Gregory C. Leitton, RN, MSHAI
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Plan of Correction Accepted
09/19/2024 1639 PM

Monark Grove Madison

FACILITY ID P4204

PLAN OF CORRECTION

A Response to the:

Alabama Department of Public Health
Bureau of Health Provider Standards
Assisted Living Facilities Unit's
Survey Report
On August 8th, 2024

Submitted by:

Julie Campbell
Administrator
License # PVII-3233

Facility Name: Monark Grove Madison

Facility ID: P4204

Survey Exit Date: August 8th, 2024

Administrator: Julie Campbell

Deficiency: A 504

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

During a tour of the facility, on the morning of August 6, 2024, surveyors noted that the facility failed to post the name, telephone number and address of the Department's Bureau of Health Provider Standards and the telephone number of the Department of Public Health toll-free Assisted Living Facilities Compliant Hotline. Employee Identifier (EI)#2 agreed with the surveyors' findings. 1

Corrective action taken:

- The Department's Bureau of Health name, telephone number, address have been posted. Provider Standards and the telephone number of the Department of Public Health toll-free Assisted Living Facilities Complaint Hotline has been posted.
- Posting attached.

Steps taken to identify other residents or concerns:

- No other contact postings were required during this survey.

Systemic changes implemented to ensure the same deficiency will not reoccur.

- Contact information for the Department Bureau of Health Provider Standards has been implemented in the new move in packet as an additional step.

Monitoring of proposed corrective action:

- The administrator will conduct random inspections of SCALF facility to ensure contact information is posted no less than weekly for two months, then monthly for two months for compliance.
- A representative of the governing authority will visit the facility no less than monthly for the next four months to verify contact information is posted and to ensure continued compliance with the facilities plan of correction
- A record of the governing authority's visits will be maintained in the office of the administrator.

- Any identified concerns may result in additional education and/or continued monitoring.

Administrator: Julie Capt **Date:** 9/18/24

Alabama Department of Public Health

Hotlines and Toll-Free Numbers

General Information: 1-800-252-1818, 8 a.m. - 5 p.m.

Complaint Line - Assisted Living Facilities: 1-866-873-0366

Complaint Line - Health Care Facilities: 1-800-356-9596

Complaint Line - Home Health and Hospice Agencies: 1-800-356-9596

Assisted Living Facilities Unit
Health Provider Standards
Alabama Department of Public Health
334.206.5366/866.873.0366
alfcomplaints@adph.state.al.us
alabamapublichealth.gov
Madison County Department of Human Resources 2206 Oakwood Avenue, NW Huntsville, AL 5810-4499 Phone: 256.427.6000

Health Provider Standards
201 Monroe Street, Suite 700
Montgomery AL 36104

Report suspected elder abuse by calling the Adult Hotline at 1.800.458.7214, emailing aps.dhr.alabama.gov or contacting a local DHR county office. All reports are confidential and may be made anonymously.

Facility Name: Monark Grove Madison

Facility ID: P4204

Survey Exit Date: August 8th, 2024

Administrator: Julie Campbell

Deficiency: A 508

Deficiency: A508 420-5-20-.05 (3) (d) Records and Reports.

Incident Not reported timely to OIRS

On July 29, 2024 at 4:32 PM, an report was received on the Department's OIRS of an incident involving alleged abuse of a resident which occurred on July 26, 2024 at 11:30 AM. An investigation of the incident was conducted by the facility and the employee involved was terminated. During an interview, on August 6, 2024, EI#6 stated that the incident was not reported to her (EI#6) until July 28, 2024 by a witness. On August 7, 2024, EI#2 also confirmed that the incident had not been reported to the Department timely because the witness did not report timely to management.

Incident Not Reported to OIRS

During interviews on August 7 and 8, 2024, multiple staff members reported to the surveyors that the following incident occurred at the facility. A male resident was found in the bed with a female resident with the male resident wearing only a diaper and shirt and the female wearing a nightgown and diaper. EI#5 reported to the surveyors that she (EI#5) became aware of this incident through a family member of the male resident who was notified by a caregiver several days after the incident occurred. EI#5 stated she (EI#5) was unsure if the incident was reported to the Department's OIRS. A facility Incident Form was provided to the surveyors by EI#6. The Incident Form was completed on January 13, 2024 at 8:30 AM and documented an incident which occurred on January 1, 2024 at 7:00 AM involving these two residents. According to the report, the male resident was found in the female resident's bed without the female resident's permission. The female resident asked the male resident to leave and he refused. When staff intervened, the male resident became angry and violent, cursing and swinging at staff. The male resident was transferred to an inpatient psychiatric facility for evaluation and treatment. No documentation was provided by the facility to verify that the incident was reported to the Department's OIRS and investigated as required.

