POC Accepted 4.23.24
Connie Cherry chg

POC for Thrive at Jones Farm ALF Dated: 4/16/2024.

Identification Number D4548 updated 4/19/2024

Name of Administrator Deborah Elms

Survey Exit Date 4/3/2024.

Deficiency # A504 Hand Hygiene/30-day Notice.

Handwashing

This Rule is not met as evidenced by: Based on observations and interview, the facility failed to provide health care consistent with established and recognized standards within the community by failure to provide proper hand hygiene. In addition, the facility failed to provide at least 30 days written notice of involuntary termination of residence at the facility.

Handwashing Policy & Expectations Inservice for those passing ie: Medication Technicians and Nurses reviewed and signed. All staff shall receive a copy. Administrator & Wellness Director oversight. Completion Date 4/25/2024. Kept in Administrators office.

Competency Check off Station, at next all staff meeting dated 4/26/2024. All Care providers will be assessed and checked for competency. Completion date 4/26/2024.

New Hires to sign the Handwashing Policy and Inservice at Orientation. BOM oversight.

Feedback: This will be uploaded to UltiPro, and completion is required prior to completing orientation. BOM oversight

Monitoring: Will be completed during observations during managers rounds and documented on their Walking Rounds Report. We will conduct daily for 4 weeks and then monthly for 4 months 9/20/2024 Documentation will be kept in Administrator office.

30-Day Notice

30-day notices will be issued for all internal transfers and discharges going forward regardless of the resident or family's agreement with the decision. Administrator and BOM to sign a statement of understanding. Completion Date 4/10/2024

Feedback: Notices will be part of the financial file kept in the BOM office and scanned into PCC after signatures obtained by the resident or family and Administrator.

Monitoring: Going forward Administrator will complete audits of all residents on notice of transfer and discharge within one week of date of issue. Completion 5/10/24

Deficiency # A508 Online Reporting System

This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report incidents timely to the Department's Online Incident Reporting System.

All reportable incidents will be entered into the portal within the required 24-hour period. Administrator Wellness Director and other designees will sign a statement of understanding. Kept in the administrator's office. Completion Date 4/15/24. Oversight Administrator.

Reportable Incidents will be logged and reviewed with each event. Additionally, each event will be verbally reported as they occur to clinical, on call, or administrator. On call notification policy reviewed and signed by staff. Completion 4/26/24. Oversight by HWD and Administrator

Oversight by administrator with each incident

Feedback: There was not an on-call reporting procedure in place. This will be uploaded to UltiPro, and completion is required prior to completing orientation. 4/15/2024 BOM

Deficiency # A611 Care plan

This Rule is not met as evidenced by: Based on observations, record reviews and interviews, a resident's facility care plan was not updated to address the resident's current condition with appropriate interventions to meet the care needs of the resident.

AL community care plans will be reviewed and updated to accurately reflect the residents and their needs by the nursing supervisor team Completion date 5/15/2024. PCC file.

Community Care Plans will be updated as changes are identified in weekly collaborative care meetings and or as the needs change on going. By clinical team 8/15/2024. Meeting minutes to be kept in the Administrators office.

Monthly compliance audits will be completed for 10% of the residents utilizing audit sheet beginning 5/1/2024-8/20/2024.

Oversight Administrator and Wellness Director. Forms will be kept in the POC binder in the administrator's office.

Feedback: No quality audits were previously conducted.

Deficiency # A613 Medication

This Rule is not met as evidenced by: Based on observations, record reviews and interviews, residents who were unable or unwilling to protect themselves from a medication error did not receive medication administration by licensed staff.

Immediate intervention was assigning licensed nurses to administer medication for the identified residents. Completion Date 4/2/2024 Oversight by administrator.

AL Residents will be assessed at each medication assisted med pass by the med tech. This is on the MAR, additional questions added 4/5/2024. Any issues passing the competencies will be reported to Wellness Director Oversight by Wellness Director.

Residents will have monthly medication competencies completed by 5/30/2024 in PCC. On going monthly 'scheduled PCC Oversight by Wellness Director Lead or Wellness Director.

Deficiency # A614 Complaint Dementia

This Rule is not met as evidenced by: Based on observations, record reviews and interviews, at least three residents of the facility were unable or unwilling to properly utilize the unit dose packaging system and protect themselves from medication errors.

THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

Findings:

The Alabama Department of Public Health received a complaint which alleged residents of the facility had dementia which resulted in the residents being unsafe to reside in an assisted living facility. Surveyors were able to substantiate this complaint during the onsite survey.

Immediate intervention was assigning licensed nurses to administer medication for the identified residents. Completion Date 4/2/2024 Oversight by administrator.

