

KAUHALE

Port City Communication Sheet

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Theresa Garcia ACCEPTED 4/21/26

4/21/26

A 301

1.

A 301 – 420-5-20-03 (1) (a)(b)(c)(d) Administration (Governing Authority) :

The Governing Authority failed to provide adequate oversight to the facility to ensure that the facility achieved and maintained compliance with state specific rules and regulations regarding the RN (Registered Nurse) duties and resident health supervision.

2.

Corrective Action:

The Regional Director of Clinical Care in-serviced the Governing Body regarding proper oversight of day-to-day operations of the facility.

The Governing body will ensure appropriate oversight.

Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 for further corrective actions.

3.

Steps taken to identify other residents or concerns:

All residents have the potential to be affected. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 to see how other residents were identified.

4.

Systemic changes made or measures put into place to ensure the deficiency does not recure:

There will be weekly oversight by the Governing Authority to ensure compliance with plan of correction. There will be monthly oversight and audits by Regional Nurse Consultant to ensure compliance.

5.

Monitoring of Corrective Action:

Various members of the Governing Authority will conduct facility visits no less than monthly for the next 6 months and then no less than quarterly for the next two quarters. Regional Nurse

Patsy Tipton / Patsy Tipton E.D. 4-17-26

Consultant will continue to monitor for regulatory compliance throughout the probationary period with routine monthly visits. The Regional Director of Operations or designee will provide weekly meetings with the administrative team throughout the probationary period to monitor this plan of correction and to ensure that the facility is operating in compliance with AL State Board of Health's rules and regulations for SCALF. Documentation will be kept in a POC (Plan of Corrections) Binder in the Executive Directors office.

A 302

1.

A 302 – 420-5-20-03 (e) Administration:

The facility failed to follow its own policies and procedures for management and operation of the facility to ensure that the facility achieved and maintained compliance with state specific rules and regulations regarding SCALF policy and procedures and resident health supervision.

2.

Corrective action:

The Regional Director of Operations in-serviced the Executive Director on 11/14/2025 on Kauhale Health's policy and procedures related to the state of Alabama's regulations regarding SCALF and resident health supervision.

The Executive Director started the in-service with staff on facility policy and procedures on 11/14/2025 and will continue until all staff have been in-serviced.

The previous RN was replaced on 11/14/2025. ADPH was notified on 11/14/2025. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 for further corrective actions.

3.

Steps taken to identify other residents or concerns:

All residents have the potential to be affected. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 to see how other residents were identified.

4.

Systemic changes made or measures put into place to ensure the deficiency does not recure:
The previous RN was replaced on 11/14/2025. ADPH was notified on 11/14/2025. A RN was placed

into the position to complete RN duties until a permanent RN was hired for the position of Wellness Director. The Regional Nurse Consultant in-serviced the Governing Body on AL rules and regulations in relation to sited deficiencies, A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620. There will be weekly oversight by the Governing Authority to ensure compliance with plan of correction. There will be monthly oversight and audits by Regional Nurse Consultant to ensure compliance.

5.

Monitoring of Corrective Action:

Various members of the Governing Authority will conduct facility visits no less than monthly for the next 6 months and then no less than quarterly for the next two quarters. Regional Nurse Consultant will continue to monitor for regulatory compliance throughout the probationary period with routine monthly visits. The Regional Director of Operations, or designee will provide weekly oversight to ensure compliance.

A 401

1.

A 401 - 400-5-20-04 (1)(2) Personnel:

The facility was not staffed with at least the minimum required staff at all times.

2.

Corrective Action:

The Regional Director of Operations in-serviced the ED on staffing requirements as related to AL rules and regulations for staffing requirements on SCALF on 11/14/2025.

The ED in-serviced the staff beginning on 11/14/2025 on AL rules and regulations regarding staffing requirements for a SCALF and will continue until all staff is in-serviced.

The ED reviewed the schedule to ensure that the number of staff scheduled for the SCALF meet the requirements as it relates to A 401. The ED educated the staff on procedures to follow in the event of call in's or no shows. The ED educated the staff on the regulation to have a licensed nurse on the SCALF unit at all times on 11/14/2025.