Corrective action taken:

- In-service community staff on the importance of reporting incidents in a timely manner.
- The new wellness director has been in serviced on the requirement to report to OIRS within the allowed time of an incident.

Steps taken to identify other residents or concerns:

- Administrator/ Wellness Director has posted instructions at nurses' station for immediate reporting to the two of them for every incident requiring a resident be transported for further evaluations. See attached.

Systemic changes implemented to ensure the same deficiency will not reoccur.

- Administrator/ Wellness Director will in-service entire team monthly at facilities all staff meeting about the importance of timely reporting incidents.
- Incident Alert Document attached.
- Staff Education on reporting regulation attached.

Monitoring of proposed corrective action:

- The administrator will conduct audits of all incident reports to verify all state reportable events are being reported in the allotted times no less than weekly for two months, then monthly for two months for compliance.
- A representative of the governing authority will visit the facility no less than monthly for the next four months to review a sample of the state reportable events and to ensure continued compliance with the facilities plan of correction
- A record of the governing authority's visits will be maintained in the office of the administrator.
- Any identified concerns may result in additional education and/or continued monitoring.

Administrator:  **Date:** 9/18/24

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The below are to be contacted in the event of an incident:

- A group text will be sent to the below individuals
- A phone call will be placed through the chain of command, in the below order, until contact is made:

Memory Care Coordinator

Wellness Director

Executive Director

Incident Alert

Month _____Year_____

Date/Time	Resident	Incident Type	ER/Hospital Y or N	Contacts and Report Completed by	Addendum to Care Plan by LPN	Focus Assessment/ Behavior Screen and PSMS completed by LPN	State Reportable Y or N	Reviewed, Comprehensive completed and Care Plan updated by WD

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16. Religious preferences.

17. Information from insurance policies regarding funeral arrangements and burial provisions.

18. Written documentation that the facility has devised a plan to transfer the resident to a hospital, nursing home, or other appropriate setting if and when the facility becomes unable to meet the resident's needs. The resident's preference, if any, with respect to any particular hospital or nursing home shall be recorded. The facility shall keep written documentation that demonstrates the transfer plan has been thoroughly explained to the resident or sponsor, as appropriate, and that the resident or sponsor understands the transfer plan.

19. The written documentation of the procedure to follow in case of serious illness, accident, or death to the resident (including the name and telephone number of the physician to be called, the names and telephone numbers and addresses of family members or sponsor to be contacted, the resident's or, if appropriate, the sponsor's wishes with respect to disposition of personal effects, and the name and telephone number of the funeral home to be contacted).

(h) Incident Investigation. When an incident, as defined below, occurs in a specialty care assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review.

1. Incidents which require investigation are:

(i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as extensive bruising, pain, or injury that is not consistent with actions necessary in providing day-to-day care to a resident or for which medical treatment was sought.

(ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid including but not limited to

a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office.

(iii) The onset of wandering behavior by any resident who is not fully cognitively intact.

(iv) Elopement by a resident.

(v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules.

(vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules.

(vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules.

(viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or Staphylococcus aureus).

(ix) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility.

(x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident.

(xi) An unplanned occurrence that results in media attention.

(xii) A medication error, overdose, or over sedation.

(xiii) Ingestion by a resident of a toxic substance that requires medical attention.

(xiv) Any indication of malfunction of the

sprinkler system, or fire alarm system.

2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following:

(i) Names of all residents involved.

(ii) Names of all staff involved including person in charge at the time of the incident.

(iii) When the administrator was notified (date and time).

(iv) Circumstances under which the incident occurred.

(v) When the incident occurred (date and time).

(vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn).

(vii) Immediate actions taken.

(viii) The extent and description of injury, if any, to the affected resident or residents.

(ix) Immediate treatment rendered.

(x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified.

(xi) Names, telephone numbers, and addresses of witnesses.

(xii) Date and time relatives or sponsor were notified.

(xiii) Out-of-facility treatment.

(xiv) Follow-up care.

(xv) Outcome resolution.

(xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future.

