POC Accepted 1.15.25

Connie Cherry

PLAN OF CORRECTION

Facility Name: Haven Memory Care on Halcyon **Facility ID #:** P5110

Survey Exit Date: 10/31/2024 **Administrator:** Evelyn Garrett

A504 **Deficiency Number:** 420-5-20-.05(3)(d) Records and Reports

The facility failed to provide residents with a decent environment by requiring residents to lock their room doors at all times to prevent a resident with unmanageable behaviors from entering their rooms.

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.**

   100% of all resident rooms were unlocked immediately by staff of the facility on 10/31/24.

2. **Specify how you will identify other residents, 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 residents were assessed by the Community Development Director and Maintenance Director for their ability to utilize a room key and whether they preferred for their room to stay locked/unlocked when not occupied by the resident. Those residents who preferred to have a room key were assessed for their ability to use a room key; a key was provided to those residents by the Maintenance Director. Done on 11/14/24. Residents who voiced that they preferred their doors to be kept locked, do have a room key and able to utilize room key appropriately. This was documented on those resident's care plan.

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 11/13/24 by Administrator reviewing resident rights with specific attention to not restricting residents from their own rooms by keeping doors locked. This will be completed by 12/20/24.

4. **Explain how you will monitor your proposed corrective actions to ensure that 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 Administrator will randomly monitor resident rooms for locked apartment doors. Doors that are locked will be investigated by the Administrator as to whether the resident has access to unlock the door, may have locked their door themselves, or to identify if staff locked the apartment door. Any identified concerns with staff locking doors will be promptly addressed. This will be completed weekly x 4 weeks, then monthly x 3 months. Began December 2024.

PLAN OF CORRECTION

Facility Name: Haven Memory Care on Halcyon **Facility ID #:** P5110

Survey Exit Date: 10/31/2024 **Administrator:** Evelyn Garrett

A508 **Deficiency Number:** 420-5-20-.05(3)(h) Records and Reports.

The facility failed to report an incident as required.

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#7 incident was reported to ADPH by EI#1 on 10/30/24.

2. **Specify how you will identify other residents, 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 incident reports for October 2024 were reviewed by Sage Consultant on 10/30/24. Any identified incident reports that required reporting to ADPH were promptly submitted by the Administrator.

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.**

   Education provided to Resident Care Coordinator, RN/Resident Care Director, all nurses, and Administrator by RN (from sister community who is assisting this facility with review of rules and regulations for Incident Reporting, Investigations, and ADPH Reporting). This education included that all incidents shall be immediately reported to Administrator and review of incident reports shall be completed daily to ensure that investigations are completed and determine whether each incident warrants reporting to ADPH online incident reporting system. Done on 11/13/24.

4. **Explain how you will monitor your proposed corrective actions to ensure that 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.**

   During daily stand-up meetings on scheduled workdays, incident reports will be reviewed by the Administrator and Resident Care Director and/or Resident Care Coordinator. During any scheduled time off of the Administrator and Resident Care Director or Resident Care Coordinator,

those prior days incidents will be reviewed upon return to the facility on the next scheduled workday. Any pending incident reports, investigations, or those that require reporting to ADPH will be completed immediately during this planned review period by the Resident Care Coordinator or Resident Care Director, and Administrator. Effective 11/13/24.

PLAN OF CORRECTION

Facility Name: Haven Memory Care on Halcyon **Facility ID #:** P5110

Survey Exit Date: 10/31/2024 **Administrator:** Evelyn Garrett

A601 **Deficiency Number:** 420-5-20-.06(1) Care of Residents

The facility failed to follow physician orders.

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.**

   EI#8 was verbally educated by EI#17 that if the resident is requesting medication to be given at a different time than the scheduled medication time on the EMAR, the physician shall be promptly notified with the resident's request to change the medication time, done on 10/30/24.

2. **Specify how you will identify other residents, 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.**

   Discussion took place by Resident Care Coordinator, RN/Resident Care Director, and Administrator with all nursing staff, initiated on 11/12/24 to identify any residents who normally request medications to be given at a different time than what is scheduled. Any identified residents who request medications at different times than those ordered by the physician's order, those primary physicians were notified in request and approval to change those specific medication times. Done by 11/13/24.