3.

Steps taken to identify other residents or concerns:

All residents have the potential to be affected. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 to see how other residents were identified.

4.

Systemic changes made or measures put into place to ensure the deficiency does not recure:

The ED was educated on AL rules and regulations as it relates to a SCALF. The ED educated the staff on the staffing regulations for a SCALF in AL. The ED reviewed the monthly schedule to ensure the correct number of staff were always assigned to the SCALF.

The ED or designee will review daily staffing for the SCALF unit. each morning in the stand-up meeting.

The Director of Operations will review staffing with the ED no less than monthly during the probationary period to ensure compliance with staffing requirements.

401 cont.

5.

Monitoring of Corrective Action:

The ED will take findings from daily staffing review to the monthly QA meeting for review.

Various members of the Governing Authority will conduct facility visits no less than monthly for the next 6 months and then no less than quarterly for the next two quarters. Regional Nurse Consultant will continue to monitor for regulatory compliance throughout the probationary period with routine monthly visits. The Regional Director of Operations, or designee, will provide weekly review to ensure compliance.

A 405

1.

A 405 420-5-20-04 (6)(7)(8) Personnel:

The facility RN (Registered Nurse) and Care Coordinator duties were not performed consistently to ensure the facility operated in compliance with SBOH rules for SCALFS.

2.

Corrective Action:

The RN was termed on 11/14/2025.

The Regional Director of Operations in-serviced the ED on RN and Care Coordinator duties as related to AL rules and regulations to ensure proper care for residents on SCALF on 11/14/2025.

The ED in-serviced the staff beginning on 11/14/2025 on AL rules and regulations regarding RN and Care Coordinator duties as related to AL rules and regulations to ensure proper care for residents on SCALF on 11/14/2025.

On 11/15/2025 the Regional Nurse completed assessments on current residents located on the SCALF to ensure proper admission documents and to ensure that the resident was appropriate for the SCALF placement.

3.

Steps taken to identify other residents or concerns:

All residents have the potential to be affected. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 to see how other residents were identified.

4.

Systemic changes made or measures put into place to ensure the deficiency does not recure:

The facility must notify Regional Staff of all referrals received for placement on the SCALF unit for approval prior to acceptance. All referrals and any change in condition will be discussed on weekly calls with Regional Team to identify any issues. The Medical Director will be notified prior to referrals acceptance on the SCALF.

5.

Monitoring of Corrective Action:

Various members of the Governing Authority will conduct facility visits no less than monthly for the next 6 months and then no less than quarterly for the next two quarters. Regional Nurse Consultant will continue to monitor for regulatory compliance throughout the probationary period with routine monthly visits. The Regional Director of Operations, or designee, will provide weekly review to ensure compliance.

The ED will take all new admissions to the monthly QA meeting for review.

A 504

1.

A 504 420-5-20-5 (3)(d) Records and Reports:

The facility failed to provide a safe and decent environment.

2.

Corrective Action:

The ED and resident care staff conducted a room to room sweep to observe for any chemicals or medications and removed any and all that was identified on 11/14/2025

All staff was trained on regulations regarding having any chemicals or medications in resident care area on 11/14/2025.

3.

Steps taken to identify other residents or concerns:

All residents have the potential to be affected. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 to see how other residents were identified.

4.

Systemic changes made or measures put into place to ensure the deficiency does not recure:

ED or designee and Direct Care Staff will make daily rounds on SCALF in resident care areas to identify safety issues and correct immediately.

5.

Monitoring of Corrective Action:

Various members of the Governing Authority will conduct facility visits no less than monthly for the next 6 months and then no less than quarterly for the next two quarters. Regional Nurse Consultant will continue to monitor for regulatory compliance throughout the probationary period

with routine monthly visits. The Regional Director of Operations, or designee, will provide weekly review to ensure compliance.

The ED will take audits of SCALF checks to the monthly QA meeting for review.

A 508

1.

