POC Accepted 3.7.25

PLAN OF CORRECTION Connie Cherry

Facility Name: The Pearl of the Shoals ALF **Facility ID#: D1705**

Survey Exit Date: 02/12/2025 **Administrator: Sharon Byears**

chg

A405 420-5-4-.04(6) Personnel.

Facility staff were not properly trained in special needs of residents.

1. **Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.**

   - On 02/12/2025, Sage Management consultant initiated all nursing staff in-service on manufacturer instructions of CGM devices currently in use for residents of the facility. This was completed by EI#6 on 02/19/2025 after Sage Management consultant exiting the building.

2. **Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems similar to those listed in each example. Include specific timetables and the title of staff responsible.**

   - A review of all 100% of all current resident's special needs was done by EI#6 and EI#1 to identify any additional special needs of residents and to ensure that staff training was completed. No other special needs identified.

3. **Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.**

   - EI#6 was educated by EI#1 on importance of ensuring that when assessing residents for eligibility for admission or when change of conditions occur requiring additional special needs of residents, those special needs should be identified and staff shall be trained on the special need and the facility shall ensure that a policy is in place for that individuals special need. Completed on 02/12/2025.

4. **Explain how you will monitor your proposed corrective actions to ensure they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.**

   - The RN and Administrator will conduct a meeting to review any changes in resident conditions that require special needs or potential prospects for admission who have special needs. If special needs are identified, staff training will be conducted by the RN and the Administrator will coordinate with the governing authority to ensure that a policy is in place at the facility for the identified special needs. This policy will

be included in staff training. This will be documented weekly x 4 weeks, then monthly x 3. Will be initiated on 03/07/2025.

PLAN OF CORRECTION

Facility Name: The Pearl of the Shoals ALF **Facility ID#: D1705**

Survey Exit Date: 02/12/2025 **Administrator: Sharon Byears**

A601 420-5-4-.06(1) Care of Residents.

The facility failed to follow the physicians' orders for assistance with residents' medications.

1. **Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.**

   - RI#2 was assessed by EI#6 for ability to safely self-administer Ipratropium Bromide and Antacid medications. Resident passed ability to self-administer these medications on 02/12/2025.
   - EI#6 contacted RI#2's primary physician and an order was provided to the facility on 02/13/2025, that resident may self-administer Ipratropium Bromide and Antacid medications.
   - RI#2 care plan was updated by EI#6 to reflect the above order noted on the resident chart at the facility, done 02/13/2025.
   - On the evening of 02/11/2025, after the finding from the surveyor, facility staff began assisting and supervising RI#5 with medications and informed RI#5's spouse that he no longer can assist RI#5 with medications and that only facility staff may assist in the self-administration of medications to the resident.

2. **Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems similar to those listed in each example. Include specific timetables and the title of staff responsible.**

   - A review of all 100% of all current resident's medication orders and medication care plans were reviewed by EI#6 to identify any discrepancies in assistance in self-administration of medications or self-administration of medications of residents. No other issues were identified. Done on 02/14/2025.
   - 100% of all current residents of the facility were assessed during medication pass by EI#6 for their ability properly pass medication awareness and ensure staff are supervising residents during times medications are given by facility staff. This was completed on 03/06/2025.

3. **Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.**

   - All staff in-service initiated on 02/13/2025 by EI#6 to include review of ADPH rule and regulation "Medications" page 50-56, with specific attention to "a physician order is required for a resident to manage and have custody of his or her own

medications" and "a resident that cannot self-manage his or her own medication without creating an unreasonable risk to health and safety may be assisted with self-administration of medication by any assisted living facility staff, including staff members who hold no professional licensure provided the resident can and does identify his or her name on the medication package and has a reasonable understanding of the unit dose packaging system in use by the facility such that the resident could protect himself or herself from medication errors when unit dose packages are brought to the resident by facility staff. The resident shall have the opportunity to demonstrate his or her ability to correctly utilize the unit dose package system at every opportunity for medication use." This training included the inability for family members or other residents to assist with the self-administration of medications to residents, securing medications, unit dose packaging and requirements for licensed nursing staff or physician to administer medications that are not available in unit dose packaging unless resident has ability to direct dosage of medication to unlicensed staff provided that resident is capable of determining the amount of medication to be given, and proper storage of medications per ADPH rules and regulations for ALF. Will be completed by 03/11/2025.

4. **Explain how you will monitor your proposed corrective actions to ensure they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.**

- The RN, or delegated designee, will conduct room rounds monthly on 100% of all current resident rooms of the facility to identify any medications at bedside without a physician's order, and proper storage and security of medications. Any medications identified will be removed from the resident's room and kept in the nursing office until a physician's order is obtained. This will be documented on the Monthly QA Form that the administrator will complete, ongoing. Starting March 2025.
- The RN, or delegated designee, will conduct random medication pass observations with staff to identify any resident issues with properly identifying medications, people other than staff assisting residents with medications, and determining if administration by licensed nurse is warranted for medication awareness failures, and issues with staff properly supervising residents during medication passes. Any issues identified will be promptly reported to the Administrator. This will be done weekly x 4 weeks, then monthly x 3. Starting March 2025.