(xvii) The investigative file includes the

incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation.

(xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request.

(xix) The entire investigative file and documentation of all corrective action taken shall be retained for a period of not less than 3 years after the resident is discharged or dies.

(xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff.

3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident:

(i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention.

(ii) Elopement by a resident.

(iii) Suspected, alleged, confessed, witnessed, or actual abuse, neglect, or exploitation of a resident or residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file.

(iv) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility.

(v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident.

(vi) An unplanned occurrence that results in

media attention.

(vii) Any medication error, overdose, or over sedation. The incident shall be immediately reported to the attending physician, facility medical director, or back-up physician.

(viii) Ingestion by a resident of a toxic substance that requires medical attention.

(ix) Notifiable diseases and health conditions listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04. shall also be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1-.04. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than three years.

(x) Any indication of a malfunction of the sprinkler system, fire alarm system, or a door locking device.

4. The report to the Department's Online Incident Reporting System shall include the following:

(i) Facility name and direct phone number.

(ii) Time and date of the report.

(iii) Reporter's name.

(iv) Name of resident(s), staff, or visitor(s) involved in the incident.

(v) Names of staff on duty at the time of the incident.

(vi) Date and time of the incident.

(vii) A brief description of the incident.

(viii) Any injury or injuries to resident(s).

(ix) Action taken by the facility in response to the incident.

(i) Vital Statistics Reports. A record shall be kept of all births, deaths, and stillbirths that occur within the specialty care assisted living facility. By

Facility Name: Monark Grove Madison

Facility ID: P4204

Survey Exit Date: August 8th, 2024

Administrator: Julie Campbell

Deficiency: A 604

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

The Alabama Department of Public Health received two complaints which alleged residents were not promptly assessed by facility nurses when changes in the residents' status occurred. The surveyors were able to substantiate these complaints during the onsite survey.

Review of resident records, on August 7 and 8, 2024, revealed the following information.

Resident Identifier (RI)#2

RI#2 was admitted to the facility on December 20, 2023 and had diagnoses which included dementia with behavioral disturbance, allergic rhinitis, hypertension, bipolar disorder, insomnia and gastroesophageal reflux disease. Refer to deficiency 611 for additional information on RI#2. RI#2 sustained falls at the facility on March 25, 2024, April 3, 2024, June 25, 2024, July 5, 2024, July 29, 2024 and August 2, 2024. The most recent PSMS score documented for RI#2 was on May 13, 2024 and showed a total score of 11. However, the PSMS documented on May 13, 2024 was incomplete with a score of 0 (zero) documented for toileting. RI#2 was observed during the onsite survey with the physical therapist. RI#2 had much difficulty following instructions from the therapist and required repeated instructions for approximately 10 minutes and physical assistance from the therapist to stand from the chair. Multiple staff members reported that RI#2 frequently resisted care. At the request of the surveyor, EI#4 obtained a current PSMS for RI#2 on August 8, 2024 with a total score of 19. RI#2 had not been properly assessed to determine his/her current functional status.

RI#4

RI#4 was admitted to the facility on July 11, 2023 and had diagnoses which included benign hypertension, Alzheimer's disease, diabetes mellitus type II, hypothyroidism, chronic kidney disease stage III, hyperlipidemia, and osteoporosis. RI#4 was discharged to another facility on November 8, 2023. On September 15, 2023, RI#4 developed edema in the lower

extremities and a physician's order for Lasix (fluid pill) was obtained. In addition, on September 20, 2023, a chest x-ray was ordered due to coughing and congestion. No comprehensive assessment, PSMS and behavior screening were completed for RI#4 with these significant changes in condition.

RI#6

RI#6 was admitted to the facility on June 4, 2024 and had diagnoses which included essential hypertension, chronic diarrhea, degenerative joint disease, dementia, gastroesophageal reflux disease, impaired mobility, anxiety, depressive disorder, recurrent urinary tract infections, seasonal allergies and vitamin B-12 deficiency. Refer to deficiency 611 for additional information on RI#6. RI#6 was discharged from the facility on July 27, 2024. RI#6 sustained falls at the facility on June 8 and 14, 2024. A comprehensive assessment of RI#6 was not performed until June 17, 2024, three days after the second fall occurred.

On the morning of August 8, 2024, the surveyor discussed residents' assessments with EI#4, RN, who agreed residents had not been assessed as required. EI#4 added that she (EI#4) had just assumed the role of facility RN that same week and planned to work on assessing residents' current functional status.