A 508 420-5-20-05 (3)(h) Records and Reports:

The facility failed to identify a reported incident as attempted suicide, failed to conduct a complete investigation of the event and failed to take actions to prevent recurrence.

2.

Corrective Action:

The RN was termed on 11/14/2025.

On 11/14/2025 the Director of Operations in serviced the ED on completing an investigation and reporting. ED was in-serviced regarding things that should be reported to the ASBOH immediately. ED educated on immediate notification of Regional Staff with all incidents that occur.

On 11/14/2025 the ED in serviced staff on completing an investigation with all incidents that occur and immediate notification to the ED of all said incidents.

On 11/15/2025 Regional Nurse reviewed incidents for last month to ensure that an investigation was completed with each incident. Regional Nurse in serviced staff on complete and proper investigation procedures as well as immediate notification to ED and parties required to be notified of incidents.

3.

Steps taken to identify other residents or concerns:

All residents have the potential to be affected. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 to see how other residents were identified.

4.

Systemic changes made or measures put into place to ensure the deficiency does not recure:

ED or designee will review incidents to ensure complete investigations and documentation are present with incident reports. ED will review notifications involving incidents in daily stand-up meetings.

ED will send the Regional Team a copy of the complete investigation on each incident for review.

Regional Staff will review incident reports when at the facility to ensure a complete investigation was conducted with each incident and required notification and documentation is present.

A 508 cont

5.

Monitoring of Corrective Action:

ED will bring incidents to QA meeting monthly for review of complete investigation and notification.

Various members of the Governing Authority will conduct facility visits no less than monthly for the next 6 months and then no less than quarterly for the next two quarters. Regional Nurse Consultant will continue to monitor for regulatory compliance throughout the probationary period with routine monthly visits. The Regional Director of Operations, or designee, will provide weekly review to ensure compliance.

A 601

1.

A 601 420-5-20-06 (1) Care of Residents:

The facility failed to follow physician's orders to keep hazardous items from a resident. Also a physician's order was not written in accordance with community standards.

2.

Corrective Action:

The RN was termed on 11/14/2025.

On 11/14/2025 the Director of Operations in serviced the ED on AL state regulations for following physician's orders.

On 11/14/2025 the ED in serviced Direct Care Staff on AL state regulations for following physician's orders.

On 11/15/2025 the Regional Nurse and the Medical Director reviewed physician's orders for residents on the SCALF unit for accuracy.

On 11/15/2025 the Regional Nurse in serviced Direct Care staff on following physician orders and plans of care in relation to AL rules and regulations regarding physician orders.

3.

Steps taken to identify other residents or concerns:

All residents have the potential to be affected. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 to see how other residents were identified.

4.

Systemic changes made or measures put into place to ensure the deficiency does not recure:

ED or designee will review physician orders daily 5 days a week in the morning stand up meeting for accuracy and follow through of new physician orders.

Regional Staff will review random SCALF resident's physician orders when in facility for compliance with AL rules and regulations regarding physician orders and plans of care no less than monthly for the next 6 months. Then quarterly for the next two quarters.

A 601 cont.

5.

Monitoring of Corrective Action:

ED will bring audits of physician orders to QA meeting monthly for review.

Various members of the Governing Authority will conduct facility visits no less than monthly for the next 6 months and then no less than quarterly for the next two quarters. Regional Nurse Consultant will continue to monitor for regulatory compliance throughout the probationary period with routine monthly visits. The Regional Director of Operations or designee, will provide weekly review to ensure compliance

A 604

1.

A 604 420-5-20-06 (5)(a)(b)(c)(d)(e) Care of Residents:

The facility RN E#3 failed to perform her duties to ensure the safety and welfare of all residents.

2.

Corrective Action:

The RN was termed on 11/14/2025.

On 11/14/2025 the Director of Operations in serviced the ED on AL State regulations regarding the responsibility of the Wellness Director or Nurse to provide a safe environment for all residents, importance of a true and accurate assessment of each resident and the caregiver's role in any change of condition that presents itself. ED in- serviced on immediate notification to the ED by caregivers regarding any safety issue that presents.

