POC accepted on November 14, 2024

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November 8, 2024

Alabama Department of Public Health
Division of Health Care Facilities
Assisted Living Unit (SCALF)
201 Monroe Street, Suite 700
P.O. Box 30317
Montgomery, Alabama 36130

Dear Mr. Black,

Enclosed is the Plan of Correction in response to the Wesley Place on Honeysuckle survey conducted on Monday, September 30, 2024, through Wednesday, October 2, 2024.

If you have any questions, please feel free to contact me at 334-792-0921. Alternate points of contact are Mr. Hubert Paul, Jr., Executive Director, or Ms. Nancy Thompson, Registered Nurse.

Sincerely,

Vivian Readus 11-08-2024

Vivian Readus, Administrator

POC accepted on November 14, 2024

PLAN OF CORRECTION

Wesley Place on Honeysuckle Assisted Living Community

Vivian Readus, Administrator

1. A 403 420-5-20-.04 (4) Personnel.

2. All employees hired prior to September 30, 2024, did not have a documented resident contact date in their employee file during the survey. All newly hired employees effective September 30, 2024, and beyond will complete New Employee Orientation in a non-residential location prior to any resident contact. New employees resident contact date will be listed in the company UKG application by the Administrator or designee during employee first day of resident contact.

3. All residents and employees have the potential to be affected by this deficient practice; therefore, are included in this plan of correction. All employees hired prior to September 30, 2024, will have "not available" as resident contact date in the UKG application on or before November 8, 2024, provided by EI#1 and/or designee.

4. Methodist Homes of Alabama and Northwest Florida added on October 8, 2024 to the Company UKG application an area to post employees date of resident contact. The Administrator or designee will post during employee first day of resident contact in the UKG application. Mission Support Services will provide upon request a list of employees with resident contact dates for any employee hired after October 2024.

5. The Administrator or designee will request and keep in a binder in the Administrator's office a list of employees that are hired during that month with the employee resident contact date listed. If no employee is hired during any given month, documentation will be provided stating, "No monthly hire."

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

2. Postings

On September 30, 2024, the following listed agencies were in a notebook on a table in the living room; The Department of Bureaus of Health Provider Standards, Department of Human Resources, Department of Human Resources Elder Abuse Hotline and Resident Rights. All agencies were removed from the notebook, framed and posted in open, visible areas on the counter top of the nurse's station before the end of the day on September 30, 2024.

Bathroom

All tile was replaced in the public restroom on October 31, 2024, by Carpetland USA employees.

Laundry Room

The bottle labeled "alcohol" was removed from laundry room and laundry detergent was placed in a locked cabinet in the laundry room. The laundry room door was immediately locked after notification from surveyor and remained locked thereafter.

The laundry room door was replaced on October 10, 2024, to include a lockset door knob that locks automatically when closed and requires a key to unlock and open by staff only.

Storage Room

Upon notification from Surveyor, the wasp spray and furniture polish were removed from storage room and the door was locked immediately.

The storage room and mechanical room doors were replaced on October 10, 2024, with lockset door knobs that lock automatically when closed and requires a key to unlock and open. The exit door inside the mechanical room was replaced on October 10, 2024 with a storage room lock at exit door.

3. All residents have the potential to be affected by this deficient practice; therefore, are included in this plan of correction. All employees were in-serviced during the Survey of securing chemicals and locking doors by the Administrator and or Registered Nurse.

4. All employees were in-serviced on October 10, 2024, after the new lockset door locks were installed. Employees were in-service on storage and of locking up chemicals by the Administrator. Doors will be checked every shift by staff to ensure that they are not only closed but locked with the results on the door check form.

5. The Administrator or designee will perform random weekly checks for 3 months with the checks documented in a Door Check Form kept in a binder in the Administrators office. After 3 months of compliance, the checks will be performed monthly.

1. A 611 420-5-20 - .06(4) (a) (b) Care of Residents.

2. RI#1 did not have care plans for all diagnosis and falls during survey on September 30, 2024. The RN updated careplans on October 23, 2024, for R1#1, Alzheimer's disease, Atrial Fibrillation, Chronic obstructive pulmonary disease, Falls, Hypertension, Gastroesophageal reflux disease, Hyperlipidemia, Insomia, Mixed Anxiety, Neuropathy, Osteoporosis, and Chronic Kidney Disease stage 4 to include goals and interventions. The RN will in-service all employees on or before November 8, 2024, to review care plans daily for any updates.

RI#3 The Administrator had already met with RI#3 Sponsor in the past to discuss resident needing a higher level of care. Sponsor requested that his mother be discharged to WPH skilled nursing when a bed became available. RI#3 sponsor was issued a discharge letter on October 1, 2024. Resident was discharged to WPH skilled nursing on October 16, 2024.