PLAN OF CORRECTION

Facility Name: The Pearl of the Shoals ALF **Facility ID#: D1705**

Survey Exit Date: 02/12/2025 **Administrator: Sharon Byears**

A613 420-5-4-.06 (5)(a)(b)(c)(d)(e) Care of Residents.

The facility failed to obtain written approval from a physician for residents to have custody of and manage their medications.

1. **Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.**

   - RI#2 was assessed by EI#6 for ability to safely self-administer Ipratropium Bromide and Antacid medications. Resident passed ability to self-administer these medications on 02/12/2025.
   - EI#6 contacted RI#2's primary physician and an order was provided to the facility on 02/13/2025, that resident may self-administer Ipratropium Bromide and Antacid medications.
   - RI#2 care plan was updated by EI#6 to reflect the above order noted on the resident chart at the facility, done 02/13/2025.
   - On the evening of 02/11/2025, after the finding from the surveyor, facility staff began assisting and supervising RI#5 with medications and informed RI#5's spouse that he no longer can assist RI#5 with medications and that only facility staff may assist in the self-administration of medications to the resident.

2. **Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems similar to those listed in each example. Include specific timetables and the title of staff responsible.**

   - A review of all 100% of all current resident's medication orders and medication care plans were reviewed by EI#6 to identify any discrepancies in assistance in self-administration of medications or self-administration of medications of residents. No other issues were identified. Done on 02/14/2025.
   - 100% of all current residents of the facility were assessed during medication pass by EI#6 for their ability properly pass medication awareness and ensure staff are supervising residents during times medications are given by facility staff. This was completed on 03/06/2025.

3. **Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.**

   - All staff in-service initiated on 02/13/2025 by EI#6 to include review of ADPH rule and regulation "Medications" page 50-56, with specific attention to "a physician

order is required for a resident to manage and have custody of his or her own medications" and "a resident that cannot self-manage his or her own medication without creating an unreasonable risk to health and safety may be assisted with self-administration of medication by any assisted living facility staff, including staff members who hold no professional licensure provided the resident can and does identify his or her name on the medication package and has a reasonable understanding of the unit dose packaging system in use by the facility such that the resident could protect himself or herself from medication errors when unit dose packages are brought to the resident by facility staff. The resident shall have the opportunity to demonstrate his or her ability to correctly utilize the unit dose package system at every opportunity for medication use." This training included the inability for family members or other residents to assist with the self-administration of medications to residents, securing medications, unit dose packaging and requirements for licensed nursing staff or physician to administer medications that are not available in unit dose packaging unless resident has ability to direct dosage of medication to unlicensed staff provided that resident is capable of determining the amount of medication to be given, and proper storage of medications per ADPH rules and regulations for ALF. Will be completed by 03/11/2025.

4. **Explain how you will monitor your proposed corrective actions to ensure they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.**

- The RN, or delegated designee, will conduct room rounds monthly on 100% of all current resident rooms of the facility to identify any medications at bedside without a physician's order, and proper storage and security of medications. Any medications identified will be removed from the resident's room and kept in the nursing office until a physician's order is obtained. This will be documented on the Monthly QA Form that the administrator will complete, ongoing. Starting March 2025.
- The RN, or delegated designee, will conduct random medication pass observations with staff to identify any resident issues with properly identifying medications, people other than staff assisting residents with medications, and determining if administration by licensed nurse is warranted for medication awareness failures, and issues with staff properly supervising residents during medication passes. This will be done weekly x 4 weeks, then monthly x 3. Starting March 2025.

PLAN OF CORRECTION

Facility Name: The Pearl of the Shoals ALF **Facility ID#: D1705**

Survey Exit Date: 02/12/2025 **Administrator: Sharon Byears**

A616 420-5-4-.06 (7)(k)(l)(m)(n)(o) Care of Residents.

A resident's medications were not administered and stored according to ALF rules.

1. **Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.**

   - On the evening of 02/12/2025, after the surveyor's findings, EI#6 immediately secured RI#5 medications and educated EI#7 to administer the medications until medications could be packaged in unit dose packaging.

2. **Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems similar to those listed in each example. Include specific timetables and the title of staff responsible.**

   - 100% of all resident rooms were rounded on by EI#6 to identify any unsecure medications, after the findings from the surveyor were identified. Completed on 02/12/2025 by EI#1, EI#6, and EI#7.
   - A review of all 100% of all current resident's medication orders and medication care plans were reviewed by EI#6 to identify any discrepancies in assistance in self-administration of medications or self-administration of medications of residents. No other issues were identified. Done on 02/14/2025.
   - 100% of all current residents of the facility were assessed during medication pass by EI#6 for their ability properly pass medication awareness and ensure staff are supervising residents during times medications are given by facility staff. This was completed on 03/06/2025.