A new RN was assigned the duties of the Wellness Director until a permanent Wellness Director is hired. The ED in serviced Direct Care Staff on providing a safe environment for all residents, true and accurate assessments and observations of residents at all times and reporting to the ED immediately any changes that arise.

3.

Steps taken to identify other residents or concerns:

All residents have the potential to be affected. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 to see how other residents were identified.

4.

Systemic changes made or measures put into place to ensure the deficiency does not recure:

The ED will follow up and review assessments and required paperwork on each new potential admission 5 days a week in the daily stand-up meetings to ensure compliance with SCALF regulations.

The Regional Team will review all required admission documentation prior to acceptance of a resident being admitted to the SCALF during the probationary period.

A 604 cont

5.

Monitoring of Corrective Action:

The Regional Team will review assessments and plans of care on new admissions while in the facility monthly for accuracy and completion.

The ED will bring all new SCALF admission paperwork to the monthly QA meeting for review.

A 605

1.

A 605 420-5-20-06 (3)(f) Care of Residents:

The facility failed to utilize general observation and health supervision of a resident who required medical attention.

2.

Corrective Action:

On 11/14/2025 the Wellness Director was replaced by an assigned RN to perform RN duties until a new Wellness Director is hired.

On 11/14/2025 the Director of Operations in serviced the ED on AL State regulations on requirements for admission to a SCALF unit. ED was in serviced on immediate notification to the ED of any changes in condition requiring intervention or referral to a different level of care.

On 11/14/2025 the ED in-serviced Direct Care Staff on immediate notification to the ED of any change in a resident's condition that requires intervention or referral to a different level of care or discipline to ensure safety of residents. Direct Care Staff in serviced on observation of residents during all activities.

3.

Steps taken to identify other residents or concerns:

All residents have the potential to be affected. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 to see how other residents were identified.

4.

Systemic changes made or measures put into place to ensure the deficiency does not recure:

The ED or designee will review new orders 5 days a week in the daily stand-up meeting for SCALF residents to identify any changes in medications that resulted from a change of resident's condition to help identify residents at a higher risk for incidents.

The Regional Nurse will review new orders during monthly visits to ensure that residents that required an increase in monitoring were identified and the additional oversight was provided.

5.

Monitoring of Corrective Action:

The ED will take audits with new orders requiring an increase in monitoring to monthly QA meeting for review and follow-up.

The Regional Team will do random reviews on SCALF residents while in the facility monthly for 6 months then quarterly for two quarters to identify residents with a change in condition that requires increase in monitoring.

A 607

1.

A 607 420-5-20-06 (3)(h)(i) Care of Residents:

The facility staff delayed notifications of 911 during a medical emergency that could have resulted in death, serous medical impairment or disability of the resident.

2.

Corrective Action:

On 11/14/2025 the Director of Operations in serviced the ED on immediate notification of emergency services with no delay for any resident needing emergent care. In serviced on notification to the Medical Director, Responsible Party and the ED immediately following notification to 911 services. The ED was in serviced on notification to the Regional Team after all other parties were notified.

On 11/14/2025 the ED in serviced all staff on immediate notification of 911 services during an emergency with no delay. Staff in serviced to notify Medical Director, Responsible Party and ED immediately following 911 notification.

On 11/15/2025 the Regional Nurse in serviced staff on the immediate notification of 911 services during an emergency with no delay in notification. . Staff in serviced to notify Medical Director, Responsible Party and ED immediately following 911 notification.

3.

Steps taken to identify other residents or concerns:

All residents have the potential to be affected. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 to see how other residents were identified.

4.

Systemic changes made or measures put into place to ensure the deficiency does not recure:

ED will review each incident as it occurs to ensure proper 911 notification and notification of all other parties involved were completed and documented timely.

ED or designee will notify the Regional Director of Operations and or the Regional Nurse when there is an incident that requires 911 notification for review.

A607 cont

Regional Staff will perform random chart reviews monthly for six months, then quarterly for two quarters while in the facility on anyone requiring an emergency transfer to ensure no delay occurred in notification of emergency services or other parties involved requiring notification.