Corrective Action Taken:

- RI#2 had a monthly assessment completed on August 8th, 2024, with a total PSMS score of 19.
- RI#4 no longer resides in the facility.
- RI#6 no longer resides in the facility.

Steps taken to identify other residents or concerns.

- All residents have had a monthly assessment completed.

Systemic changes implemented to ensure the same deficiency will not reoccur.

- The new Wellness Director was educated on this rule during her initial employment training.
- The new Wellness Director is responsible for continued compliance.
- Staff Education for assessment responsibilities attached.

Monitoring of proposed corrective action:

- The administrator will conduct random inspections of 5 resident's monthly assessments no less than weekly for two months, then monthly for two months for compliance.

- A representative of the governing authority will visit the facility no less than monthly for the next four months to review a sample of 5 resident's monthly assessments and to ensure continued compliance with the facilities plan of correction
- A record of the governing authority's visits will be maintained in the office of the administrator.
- Any identified concerns may result in additional education and/or continued monitoring.

Administrator: _____ **Date:** 9/18/24

Education/Inservice for all Nursing Staff

September 3, 2024

When Assessments are to be completed and by whom

- Initial Assessment/Prior to admission-RN
  - Clinical History
  - MMSE
  - Aphasia Screening
  - Geriatric Depression Scale
  - PSMS
  - Behavior Screening
- Upon Admission, annually, and with change in condition-RN/Care Coordinator
  - PSMS
  - Behavior Screening
- Comprehensive-RN
  - Each Prospect for facility eligibility (baseline for care plan and future assessments)
  - Weight loss/Sig change in wt
  - Falls/2 or more in 30 days
  - Elopement
  - Signs/Symptoms of adverse drug reactions, interactions, over sedation, contraindicated medications
  - Unmanageable, combative or potentially harmful behavior(s)
  - Any accident with injury
- Focused Assessments-RN/LPN
  - When necessary to ID changes is resident status
    - Requires immediate documentation and implementation or reassessment of existing intervention
- Monthly Assessments and Review-RN
  - Monthly weights
  - Falls review
  - Incidents
  - Elopements
  - Behavioral Symptoms
  - Medications
  - Changes in residents' status
  - Appropriateness of Care Plans

Facility Name: Monark Grove Madison

Facility ID: P4204

Survey Exit Date: August 8th, 2024

Administrator: Julie Campbell

Deficiency: A 611

Deficiency: A 611 420-5-2-.06 (4)(a)(b) Care of Residents

This Rule is not met as evidenced by: Based on observations, record reviews and interview, the facility Registered Nurse (RN) failed to update residents' care plans with appropriate interventions to meet the current care needs of the residents.

Findings:

Review of resident records, on August 7th and 8th, 2024, revealed the following information.

RI#2

RI#2 had resided at the facility since December 20, 2023. Refer to deficiency 604 for additional information on RI#2. RI#2 sustained falls at the facility on March 25, 2024, April 3, 2024, June 25, 2024, July 5, 2024, July 29, 2024 and August 2, 2024. These falls were not addressed on RI#2's facility care plan with appropriate interventions after each fall to prevent a recurrence. In addition, RI#2 was found in bed with another resident on January 1, 2024. This behavior was not addressed on RI#2's facility care plan.

RI#5

RI#5 was admitted to the facility on August 4, 2022 and had diagnoses which included neoplasm of prostrate, hyperlipidemia, peripheral neuropathy and adjustment disorder with depressed mood. RI#5 sustained falls at the facility on February 6, 2024, April 15, 2024 and June 12, 2024 which were not addressed on RI#5's care plan with appropriate interventions to prevent a recurrence.

RI#6

RI#6 resided at the facility from June 4, 2024 until July 27, 2024. Refer to deficiency 604 for additional information on RI#6. RI#6 sustained falls at the facility on June 8 and 14, 2024 which were not addressed on RI#6's facility care plan with appropriate interventions to prevent a recurrence. On the morning of August 8, 2024, the surveyor discussed residents'

care plans with EI#4, RN, who agreed the care plans had not been updated as required. EI#4 added that she (EI#4) had just assumed the role of facility RN that same week and planned to work on updating residents' care plans.

Corrective Action:

- RI#2 Fall interventions have been added to updated care plan. See attached.
- RI#5 Fall interventions have been added to updated care plan. See attached.
- RI#6 no longer resides in the facility.