3. **Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.**

   - All staff in-service initiated on 02/13/2025 by EI#6 to include review of ADPH rule and regulation "Medications" page 50-56, with specific attention to "a physician order is required for a resident to manage and have custody of his or her own medications" and "a resident that cannot self-manage his or her own medication without creating an unreasonable risk to health and safety may be assisted with self-administration of medication by any assisted living facility staff, including staff members who hold no professional licensure provided the resident can and does identify his or her name on the medication package and has a reasonable understanding of the unit dose packaging system in use by the facility such that the

resident could protect himself or herself from medication errors when unit dose packages are brought to the resident by facility staff. The resident shall have the opportunity to demonstrate his or her ability to correctly utilize the unit dose package system at every opportunity for medication use." This training included the inability for family members or other residents to assist with the self-administration of medications to residents, securing medications, unit dose packaging and requirements for licensed nursing staff or physician to administer medications that are not available in unit dose packaging unless resident has ability to direct dosage of medication to unlicensed staff provided that resident is capable of determining the amount of medication to be given, and proper storage of medications per ADPH rules and regulations for ALF. Will be completed by 03/11/2025.

4. **Explain how you will monitor your proposed corrective actions to ensure they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.**

- The RN, or delegated designee, will conduct room rounds monthly on 100% of all current resident rooms of the facility to identify any medications at bedside without a physician's order, and proper storage and security of medications. Any medications identified will be removed from the resident's room and kept in the nursing office until a physician's order is obtained. This will be documented on the Monthly QA Form that the administrator will complete, ongoing. Starting March 2025.
- The RN, or delegated designee, will conduct random medication pass observations with staff to identify any resident issues with properly identifying medications, people other than staff assisting residents with medications, and determining if administration by licensed nurse is warranted for medication awareness failures, and issues with staff properly supervising residents during medication passes. This will be done weekly x 4 weeks, then monthly x 3. Starting March 2025.

PLAN OF CORRECTION

Facility Name: The Pearl of the Shoals ALF **Facility ID#: D1705**

Survey Exit Date: 02/12/2025 **Administrator: Sharon Byears**

A1002 420-5-4-.10(2) Sanitation and Housekeeping.

The facility failed to secure cleaning supplies.

1. **Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.**

   - On 02/11/25, after the surveyor's findings, EI#1 secured the door to the facility's spa.
   - On 02/24/2025, EI#3 replaced the door lock with a self-locking system to prevent door from being left unlocked.

2. **Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems similar to those listed in each example. Include specific timetables and the title of staff responsible.**

   - On the evening of 02/11/25, all facility common areas were assessed by EI#12 for concerns with unsecure cleaning supplies. Any unsecure cleaning supplies were immediately secured behind a locked door or cabinet of the facility.

3. **Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.**

   - All staff in-service initiated on 02/19/2025 by RN, with review of ADPH rule and regulations that all cleaning supplies and poisons shall be attended to at all times or shall be kept in a secure area. Will be completed by 03/07/2025.

4. **Explain how you will monitor your proposed corrective actions to ensure they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.**

   - The Housekeeping Manager will round the common areas daily on scheduled workdays to identify any unsecure cleaning supplies. This will be documented daily x 2 weeks, then weekly x 4 weeks, then monthly x 3. Started 03/05/2025.

PLAN OF CORRECTION

Facility Name: The Pearl of the Shoals ALF **Facility ID#: D1705**

Survey Exit Date: 02/12/2025 **Administrator: Sharon Byears**

A1101 420-5-4-.11 (1) Fire and Safety.

The facility failed to have the sprinkler and fire alarm systems inspected semiannually by licensed personnel.

1. **Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.**

   - A review of the past semiannual sprinkler alarm system inspections for 2024 was completed by EI#3. Done on 02/13/2025.
   - A review of the past semi-annual fire alarm system inspection for 2024 was completed by the EI#3 Done on 02/13/2025.
   - A letter was provided to the facility by the Muscle Shoals Fire Department, signed by the Fire Marshall on 02/13/2025, stating that the facility is in good standing with their fire and sprinkler systems. No deficiencies were identified.
   - EI#3, Maintenance Director, was hired by the facility on 09/11/2024. No inspections have been missed since the new Maintenance Director was hired.

2. **Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems similar to those listed in each example. Include specific timetables and the title of staff responsible.**

   - EI#3 reviewed all other last inspections to include but not limited to fire extinguishers and kitchen hood and verified upcoming scheduled dates with Fire Pro on 03/03/2025. These inspections will be added to the Monthly QA Form that will be completed by the Administrator each month, starting March 2025.