5.

Monitoring of Corrective Action:

The ED will bring all emergency transfer logs and documentation to monthly QA meeting for review.

Various members of the Governing Authority will conduct facility visits no less than monthly for the next 6 months and then no less than quarterly for the next two quarters. Regional Nurse Consultant will continue to monitor for regulatory compliance throughout the probationary period with routine monthly visits. The Regional Director of Operations or designee, will provide weekly review to ensure compliance

A 608

1.

A 608 420-5-20-06 (3)(j) Care of Residents:

The facility treated a resident who exhibited suicidal and homicidal ideations with antipsychotics medication.

2.

Corrective Action:

The RN was termed on 11/14/2025.

On 11/14/2025 the Director of Operations in serviced the ED on AL State regulations regarding treating residents having an emergency with medication instead of involving emergency services.

On 11/14/2025 The ED in serviced Direct Care Staff on immediate notification of emergency services for any resident having an emergency behavioral episode.

3.

Steps taken to identify other residents or concerns:

All residents have the potential to be affected. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 to see how other residents were identified.

4.

Systemic changes made or measures put into place to ensure the deficiency does not recure:

Staff will notify emergency services immediately for any resident suffering an emergency behavioral episode to be transferred to a higher level of care for evaluation

The ED will review records on any resident transferred to a higher level of care for evaluation to ensure compliance.

The Regional Nurse will complete random audits of residents with new medication orders during monthly visits for six months then quarterly for two quarters to ensure compliance with regulations.

A 608 cont

5.

Monitoring of Corrective Action: A 608 –

Regional Staff will conduct random record reviews of any resident with behaviors requiring intervention monthly for six months then quarterly for two quarters to ensure compliance with AL rules and regulations.

The ED will take audits of residents that were sent to a higher level of care to the monthly QA meeting for review.

A 611

1.

A 611 420-5-20-063 (4)(a)(b) Care of Residents

The facility failed to develop a plan of care which contained interventions to meet the care and safety needs of a resident with suicidal ideations, homicidal ideations and safety risk identified in the initial physician's medical examination.

2.

Corrective Action:

On 11/14/2025 the Director of Operations in-serviced the ED on AL rules and regulations on developing a care plan for residents admitted to the SCALF. The ED was in-serviced to refuse any and all referrals with a history of suicide ideation or a resident requiring one on one care assistance.

On 11/14/2025 the ED in-serviced all staff on AL rules and regulations on requirements of eligibility to be admitted to a SCALF and on developing care plans to guide staff in providing the highest level of care for these residents.

Resident #1 was discharged. No other residents have been admitted to the SCALF.

3.

Steps taken to identify other residents or concerns:

All residents have the potential to be affected. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 to see how other residents were identified.

4.

Systemic changes made or measures put into place to ensure the deficiency does not recure:

No resident will be admitted to the facility with documented suicidal ideations or requiring assistance from a one-on-one caregiver.

The ED or designee will review new admissions during daily stand-up meetings to ensure care plans were developed for any condition needed to provide the highest level of care for these residents.

The Regional Nurse will review new admissions monthly for six months then quarterly for two quarters to ensure that care plans were developed to guide that residents care.

A 611 cont

5.

Monitoring of Corrective Action:

The ED will bring all new SCALF admissions to the monthly QA meeting for review of required health documents and the development of care plans.

Various members of the Governing Authority will conduct facility visits no less than monthly for the next 6 months and then no less than quarterly for the next two quarters. Regional Nurse Consultant will continue to monitor for regulatory compliance throughout the probationary period with routine monthly visits. The Regional Director of Operations or designee, will provide weekly review to ensure compliance

A 612

1.

A 612 420 5 20 06 (4)(c)(d)(e)(f) Care of Residents

The facility failed to develop a specific activity program to meet the needs of a resident who had wandering behaviors.

2.

Corrective Action:

On 11/14/2025 the Director of Operations in serviced the ED on implementation of activities for residents that have an increase in wandering behavior. The ED was in-serviced that behaviors should also be reported to the Medical Director, Responsible Party, the ED and the Regional Staff.