Steps taken to identify other residents or concerns:

- All residents have been reviewed and care plans have been updated.
- The Facility has in serviced the new Wellness Director & Executive Director about the importance of care planning interventions for falls.

Systemic changes implemented to ensure the same deficiency will not reoccur.

Care Plan addendum attached.

Monitoring of proposed corrective action:

- The administrator will conduct random inspections of all resident incidents to identify falls are being care planned with interventions are in place no less than weekly for two months, then 5 resident incidents monthly for two months for compliance.
- A representative of the governing authority will visit the facility no less than monthly for the next four months to review 5 resident incidents to identify falls are being care planned with interventions are in place and to ensure continued compliance with the facilities plan of correction.
- A record of the governing authority's visits will be maintained in the office of the administrator.
- Any identified concerns may result in additional education and/or continued monitoring.

Administrator: Julie Card **Date:** 9/18/24

Addendum to Care Plan Resident_____

Information is to be added to the Care Plan by RN when a new care plan is generated.

New Information (i.e., Incident , Change of Condition, Home Health, Hospice)

Date:_____

Date:_____

Date:_____

Date:_____

Facility Name: Monark Grove Madison

Facility ID: P4204

Survey Exit Date: August 8th, 2024

Administrator: Julie Campbell

Deficiency: A 617

Deficiency: A 617 420-5-2-.06 (6) Care of Residents

(6) Disposal of medications.

(a) Controlled substances and legend drugs dispensed to residents, that are expired or unused because the medication is discontinued or because the resident dies, shall be destroyed within 30 days. Unused legend drugs that are not expired may be donated to a charitable clinic pursuant to Alabama Administrative Code Chapter 420-11-11, et. Seq. Under no circumstances shall expired, discontinued, or unused medications be stored or housed in the facility beyond 30 days.

(b) Medications of residents who are discharged or transferred to another facility shall be returned to the residents. The responsible party will sign a statement that these medications have been received. The statement shall list the pharmacy, prescription number, date, resident's name, and strength of the medication and the amount. This statement shall be maintained in a file for at least three years.

(c) When medications are destroyed on the premises of the specialty care assisted living facility, a record shall be made and retained for at least three years. This record shall include: the name of the specialty care assisted living facility, the method of disposal, the pharmacy, the prescription number, the name of the resident, the name, the strength, and the dosage of the medication, and the amount and the reason for the disposal.

This Rule is not met as evidenced by: Based on observations, record reviews and interview, the facility failed to dispose of medications timely when a resident was discharged or transferred to another facility and failed to dispose of an expired solution.

Findings

On the morning of August 6, 2024, the surveyor and E#5 observed the following in the medication cart: medications for a resident who was discharged from the facility on April

30, 2024; a bottle of glucose test solution which expired on September 20,2023. E#5 agreed with the surveyor that the medications and solution should have been destroyed.

Corrective Action:

- All expired meds have been disposed of from the carts

Steps taken to identify other residents or concerns:

- in-serviced all nurses on the importance of pulling expired medications
- new Wellness Director in-serviced on company medication destruction policy

Systemic changes implemented to ensure the same deficiency will not reoccur.

- Quarterly nurse's meetings established to continue ongoing training of policies
- The MC Coordinator or the Wellness Director will conduct monthly cart inspections.

Monitoring of proposed corrective action:

- The administrator will check carts weekly for 2 months and then monthly for 4 months to check for expired medications.
- A representative of the governing authority will visit the facility monthly for the next four months to check for expired medications
- A record of the governing authority's visits will be maintained in the office of the administrator.
- Any identified concerns may result in additional education and/or continued monitoring.

Administrator: [signature] **Date:** 9/18/24

Scheduled Medication Destruction Audits

Month and Year_____

Wednesdays- Medications for destruction completed every week by RCC or designee

Thursdays-Last Thursday of the month, Medication Destruction audited by Wellness Director or designee.

Quarterly- Pharmacy Audit to include Medications for Destruction.