3. RI#1 Care plans have been addressed to include diagnosis and falls by the RN. RI#3 has been issued a 30-day discharge notification letter. All resident care plans will be removed and updated accordingly by the RN on or before November 8, 2024.

4. The RN will review changes in condition provided by the staff immediately or the next business day and update care plans as needed. All monthly summaries done by the RN will include any resident change in condition. The RN will meet and discuss resident change in condition with the Administrator daily and/or weekly.

5. The Administrator will keep a change in condition binder in the office to document meetings with RN on resident potentially needing a different level of care.

1. A 621 420-5-20 - .06 (a) (b) Care of Residents

2. On October 1, 2024, a 30-day notice was issued to sponsor due to RI#3 behaviors, increased time to take medications, coaching to eat meals, and disruptions to other residents. The Administrator spoke to R1#3 sponsor and provided assistance with the discharge process.

3. On October 3, 2024, Administrator and RN reviewed the files of all residents currently in the building for any that were identified as needing to move to a different level of care. No other residents were identified.

4. Upon the identification of RI#3 no longer meeting requirements of eligibility for the Specialty Care Assisted Living level of care, the Administrator met with the sponsor prior to and on October 7, 2024, to discuss higher level of care. Sponsor requested that his mother be moved to a skilled bed at WPH when one became available. Resident was discharged to WPH skilled nursing on October 16, 2024.

5. The Administrator will keep a copy of 30-day discharge notification letters along with discharge disposition and date in a binder in the Administrator's office.

1. A 702 420-5-20-.07(2) Food Service.

2. Aprons
All employees serving or assisting with serving meals will wear a apron during meal times. All employees will be inserviced on or before November 1, 2024, of wearing an apron during meal time by the Administrator or designee.

Use by Date
Items in walk-refrigerator did not have use by date when surveyed on October 2, 2024. Used by dates were put on items immediately after tour by dining services staff and verified by CDM on October 2, 2024. All staff was inserviced by the CDM on applying use by date upon opening food items on October 2, 2024.

Food Temperature
Three food items brought to unit from kitchen in carrier were either too cold or warm during evening meal on September 30, 2024. Items were returned to kitchen and items were warmed, chilled and temped before sending back to unit. Cooks will temp and record all food items loaded in carrier. Temp logs will be kept on a clipboard next to the serving line. Dining room servers will load all cold items on a bed of ice for transport.

3. All residents have the potential to be affected by this deficient practice; therefore, are included in this plan of correction. The CDM and or designee will observe daily for compliance.

4. The administrator or designee will observe all meal passes to ensure staff are wearing aprons. Observations will be done three times a day for two weeks, then two times a week for two weeks, and weekly for one month. Observations will be recorded on a log sheet by the Administrator of designee.

5. The Administrator, CDM, or designee will meet weekly for a month to discuss compliance or non-compliance of wearing of aprons, use by date labels and food temps. If any areas found to be non-compliant, inservicing will be done and monitoring will start over.

1. A 703 420-5-20 -.07 (3) Food Service.

2. Meal times were in a binder on the desk top at nurses' station on September 30, 2024. Meal times were removed from binder and posted in a frame and placed on the desktop at the nurses' on September 30, 2024 by EI#1.

3. All residents have the potential to be affected by this deficient practice, and therefore, are included in this plan of correction. All residents, visitors and employees can review meal times at their discretion.

4. The Administrator or designee will observe meal time postings daily for 30 days then weekly for 30 days. Any postings missing will be replaced immediately by the Administrator or designee.

5. The Administrator will keep the above results in a binder in the Administrator's office for review and compliance.

1. A 804 420-5-20-.08 (4) Physical Facilities.

2. The door that separates the kitchen from the dry storage area with the missing bottom portion and with rust on the door was checked by one vendor on October 31, 2024, for possible repair or replacement. EI#6 is working to get additional vendor quotes for a possible repair or replacement.

The double door that separates the kitchen from the food serving area was coming apart, rusty, and in need of painting during survey. The maintenance staff repaired, cleaned and painted the door on October 31, 2024.

The double door that separates the kitchen from the South Wing was in need of repair or replacement during survey. The doors and frames were painted and adjustments made for better operation on October 31, 2024.

The door from the food service area to the exterior of the facility had rust on bottom of door frame and handle during survey. The door frame and handle were cleaned and painted by the Maintenance Department on November 1, 2024.

The cracked and missing tiles in the various areas of the kitchen were cleaned, filled with concrete, and sealed by the Maintenance Department on October 31, 2024. Grout was filled in missing areas throughout the kitchen on October 31, 2024 by the Maintenance Department.

The Maintenance Department cleaned and filled in missing tiles with concrete and grout behind the oven on October 31, 2024.

The floor underneath the serving table that holds the coffee and tea makers was cleaned and the concrete used for missing tile was sealed by the Maintenance Department on October 31, 2024.