On 11/14/2025 the ED in serviced the Direct Care Staff of ensuring that residents with an increase in behavior or increased wandering should have specialized activities assigned to them to help decrease their behavior and notification to the Medical Director, Responsible Party and ED should be made immediately.

3.

Steps taken to identify other residents or concerns:

All residents have the potential to be affected. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 to see how other residents were identified.

4.

Systemic changes made or measures put into place to ensure the deficiency does not recure:

Direct care staff will observe residents for wandering behavior. Residents who are identified as wandering will be engaged in an activity to decrease their behavior.

The Direct care staff will notify the ED of any resident identified as having wandering behavior.

The Activity Director will ensure that there are daily activities scheduled for 7 days a week.

The Activity Director will report in daily stand up meetings on the activity that is scheduled for the SCALF unit and the person responsible for completing the activity.

A 612 cont.

5.

Monitoring of Corrective Action:

The Regional Team will perform random reviews of residents with a wandering behavior to ensure that the residents are involved in an activity to attempt to decrease agitation and behavior during monthly visits.

The ED will take audits conducted for residents with a change of condition or wandering behaviors to the monthly QA meeting to review to ensure that the resident was identified and an activity care plan was implemented to decrease the behavior.

A613

1.

A 613 420-5-20-06 (5)(a)(b)(c)(d)(e) Care of Residents:

The facility failed to obtain a physician's order for residents to manage or have custody of their own medications.

2.

Corrective Action:

On 11/14/2025 The Director of Operations in-serviced the ED on notification of physician and obtaining a physician order, completion of self-administration assessments and care plans for all residents that will self-medicate.

On 11/15/2025 The Regional Nurse in-serviced Direct Care Staff regarding residents with the potential to self-medicate, obtaining physician orders and the regulation as it relates to the Al State rules and regulations for SCALF.

On 11/16/2025 The Regional Nurse along with the Medical Director reviewed resident records on the SCALF unit for accuracy with assessments and physician orders.

The ED sent letters to families to inform them on delivering any medications to the nurse at the facility and to not take any medication into a resident care area or in a resident room.

3.

Steps taken to identify other residents or concerns:

All residents have the potential to be affected. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 to see how other residents were identified.

4.

Systemic changes made or measures put into place to ensure the deficiency does not recure:

Residents on the SCALF unit are not allowed to self-medicate or have any medications or chemicals in their access.

If bringing medication into the facility for residents the family will give them to the Nurse or to the ED and not leave any medication in a resident room.

Direct Care Staff will conduct an audit of resident care areas daily to ensure that there are no chemicals or medications accessible to any resident.

The ED or designee will conduct weekly audits of resident rooms and resident care areas to observe for any chemicals or medications accessible to residents.

The Regional Nurse will conduct monthly rounds on the SCALF unit to ensure there is no chemicals or medications available and accessible to SCALF residents.

5.

Monitoring of Corrective Action:

The ED will bring findings from SCALF audits to monthly QA meeting for review.

Various members of the Governing Authority will conduct facility visits no less than monthly for the next 6 months and then no less than quarterly for the next two quarters. Regional Nurse Consultant will continue to monitor for regulatory compliance throughout the probationary period with routine monthly visits. The Regional Director of Operations or designee, will provide weekly review to ensure compliance

A615

1.

A 615 420-5-20-06 (5)(h) Medications:

The facility failed to ensure medications were documented contemporaneously on the medication administration record. (MAR)

2.

Corrective Action:

The RN was termed on 11/14/2025.

On 11/14/2025 the Director of Operations in-serviced the ED on the 5 rights of medication pass. The ED was in-serviced regarding documentation of medication of all medications.

On 11/14/2025 The ED in-serviced Direct Care Staff on the 5 rights of medication administration and documentation.

3.

Steps taken to identify other residents or concerns:

All residents have the potential to be affected. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 to see how other residents were identified.

4.

Systemic changes made or measures put into place to ensure the deficiency does not recure:

The ED will review Medication Administration Records 3 x a week for 4 weeks then weekly thereafter for omissions.