Date/Wednesday	#Meds for Destruction	# of Meds destroyed	Completed by
Date/Last Thursday	Audit, # of Meds for Destruction	# of Meds past 30 days for Destruction	Audit completed by
Date/Quarterly	Audit, # of Meds for Destruction	# of Meds past 30 days for Destruction	Audit Completed by

Facility Name: Monark Grove Madison

Facility ID: P4204

Survey Exit Date: August 8th, 2024

Administrator: Julie Campbell

Deficiency: A 702

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

On the afternoon of August 7, 2024, during a tour of the kitchen with EI#8, it was noted that kitchen refuse was not placed in garbage cans with tight fitting lids. The surveyor observed refuse being placed in plastic bags and stacked next to the exit from the kitchen. The surveyor also observed that cardboard boxes were broken down and stacked on the floor next to the door egress area. EI#8, Food Service Director, informed the surveyor that the garbage dumpster was full and the administrator had requested the dumpster be emptied the previous day. EI#8 was unsure where the garbage cans with lids were stored.

Corrective Action:

- The facility corrected citation during the survey and garbage was disposed of properly in the facility dumpster.
- The facility dining services team has been in serviced on the importance of properly disposing of garbage during the day.

Steps taken to identify other residents or concerns:

- The facility has purchased additional large trash cans to be placed throughout the kitchen to assist in disposing of garbage.

Systemic changes implemented to ensure the same deficiency will not reoccur.

- The facility Dining Services Director has implemented monthly dining services meetings in which garbage disposal will be a part of the continued education.

Monitoring of proposed corrective action:

- The administrator will conduct random inspections of the facility kitchen to verify trash is being disposed of appropriately and in appropriate containers no less than weekly for two months, then monthly for two months for compliance.
- A representative of the governing authority will visit the facility no less than monthly for the next four months to conduct random inspections of facility kitchen to verify trash is being disposed of appropriately and to ensure continued compliance with the facilities plan of correction
- A record of the governing authority's visits will be maintained in the office of the administrator.
- Any identified concerns may result in additional education and/or continued monitoring.

Administrator: Julie Cook **Date:** 9/18/24

Facility Name: Monark Grove Madison

Facility ID: P4204

Survey Exit Date: August 8th, 2024

Administrator: Julie Campbell

Deficiency: A 804

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

On the afternoon of August 7, 2024, during a tour of the kitchen with EI#8, the main oven, gas grill range and steam oven were dirty with grease, grime, and debris. EI#8 concurred with the surveyor's observations.

Corrective Action:

- Facility corrected citation on site during survey.
    - Facility has deep cleaned main oven.
    - Facility has deep cleaned gas grill range
    - Facility has deep cleaned steam oven

Systemic changes implemented to ensure the same deficiency will not reoccur.

- The facility Dining Services Director will do ongoing/ continuous training with the entire dining services team on proper cleaning techniques.
- The facility has implemented back-of-house cleaning responsibilities.

Monitoring of proposed corrective action:

- The administrator will conduct random inspections of the facility kitchen to verify cleaning procedures are being followed no less than weekly for two months, then monthly for two months for compliance.
- A representative of the governing authority will visit the facility no less than monthly for the next four months to conduct random inspections of facility kitchen to verify cleaning procedures are being followed and to ensure continued compliance with the facilities plan of correction
- A record of the governing authority's visits will be maintained in the office of the administrator.
- Any identified concerns may result in additional education and/or continued monitoring.

Administrator: Julie Campbell **Date:** 9/18/24

Facility Name: Monark Grove Madison

Facility ID: P4204

Survey Exit Date: August 8th, 2024

Administrator: Julie Campbell

Deficiency: A 1002

Deficiency: A 1002 420-5-20-.10 (2) Sanitation and Housekeeping

The Alabama Department of Public Health received a complaint which alleged a resident's toilet was left dirty with a bad odor. The surveyors were able to substantiate this complaint during the onsite survey.

On the morning of August 6, 2024, during a tour of the facility with EI#2, the following observations were made. In resident room 1312, the toilet was dirty with odor. In resident room 1207, the toilet seat was loose causing a potential for fall and the toilet bowl was dirty with odor. In resident room 1203, the toilet seat was loose causing a potential for fall. EI#2 concurred with the surveyor's observations.

Corrective Action:

- Facility has fixed toilet seat in apartment 1207
- Facility has fixed toilet seat in apartment 1203
- Facility has deep cleaned all resident bathrooms to ensure cleanliness and no odors.
- The facility has in serviced all associates about the facility work order process to ensure all associates report any abnormalities with resident apartments.

Systemic changes implemented to ensure the same deficiency will not reoccur.

- Facility has implemented apartment cleaning checklists to be completed by housekeeping staff daily.