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 nursing staff in-service initiated on 11/13/24 by Resident Care Coordinator, RN/Resident Care Director, and Administrator with review that medications must be given at scheduled time listed on the EMAR and that medications shall not be given at various times than what is reflected on the EMAR for each resident. Shall a resident request medication to be given at a different time, the primary physician shall be promptly notified with a request to change the medication time. Done by 12/18/24.

4. **Explain how you will monitor your proposed corrective actions to ensure that 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.

Random medication pass observations will be conducted by Resident Care Coordinator or RN/Resident Care Director weekly x 4 weeks, then monthly x 3 months to identify any concerns with following medication times scheduled on EMAR's for residents. Will begin on 11/18/24.

PLAN OF CORRECTION

Facility Name: Haven Memory Care on Halcyon **Facility ID #:** P5110

Survey Exit Date: 10/31/2024 **Administrator:** Evelyn Garrett

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

The facility Registered Nurse (RN) failed to complete a comprehensive assessment of a resident as required.

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#7 comprehensive assessment was completed on 10/29/24 by EI#17.

2. **Specify how you will identify other residents, 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.**

   RN Director of Compliance completed an audit of all resident records in October 2024 to identify any other omitted assessments. Any other omitted assessments were completed by EI#17/RN Director of Compliance. This was completed on 10/31/24.

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.**

   Verbal education provided to EI#6 by 10/30/24 by EI#17 regarding comprehensive assessments and rule requirements and how comprehensive assessments shall be promptly completed.

   New RN hired on 12/09/24 reviewed facility policy and procedure training that provided education on comprehensive assessments and ADPH rule and regulation. On 12/18/24, RN was educated on comprehensive assessments ADPH rule and regulation with review of required occurrences in which an assessment is warranted and importance of completing assessments promptly.

4. **Explain how you will monitor your proposed corrective actions to ensure that 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.**

During daily stand-up meetings, discussion will be held with Resident Care Coordinator and/or RN/Resident Care Director with specific attention to any concerns of resident eligibility, PSMS scoring near or exceeding eligibility, or behavior concerns. In addition, a team member from the care staff department will attend these meetings. These meetings will include a review of pending assessments in the electronic health record or needed new assessments based on resident significant change in conditions in which comprehensive assessments are required. This will be documented on daily stand-up meeting minutes on scheduled workdays by the Administrator. Ongoing, effective 11/13/24.

PLAN OF CORRECTION

Facility Name: Haven Memory Care on Halcyon **Facility ID #:** P5110

Survey Exit Date: 10/31/2024 **Administrator:** Evelyn Garrett

A606 **Deficiency Number:** 420-5-20-.06(3)(g) Care of Residents.

The facility failed to discharge residents, who required a higher level of care, to an appropriate setting.

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 issued a 30-day notice of discharge by the Administrator on 11/04/24. Resident was discharged from the facility on 12/12/24.

2. **Specify how you will identify other residents, 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 baseline assessment with a PSMS and Behavior Screen was initiated on 11/01/24 and completed on 100% of all residents to identify any other residents who may have concerns for eligibility. Any other residents identified as exceeding the level of care in which the facility can provide or in which ADPH rules and regulations allow was promptly issued a 30 notice of discharge by the Administrator. Assessments were completed by Resident Care Coordinator by 11/15/24.

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.**

   Education provided to all nurses and Administrator on 11/13/24 by RN with review of ADPH rule and regulation of PSMS scoring. Discussion took place in which a PSMS score is greater than a 23 or a score of five in feeding, dressing, grooming, bathing, or a score of four or five in physical ambulation, that notification immediately to Administrator is required. In addition, all current behaviors or behaviors that have occurred in the past 6 months shall be documented on the behavior screen. Any concerns with managing resident behavior shall be promptly reported to the Administrator. ADPH rule and regulation of admission and retention of residents was reviewed.

4. **Explain how you will monitor your proposed corrective actions to ensure that 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.

