___

All resident/family provided electrical equipment must be UL (Underwriters Laboratory) approved and in good, safe working order.

Amendments or adjustments shall be made on all copies of the Inventory of Personal Effects Record each time personal property valued in excess of one hundred fifty ($150) dollars is brought to the Facility and the resident or sponsor requests that it be added to the Inventory of Personal Effects Record, or when any item on the Inventory of Personal Effects Records is removed from the Facility. All amendments shall be signed by the Administrator and the resident or sponsor.

NOTE: The facility has a safe for the secure storage of valuables and /or cash. Residents are discouraged from retaining large amounts of cash on hand. The facility will only warrant up to $100.00, unless the money is secured in the facility safe.

SIGNED_____ DATE_____
Facility Representative

SIGNED_____ DATE_____
Sponsor or Resident

ATTACHMENT C

The Harbor

at Hickory Hill

A* Premier *Memory Care Center

During the absence of the Administrator, Allen Chamber the acting Administrator Designee will be Chasity Conaway, in charge unless otherwise designated by the Administrator.

Administrator: _____

Administrator Designee: _____

Infection Control/Safety Tean consists of the following employees:

Allen Chambers

Chasity Conaway

Peyton McIntyre

Rhonda Terrell

Michelle Garrett

Mark Otwell

Danielle Prieur

ATTACHMENT D

The Harbor
at Hickory Hill
A Premier Memory Care Center

Employee Name: _____

Title: _____

Date of Hire: _____

Date of Initial Resident Contact: _____

- Application Date: _____
- Abuse Registry Check Date: _____
- DHR Abuse Registry Check Date: _____
- Drug Test Date: _____
- Vaccine Acceptance/Declination Date: _____
- Background Check Date: _____
- Verification of Licensure and/or Certifications
  (If Applicable _____CHR Input date: _____
- CPR Certification: _____ Exp: _____ CHR Input date: _____
- Initial Training Checklist Completion Date: _____

_____ _____

BOM/HR Date

_____ _____

Administrator Date

ATTACHMENT E

RN MONTHLY ASSESSMENT

Resident:_____ Room # _____ Year _____

Month	Weight	Changes in Status	Elopements	Falls (2 in 30 days, must see PCP)	Behaviors	Skin	New Orders	EMAR verification
January								
February								
March								
April								
May								
June								
July								
August								
September								
October								
November								
December								

Date:_____ RN Signature: _____
BP:_____/_____ Assessment & Care Plan Review: _____

Is comprehensive assessment indicated? _____

Date:_____ RN Signature: _____
BP:_____/_____ Assessment & Care Plan Review: _____

Is comprehensive assessment indicated? _____

Date:_____ RN Signature: _____
BP:_____/_____ Assessment & Care Plan Review: _____

Is comprehensive assessment indicated? _____

Date:_____ RN Signature: _____
BP:_____/_____ Assessment & Care Plan Review: _____

Is comprehensive assessment indicated? _____

Date:_____ RN Signature: _____
BP:_____/_____ Assessment & Care Plan Review: _____

Is comprehensive assessment indicated? _____

ATTACHMENT F

The Harbor at Hickory Hill
A Premier Memory Care Center

Resident Chart Table of Contents

Tab 1: Chart Contents

1. Picture in Front of Chart
2. Face Sheet
3. Insurance Cards/ID
4. Admission Record
5. Pharmacy/Provider Agreement(s)
6. Inventory Sheet

Tab 2: Legal Tab

1. DNR, POA and Advance Directive (if applicable)
2. Resident Rights
3. Financial Agreement

Tab 3: Medical Exam (PPOC)

1. Original PPOC
2. Current PPOC

Tab 4: Physician Orders

1. Physician Orders
2. Hospital Discharge Information

Tab 5: Medication Records

1. Narcotic Records

Tab 6: RN Admission Assessment

1. Clinical Assessment/Comprehensive
2. Mental Status Exam
3. Geriatric Depression Screen
4. Fall Assessment
5. Elopement Assessment
6. PSMS
7. Behavior Screen
8. Aphasia Screen- Milk Story & Cowboy Story

Tab 7: RN Assessments

1. Monthly Summaries
2. Comprehensive Assessments, PSMS, and Behavior Screens
3. Care Plans

Tab 8: Labs/Special Reports

1. All Labs
2. Miscellaneous Medical Tests

Tab 9: Outside Organizations – Plan of Care/485

Tab 10: Miscellaneous Tab

Administrator/Designee Signature _____ Date: _____

ATTACHMENT G

The Harbor
at Hickory Hill
A Premier Memory Care Center

MEDICATION DESTRUCTION LOG

Resident Name _____ Date _____

Medication List:

List of Medications	Prescription No.	Date	Strength	Amount Destroyed

Pharmacy: INTEGRACARE PHARMACY,199 Corporate Woods Drive, Alabaster, AL 35007, 205-406-0093
OR List Other Pharmacy:_____

Received by _____
Resident or Responsible Party

Released by _____
Title of Facility Personnel

For Disposal:

Method _____

Reason _____

Destroyed by: _____

Witness: _____

ATTACHMENT H

MONTHLY ENVIRONMENTAL SAFETY CHECKLIST

_____/_____ MONTH/YEAR

Location	Date	Only Approved Surge Protectors	Hand Rails Secure	Non-Slip Rugs & Bath Mats	Clutter Free Environment	Lights/Night Lights Operational	Cooking Appliances Present	Oxygen in Use Signage (if applicable)	Assessor

ATTACHMENT I

LEGACY SENIOR LIVING

Daily Stand-Up (Community Name)

Date today: _____
Rent Roll Census: _____
Heads in Bed Census: _____

Rent Ready Apts: _____
# of Companions: _____ Apt#s: _____
# of Semiprivates: _____ Apt#s: _____
# of Private Studios: _____ Apt#s: _____

Move-Ins:

Name	Date	Room #

Move-Outs:

Name	LBD	Reason

Tour and Telephone Inquiry Line-Up:

Name	Date	Follow up

Customer View: Walk Through Focus Items:	Appointments/Transportation:

Resident Care

New Incident Reports:		Assessment/Care Plans Meetings:
Additions to ROSS list:		Medication Variance/Concerns:

Business Office/Admin

Early/late/missed punches (CHR):
Team members near OT (CHR):

Human Resources

Open positions:
Interviews:
Employee Incidents:

Dining Services

Daily Menu Correct and Posted ( )