Steps taken to identify other residents or concerns:

- The Facility Maintenance Director will monitor that all checklists are being completed fully and correct anything that is observed.

Monitoring of proposed corrective action:

- The administrator will conduct random inspections of the facility to ensure housekeepers are utilizing daily checklist are being followed no less than weekly for two months, then monthly for two months for compliance.
- A representative of the governing authority will visit the facility no less than monthly for the next four months to conduct random inspections of facility ensure housekeepers are utilizing daily checklist and to ensure continued compliance with the facilities plan of correction
- A record of the governing authority's visits will be maintained in the office of the administrator.
- Any identified concerns may result in additional education and/or continued monitoring.

Administrator: Julie Cook **Date:** 9/18/24

Work Order Inservice

If you note that there is an issue in your department that needs to be addressed by Maintenance or Housekeeping, please contact the Concierge (ext. 71100) to place a work order.

If the need is immediate, please contact your supervisor for assistance or further instruction. The Maintenance Director should be contacted by the supervisor for any immediate needs.

See list of Director contacts if needed.

Housekeeping daily room check list

	1201	1202	1203	1204	1205	1206	1207	1208	1209	1210	1211	1212	1213	1214	1215
BA Floor: cleanliness/ clutter															
Toilet: cleanliness/TP															
Trash can: remove if full/ replace if needed															
Sink															
Shower															
Mirror															
Make Bed															
Laundry/Linens as scheduled															
Fridge for spills/ remove expired food															
BR Floor: cleanliness/clutter															

Housekeeping daily room check list

	1301	1302	1303	1304	1305	1306	1307	1308	1309	1310	1311	1312
BA Floor: cleanliness/ clutter												
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Fridge for spills/ remove expired food												
BR Floor: cleanliness/clutter												

Facility Name: Monark Grove Madison

Facility ID: P4204

Survey Exit Date: August 8th, 2024

Administrator: Julie Campbell

Deficiency: A 1101

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

On the afternoon of August 6, 2024, a review of fire drill documentation revealed the facility did not conduct fire drills during the following months: March 2024, April 2024, May 2024, June 2024, December 2023, November 2023, and May 2023.

During interviews, on the afternoon of August 6, 2024, both EI#2 and EI#7 concurred with the surveyor's findings.

Corrective Action:

- Facility representatives have been in serviced on the Fire Drill policy and the importance of participating in monthly fire drills.
- Facility representatives have been in serviced on SCALF Regulation 420-5-20-.11 (1)(b) Fire and Safety
    - Fire drills shall be conducted at least once per month in all facilities at varying time and days and quarterly on each shift. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least 3 years.

Systemic changes implemented to ensure the same deficiency will not reoccur.

- The administrator will maintain a copy of all current and future fire drills in the administrator's office.

Monitoring of proposed corrective action:

- The administrator will conduct and monitor all fire drills no less than monthly for six months, then once quarterly for the next six months for compliance.
- A representative of the governing authority will visit the facility no less than monthly for the next four months and will conduct an audit of the executed fire drills and to ensure continued compliance with the facilities plan of correction
- A record of the governing authority's visits will be maintained in the office of the administrator.
- Any identified concerns may result in additional education and/or continued monitoring.

Administrator: _____ **Date:** 9/18/24

DEPARTMENT	PROCESS OWNER	ORIGINAL DATE	REVISED DATE	POLICY NUMBER
Facilities	Executive Director Maintenance Director	7/1/2015		PSL_FAC_606

Emergency Procedure: Fire

Policy: Staff will provide safe, orderly assistance during an emergency.

Procedure:

When a fire alarm sounds, proceed with the following actions:

Responding to alarm:

1. Determine the location of the alarm by checking the annunciator panel.
    - From 8:00 a.m. to 8:00 p.m. the receptionist will check the panel From 8:00 a.m. to 8:00 p.m. the nurse or supervisor will check.
2. The person who checks the panel will communicate the zone in danger to other staff via the intercom or walkie talkies and will then call 911 to report the fire.
3. All other staff report to their designated areas when the alarm sounds.
    - Resident Assistants report to their regularly assigned hallways.
    - Non-care staff report to fire area, once announced, to assist with evacuation.