All residents will be assessed for mental impairment utilizing the Mini Mental to identify possible impairment in PCC by the Wellness Director or Wellness Director lead or sight by the administrator. Completion Date 5/15/2024. On going quarterly and as a change is noted.

Those identified with cognitive impairment additional interventions will be put in place to ensure safety. Licensed Nursing Med management, escorts additional ADLs as needed and or transfers/discharges as necessary. Completion 5/15/2024. Oversight by Wellness Director or Administrator

Deficiency # A617 Medication Destruction

This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to document disposition of a resident's medications upon discharge of the resident from the facility.

All Medication Technicians and Nurses in serviced for proper procedure of medication destruction, medication release and documentation requirements. By Administrator and Wellness Director. Completion 4/26/2024 Kept in training binder.

Scanned Inservice into Ultipro for all Med Tech and Nurses during orientation training for review and signing. 4/15/2024 Oversight BOM and Wellness Director

Closed Charts will have a discharged list to follow as residents are discharged ensuring all required documentation is completed. 4/26/2024 Oversight Clinical team and Supervisory personnel. Kept in locked closed file room.

Deficiency # A6214

This Rule is not met as evidenced by: Based on record reviews and interviews, the facility retained a resident who did not meet the criteria for retention in an assisted living facility.

THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

Findings:

The Alabama Department of Public Health received a complaint which alleged a resident was retained at the facility in need of skilled wound care which exceeded ninety days. Surveyors were able to substantiate this complaint during the onsite survey.

Feedback: Resident was discharged 9/30/2023.

Residents will not be retained more than 90 days who require skilled nursing services beyond the ALF licensure. Regardless of if they can direct their care. Oversight by Administrator, Wellness Director. Ongoing

If a resident is deemed inappropriate a plan will include all necessary avenues to facilitate discharge to an appropriate facility. A 30-day notice will be given, and the Ombudsman will be notified to help with the transfer if there is difficulty finding placement. Completion Date 4/15/2024 Oversight by administrator. Plans will become part of the file in PCC.

Deficiency #A702 Food Service

This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide proper handling and serving of food to prevent contamination. In addition, leftover foods were not discarded timely.

Aprons ordered received and distributed 4/8/2024. All staff in-service on proper dining room attire and aprons for a barrier, to be kept in their file. Reviewed signed and completed by 4/26/2024. Oversight by Dining Manager and other supervisor personnel.

The in-service will be included in an on-boarding orientation for review and signature, for all care and dining staff. Scanned into UltiPro. Dining Manager BOM Completion 4/26/2024. POC binder

Food Handling in-service regarding safe food storage. Dining Service personnel. Completion 4/16/2024. Retained in staff file. Oversight Dining manager and BOM.

The in-service will be included in an on-boarding orientation for review and signature, for all dining staff. Scanned into UltiPro. Completion 4/26/2024.Oversight Dining Manager and BOM

Deficiency # A804 Clean Equipment

This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain clean equipment for food service.

New prep tables ordered and received on 4/15/2024. Will be put into to place by completion date 4/20/2024.Oversight by maintenance and dining supervisor.

Cleaning list for kitchen and dining room team developed and put into place. Completion by 4/20/2024. Oversight by dining manager and administrator. Kept in dining manager's office.

Deficiency #A1002 Safe Environment

This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain a safe, functional, and sanitary environment.

The device on the closet door was immediately removed upon notification to allow for proper locking when closed 4/2/2024. Oversight Administrator

Cleaning products relocated to housekeeping locked closet for chemicals. 4/2/2024 Oversight by other maintenance and supervisory staff.

Managers walking rounds report will include checking for locked doors and proper storage. Daily for 4 weeks. Weekly for 4 months 9/20/2024. Kept in Administration office in POC binder. Oversight by administrator.

Deficiency # A1203 Emergency Lighting

This Rule is not met as evidenced by: Based on observations and interview, the facility failed to provide adequate emergency lighting.

Batteries ordered immediately on 4/1/2024, to complete all lights. Received 4/8/2024 schedule devised in place for all lights to be replaced. Completion 4/30/2024. Oversight Maintenance and Administrator

Preventive Maintenance Schedule updated in electronic systems TEL's to check all emergency lighting in the community each month. Records are kept electronically at TEL's. Completion of update 4/20/2024. Ongoing monthly. Oversight by Maintenance and Administrator.

**Additional Copies of all in services, signed documents, statements of understanding and audits will be kept in the POC binder the administrator's office

Signed: Deborah Elms

Date: 4/19/2024

Deborah Elms

Executive Director