The Regional Nurse will conduct random reviews of Medication Administration Records monthly for six months then quarterly for two quarters to ensure proper documentation of medication on the Medication Administration Records.

5.

Monitoring of Corrective Action:

The ED will review Medication Administration Records 3 x a week for 4 weeks then weekly thereafter for omissions and take audits to the monthly QA meeting for review.

A 615 cont.

Various members of the Governing Authority will conduct facility visits no less than monthly for the next 6 months and then no less than quarterly for the next two quarters. Regional Nurse Consultant will continue to monitor for regulatory compliance throughout the probationary period with routine monthly visits. The Regional Director of Operations or designee, will provide weekly review to ensure compliance

A 619

1.

A 619 420-5-20-06 (8) Care of Residents:

The facility failed to ensure stored medical supplies were inspected annually to ensure their usability.

2.

Corrective Action:

On 11/14/2025 The ED and Direct Care Staff did a sweep of the SCALF unit for any medications and medical supplies that were expired and disposed of all expired items.

On 11/14/2025 the Regional Director of Operations in-serviced the ED on checking medications and medical supplies and disposing of said items.

On 11/14/2025 the ED in-serviced the front-line staff on rules and regulations for expired medication and medical supplies.

3.

Steps taken to identify other residents or concerns: All residents have the potential to be affected. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 to see how other residents were identified

4.

Systemic changes made or measures put into place to ensure the deficiency does not recure:

ED or designee will conduct monthly checks on SCALF unit to observe for any expired medications and medical supplies and disposing of said items.

The Regional Nurse Consultant will conduct an observation monthly times 6 months then quarterly times two quarters of SCALF unit to identify any expired items.

5.

Monitoring of Corrective Action:

The ED will carry audits of SCALF units for expired items to the monthly QA meeting for review.

Various members of the Governing Authority will conduct facility visits no less than monthly for the next 6 months and then no less than quarterly for the next two quarters. Regional Nurse

Consultant will continue to monitor for regulatory compliance throughout the probationary period with routine monthly visits. The Regional Director of Operations or designee, will provide weekly review to ensure compliance

A 620

1.

A 620 420-5-20-06 (9)(a) Care of Residents

The facility admitted a resident who did not meet eligibility requirements for a SCALF.

2.

Corrective Action:

Resident #1 was discharged from the SCALF unit.

EI #3 RN was termed and ADPH notified on 11/14/2025 regarding inappropriate assessment and admission of RI#1.

On 11/14/2025 the Director of Operations in-serviced the ED on AL rules and regulations for meeting eligibility to be admitted to a SCALF unit.

On 11/14/2025 the ED in-serviced the Direct Care Staff on AL rules and regulations for meeting eligibility to be admitted to a SCALF unit.

3.

Steps taken to identify other residents or concerns:

All residents have the potential to be affected. Please refer to A 302, A 401, A 504, A 508, A 601, A 604, A 605, A607, A 608, A 611, A 612, A 613, A 615, A 620 to see how other residents were identified

4.

Systemic changes made or measures put into place to ensure the deficiency does not recure:

All referrals will be reviewed in daily stand-up meetings by the Admissions team to ensure that the resident meets the requirements to be admitted to the SCALF unit.

All referrals that meet the requirements for admission to a SCALF unit will be reviewed with the Medical Director prior to admission.

All referrals for the SCALF unit will be reviewed with the Regional Director of Operations and the Regional Nurse prior to acceptance during probationary period.

There will be no residents admitted to the SCALF unit with suicidal or homicidal ideations.

5.

Monitoring of Corrective Action:

The ED will take an audit of all referrals and admissions to monthly QA meeting for review. Various members of the Governing Authority will conduct facility visits no less than monthly for the next 6 months and then no less than quarterly for the next two quarters. Regional Nurse Consultant will continue to monitor for regulatory compliance throughout the probationary period with routine monthly visits. The Regional Director of Operations or designee, will provide weekly review to ensure compliance.

All monitoring documentation will be kept in a plan of correction book that will be kept in the ED office at all times.