Carpetland placed tiles on the side of the wall between the dishwasher station and the main kitchen on October 4, 2024.

The ceiling air vents behind the oven area were cleaned and painted by the Maintenance Department on November 1, 2024.

The main food warmer was not working during the survey. TWC repaired the food warmer on October 11, 2024, and it was put back in use by dining services.

The outside ovens and fryer were wiped down on October 2, 2024, by the dining services staff ad inspected by the CDM. Ovens and fryers will be wiped down at the end of every shift by the dining services staff and inspected every day by the CDM and or designee for two weeks, then once a week for a month.

The commercial floor standing mixer was thoroughly cleaned by the dining services staff on October 31, 2024, and painted by the Maintenance Department. The dining services staff was inserviced by the CDM on November 1, 2024 on covering mixer from contamination when not in use.

3. All residents have the potential to be affected by this deficient practice; therefore, are included in this plan of correction. On or before November 15, 2024, the CDM and Maintenance Director will provide detailed cleaning schedules and repair list to the Administrator. All areas were inspected by the Administrator, CDM, and Maintenance Director on November 4, 2024.

4. The CDM will inservice all dining staff on routine cleaning of equipment, assignments, and due dates on or before November 15, 2024. The assignment list will be kept in a binder in the CDM's office. The CDM will visually, observe assignments five days a week for one month, then weekly thereafter.

The CDM and Maintenance Director will meet weekly to discuss any equipment or facility repairs. Repairs will be inputted in the TELS System and upon completion, TELS repair ticket will be closed out by the Maintenance Director.

5. The Administrator and CDM will conduct visual inspections of the kitchen area weekly for four weeks and report results to Mission Support Services (Corporate Office). All results will be kept in a binder in the Adminsrator's Office.

1. A 1101 420-5-20-.11 (1) Fire and Safety.

2. Evacuation Plan.
During facility tour on October 1, 2024, evacuation routes were not posted on the unit as pointed out by surveyor to EI#6. EI#6 posted evacuation routes throughout unit in obvious locations for all residents and guest by the end of the day on October 1, 2024.

Fire Drills.
Fire drills were not being done once per month with varying times, days, and quarterly on each shift. The facility was not keeping written observations of the effectiveness of the fire drills performed. EI#6 has developed a form to set up monthly fire drills, shifts, and effectiveness of the drills.

3. All residents have the potential to be affected by this deficient practice; therefore, are included in this plan of correction. All residents will be observed daily for any changes that may affect their evacuation needs and care plans updated accordingly by the nurse.

4. EI#6 will inservice all employees on Fire Drill policies on or before November 8, 2024. EI#6 will inservice new employees hired after November 8, 2024, individually to ensure all staff is properly inserviced on Fire Drill Policy.

5. The Maintenance Director will keep all reports in a binder in the maintenance order for a minimum of three years. The Maintenance Director will meet with the Administrator after each drill to discuss compliance.

1. A 1203 420-5-20-.12 (5) Physical Environment.

2. Surveyor notified EI#1 on October 2, 2024, of fire extinguisher mounted in the courtyard that had not been inspected since August 2022. EI#1 contacted EI#6 of fire extinguisher needing replacement. EI#6 replaced on October 2 2024, the out-of-date extinguisher with one from the Maintenance Department which was in service.

3. All fire extinguishers were visually inspected by the Maintenance Department on October 2, 2024, to ensure inspections were correct and dated. All fire extinguishers will be visually inspected every month by the Maintenance Director or designee.

4. All maintenance staff will be inserviced on or before November 8, 2024, by the Administrator or designee as to the visual inspections with initialing and dating inspection sheet every month. The Maintenance Director or designee will be responsible for monthly inspections of the log-in sheets in the binder in the Maintenance Director's office.

5. The Maintenance Director will keep the inspection log in a binder in the office. The Maintenance Director and or designee will visually inspect fire extinguishers on the unit after completion by assigned staff.

1. A 1206 420-5-20-.12 (8) Physical Environment.

2. During facility tour on September 30, 2024, surveyor observed a padlock on wooden fence in the courtyard. EI#6 removed padlock on October 2, 2024 and replaced with another locking system. The gate was rebuilt on October 8, 2024 to include a double keyed (both sides) deadbolt.

3. All residents have the potential to be affected by this deficient practice; therefore, are included in this plan of correction. EI#6 surveyed facility on October 2, 2024, to ensure no padlocks were being used on any gates on the property. No other padlocks were found.

4. EI#6 will inservice the Maintenance Department staff on or before November 8, 2024, on the importance of looking at all areas when working daily to ensure padlock are not on gates. EI#6 will keep a log in his office for monitoring.

5. The Administrator and Maintenance Director will meet once a week for one month to discuss compliance.