During daily stand-up meetings, discussion will be held with Resident Care Coordinator and/or Resident Care Director with specific attention to any concerns of resident eligibility, PSMS scoring near or exceeding eligibility, or behavior concerns. In addition, a team member from the care staff department will attend these meetings. These meetings will include a review of pending assessments or needed new assessments based on resident significant change in conditions in which comprehensive assessments are required. This will include a review of updated care plans and ensuring in care plan book. This will be documented on daily stand-up meeting minutes on scheduled workdays by the Administrator. Ongoing, effective 11/13/24.

PLAN OF CORRECTION

Facility Name: Haven Memory Care on Halcyon **Facility ID #:** P5110

Survey Exit Date: 10/31/2024 **Administrator:** Evelyn Garrett

A611 **Deficiency Number:** 420-5-20-.06(4)(a)(b) Care of Residents.

The RN failed to plan the care of a resident with wandering behavior and weight loss. The RN also failed to ensure all resident care plans were accessible to staff.

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#10 wandering care plan was initiated on 08/14/24 per electronic health record system upon review by CSL Director of Compliance/EI#17.

   RI#10 recent aggressive wandering behavior was added to care plan by EI#17 on 10/30/24.

   RI#10 September significant weight loss was initiated on 09/11/24 per electronic health record system upon review by CSL Director of Compliance/EI#17.

   On 10/31/24 a copy of RI#A 10's care plan was placed in the care plan book by LPN on duty.

2. **Specify how you will identify other residents, 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 care plans were reviewed by RN Director of Compliance and compared to current behavior screens to identify any behaviors to include wandering that were omitted from the resident's care plan. Any omitted behaviors identified were promptly added to the resident's care plan. Done by 12/02/24.

   100% of all current resident weights for October 2024 were reviewed by RN Director of Compliance on 10/29/24 to identify any significant weight loss of residents. Follow-up review was completed to ensure that all residents who triggered with significant weight loss had notifications to physicians, Registered Dietician consults, care plan updates with interventions, and Comprehensive Assessments, PSMS's, and Behavior Screens.

100% of all current resident weights for September 2024 were reviewed by RN Director of Compliance to identify any significant weight loss of residents. Follow-up review was completed to ensure that all residents who triggered with significant weight loss had notifications to physicians, Registered Dietician consults, care plan updates with interventions, and Comprehensive Assessments, PSMS's, and Behavior Screens. Done on 11/15/24.

The care plan book was reviewed by the administrator assistant to ensure that all residents had a care plan in the facility book, done on 10/31/24. No other care plans identified as missing noted.

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.**

   Education provided to Resident Care Coordinator, RN/Resident Care Director, and Administrator by RN (from sister community who is assisting this facility) with review of rules and regulations for care plans/service plans with specific attention to that each residents behavior shall be reflective on the behavior screen at each time a behavior screen is required to be completed per ADPH rules and regulations, and each behavior shall be care planned with a staff intervention with an activity based intervention for all wandering behaviors. Review of rules and regulations for significant weight loss, required assessments for this change of condition of a resident, how to pull weight loss reports in electronic health record system, facility standard practice that weights shall be completed and addressed by 7th of each month. In addition, review that required assessments and care plan updates shall be completed promptly and care plans shall always reflect the current condition of each resident and updates shall be placed in the care plan book accessible to care staff as they occur. Done on 11/13/24.

4. **Explain how you will monitor your proposed corrective actions to ensure that 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 Resident Care Coordinator and/or RN/Resident Care Director will pull the significant weight loss report in the electronic health record system monthly to identify any weight loss concerns that require addressing. Each significant weight loss identified, will be promptly addressed by the proper discipline by completing a Comprehensive Assessment, PSMS, Behavior Screen, care plan update, physician notification and notification to the Registered Dietician for a consultation, effective immediately and ongoing. By the 8th of each month x 6 months, the weight loss report will be reviewed by the Administrator with a random review conducted to ensure that

significant weight losses are addressed. This will be documented and kept on file in the administrator's office. Effective December 2024.