3. **Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.**

   - EI# 3, Maintenance Director, training provided by EI#1, Administrator, on responsibility and importance of maintaining all required inspections, prompt notification to administrator when scheduled and/or any change in schedule and review of semi-annual inspections upon completion immediately with Administrator. Completed by Administrator on 02/12/2025. A review of all specific required inspections was done by EI# 1 and EI#3.

4. **Explain how you will monitor your proposed corrective actions to ensure they are implemented and that the corrective actions adequately address the**

identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.

- The Maintenance Director will provide the administrator with fire alarm and sprinkler inspections reports and scheduled due dates for both types of inspections. This will be done as they occur semi-annually for administrative review. Effective immediately, ongoing.
- A Monthly QA form will be implemented March 2025, for the Administrator to complete and review and monitor all monthly, semiannual, and annual inspections required.

PLAN OF CORRECTION

Facility Name: The Pearl of the Shoals ALF **Facility ID#: D1705**

Survey Exit Date: 02/12/2025 **Administrator: Sharon Byears**

A1203 420-5-4-.12 (5) Physical Plant.

The facility failed to maintain structural soundness and repair of the building.

1. **Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.**

    - The 24-inch by 24-inch hole on floor in the spa room was repaired. The faucet for the spa tub was replaced and the leaky valve was repaired. This was initiated on 02/12/2025 and completed on 02/13/2025 by EI#3.
    - On 02/27/2025, EI#3 ordered 15 cabinets from supplier, HD Supply. The estimated time on arrival of cabinets is unknown at this time, per supplier. Some cabinets have already been delivered to the facility as of 03/04/2025. The Maintenance Director has and will begin installing the new cabinets immediately after delivery.
    - On 02/27/2025, EI#3 met with 2 gutter companies to provide estimates on repairs to the facility gutters.
    - On 03/03/2025, the facility and gutter company, Ridgeline & Restoration agreed to the estimate and approved the repairs to facility gutters. The repairs are to begin on 03/17/2025, with an approximate completion date of 03/24/2025.

2. **Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems similar to those listed in each example. Include specific timetables and the title of staff responsible.**

    - 100% of all cabinets in resident rooms, common area bathroom, activity area and dining room were assessed by EI#1 and EI# 3 to identify cabinets that were cracked, worn, or in need of replacement. Done on 02/27/2025. 5 residents' rooms, bathrooms, or kitchenette cabinets were identified in need of replacement for a total of 5 cabinets. The following apartments need cabinet replacement: 101, 104, 106, 315, and 307.
    - On 02/27/2025, EI#3 ordered 15 cabinets from supplier, HD Supply. The estimated time on arrival of cabinets is unknown at this time, per supplier. Some cabinets have already been delivered to the facility as of 03/04/2025. The Maintenance Director has and will begin installing the new cabinets immediately after delivery.
    - On 02/12/2025, EI#1 and EI#3, walked the outside perimeter of the facility, assessing for additional needed repairs to windows, window screens and sidewalks. No additional repairs were needed.

3. **Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.**

    - Management staff will be educated by the Administrator on the importance of building upkeep and repairs regarding the exterior areas of the facility. The Maintenance Director education included that the facility shall be rounded weekly of the exterior of the community to ensure all gutters are working properly, in good repair and are functioning properly. In addition, training included daily rounds are to be conducted on scheduled workdays of the interior of the building to identify any concerns with broken equipment, safety hazards, cabinet wear, toilets, doors, showers, sinks, etc. malfunction. Will be completed by 03/07/2025.

4. **Explain how you will monitor your proposed corrective actions to ensure they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.**

    - The Maintenance Director of Administrator will randomly check 3 resident rooms and one common area cabinets for cracks, worn or in need of repair. All findings will be documented and reviewed with the Administrator and prompt follow-up to correct this issue will be done. This will be documented weekly x 1-month, monthly x 3 months, then quarterly x 2. Will begin on 03/07/2025.
    - The Maintenance Director or Administrator will make rounds to the exterior perimeter of the facility to ensure all gutters are in good repair and are functioning properly. All findings will be documented and reviewed with the Administrator. This will be documented weekly x 1-month, monthly x 3 months, then quarterly x 2. Began week of 02/17/2025.

NOTE: All Plan of Correction documentation will be in a binder, organized, and filed by the Administrator. The binder will be stored in the Administrator's office.

Prepared by N. Kelley, SAGE RN Director of Compliance
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251-656-7660

PLAN OF CORRECTION

Facility Name: The Pearl of the Shoals ALF **Facility ID#: D1705**

Survey Exit Date: 02/12/2025 **Administrator: Sharon Byears**

Sharon Byears, E.D. 3/5/25

Administrator Signature/Date