During daily stand-up meetings, discussion will be held with Resident Care Coordinator and/or Resident Care Director with specific attention to any concerns of resident eligibility, PSMS scoring near or exceeding eligibility, or behavior concerns. In addition, a team member from the care staff department will attend these meetings. These meetings will include a review of pending assessments or needed new assessments based on resident significant change in conditions in which comprehensive assessments are required. This will include a review of updated care plans and ensuring in care plan book. This will be documented on daily stand-up meeting minutes on scheduled workdays by the Administrator. Ongoing, effective 11/13/24.

PLAN OF CORRECTION

Facility Name: Haven Memory Care on Halcyon **Facility ID #:** P5110

Survey Exit Date: 10/31/2024 **Administrator:** Evelyn Garrett

A621 **Deficiency Number:** 420-5-20-.06(9)(B) Care of Residents.

The facility failed to discharge a resident who required a higher level of care to an appropriate setting.

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 issued a 30-day notice of discharge by the Administrator on 11/04/24. Resident was discharged from facility on 12/12/24.

2. **Specify how you will identify other residents, 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 baseline assessment with a PSMS and Behavior Screen was initiated on 11/01/24 and completed on 100% of all residents to identify any other residents who may have concerns for eligibility. Any other residents identified as exceeding the level of care in which the facility can provide or in which ADPH rules and regulations allow was promptly issued a 30 notice of discharge by the Administrator. Assessments were completed by Resident Care Coordinator by 11/15/24.

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.**

   Education provided to all nurses and Administrator on 11/13/24 by RN with review of ADPH rule and regulation of PSMS scoring. Discussion took place in which a PSMS score is greater than a 23 or a score of five in feeding, dressing, grooming, bathing, or a score of four or five in physical ambulation, that notification immediately to Administrator is required. In addition, all current behaviors or behaviors that have occurred in the past 6 months shall be documented on the behavior screen. Any concerns with managing resident behavior shall be promptly reported to the Administrator. ADPH rule and regulation of admission and retention of residents was reviewed.

4. **Explain how you will monitor your proposed corrective actions to ensure that 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.

During daily stand-up meetings, discussion will be held with Resident Care Coordinator and/or Resident Care Director with specific attention to any concerns of resident eligibility, PSMS scoring near or exceeding eligibility, or behavior concerns. In addition, a team member from the care staff department will attend these meetings. These meetings will include a review of pending assessments or needed new assessments based on resident significant change in conditions in which comprehensive assessments are required. This will include a review of updated care plans and ensuring in care plan book. This will be documented on daily stand-up meeting minutes on scheduled workdays by the Administrator. Ongoing, effective 11/13/24.

PLAN OF CORRECTION

Facility Name: Haven Memory Care on Halcyon **Facility ID #:** P5110

Survey Exit Date: 10/31/2024 **Administrator:** Evelyn Garrett

A1206 **Deficiency Number:** 420-5-20-.12(8) Physical Environment.

The facility failed to provide a safe egress from a fenced courtyard area.

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 10/30/24, Preventia Security was immediately contacted by the Maintenance Director notifying of the need for prompt visit to assess the courtyard gate for concern for not releasing during activation of fire alarm system.

   On 10/31/24, Preventia Security arrived at the facility and repaired the courtyard gate. This was verified by the Maintenance Director, in the presence of the ADPH surveyor.

2. **Specify how you will identify other residents, 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.**

   N/A

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.**

   Education provided to Maintenance Director on 10/31/24 by Administrator that the courtyard gate shall be checked for automatic release during activation of the fire alarm system during monthly fire drills. In addition, the review included that during 3rd shift simulation fire drills, the following day the fire alarm system shall be activated to assess release of the courtyard gate. Any issues identified shall be immediately reported to the Administrator.

4. **Explain how you will monitor your proposed corrective actions to ensure that 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 monitor for release or issues with releasing of the courtyard gate monthly. Any issues identified will be promptly addressed and immediately reported to the Administrator. This will begin in November 2024. The Maintenance Director was educated by Administrator that this shall be done indefinitely during monthly fire drills, but the facility will document this monitoring monthly x 6 months.

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.

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Evelyn L Sarrett
Administrator

12/23/24
Date