Evacuation:

4. Residents who are not near the fire area should stay in their rooms with their doors closed until either the fire department comes or the alarm is canceled.
5. Once in the fire area, staff will assist all residents away from the fire to the nearest exit.
    - Do not use the elevators.
    - If the fire divides a hallway, residents may have to move in two different directions, away from the fire to the nearest exit.
    - If the fire blocks the nearest exit door, residents should be escorted to the first clear exit door which may be at the other end of the building.
    - Second floor residents who require evacuation will remain in the stairwell until the fire department comes or the alarm is canceled.
    - As RCAs search and evacuate each room, the RCA should close the resident door and put a pillow in the hallway in front of that door to indicate that the room is empty.
    - Staff should always touch any closed door before opening it to test for heat. If the door is hot, do not open.

- If evacuation is called for in Memory care, residents should be taken to the enclosed courtyard.
- If fire is found in a common area, all nearby residents should be escorted out of the building.

Finding smoke/fire before the alarm has sounded:

6. If a staff member discovers smoke or fire, she should evacuate residents in immediate danger and then pull the nearest fire alarm and proceed with the steps above.

After evacuation:

7. Following evacuation, the supervisor and designees will conduct a head count using the daily census list maintained by the receptionist.
8. In the event of evacuation, the nurse or supervisor should safeguard the MARs and other resident records as necessary.

After a fire drill:

9. Following a fire drill, the drill leader will call an All Clear and staff will escort any residents back in to the building.
10. All staff should report to the drill leader after the drill for evaluation and review and sign-in.

Reminders for Staff

☐ **Rescue:** Remove anyone in immediate danger to a safe area.

- Always exit in the direction opposite the smoke or flame.
- Assemble residents to nearest exit and evacuate the building if necessary.
- If it becomes necessary to go through a closed door, touch the door or door knob before opening the door. If they are hot, do not open the door.
- After residents have been taken to safety, check to see that all residents are accounted for using the resident lists.

☐ **Alarm:** The Manager on Duty will call 911. Be sure to tell the operator your location.

☐ **Confine:** Close all doors and windows in the fire area.

- Place a pillow in front of each closed door to indicate that the room has been thoroughly checked and all residents evacuated.

- **Extinguish:** Fight the fire with an extinguisher, located next to each elevator.

Operation of the fire extinguisher can be summarized with the acronym **PASS**

- **Pull:** Pull the pin on the fire extinguisher
- **Aim:** Approach the fire, keeping low and making sure your way out is clear and will not be blocked by the fire. Aim the extinguisher at the base of the fire.
- **Squeeze:** Squeeze the trigger of the fire extinguisher to discharge the agent.
- **Sweep:** Sweep the nozzle back and forth to spray the agent on the fire.

Facility Name: Monark Grove Madison

Facility ID: P4204

Survey Exit Date: August 8th, 2024

Administrator: Julie Campbell

Deficiency: A 1201

Deficiency: A 1201 420-5-20-.12 (1) Physical Environment

Laundry Room

On the morning of August 6, 2024, during a facility tour with EI#2, the following observations were made. In the laundry room, behind the dryers, debris, lint, and a pillowcase were noted on the floor, presenting a potential fire hazard.

Also, in the laundry room, the eye neutralizing solutions for both eye wash stations were expired. In the biohazard waste storage area, non-biohazard waste was stored with the biohazard material including multiple glass flower vases stored atop the biohazard waste boxes.

Kitchenette Oven

In the kitchenette area of the dining room, the ovens were easily accessible to residents and visitors causing a potential risk for harm. EI#2 concurred with the surveyors' observations.

Corrective Action:

Laundry Room: Facility has deep cleaned the laundry room. They have installed signs stating, "Please remove lint after every use." Eye wash solution has been replaced.

The kitchenette Oven has been disconnected from the circuit and is no longer able to be used.

Systemic changes implemented to ensure the same deficiency will not reoccur.

- Signs to remove lint after each visit have been installed.

Monitoring of proposed corrective action:

- The administrator will conduct random inspections of the facility's laundry room to verify lint and clutter are being removed no less than weekly for two months, then monthly for two months for compliance.
- A representative of the governing authority will visit the facility no less than monthly for the next four months to conduct random inspections of facility's laundry room to verify lint and clutter are being removed and to ensure continued compliance with the facilities plan of correction
- A record of the governing authority's visits will be maintained in the office of the administrator.
- Any identified concerns may result in additional education and/or continued monitoring.

Administrator: Jodie Capps **Date:** 9/18/24

This information has been laminated and posted on each dryer for visibility

Please remove lint after every use

Facility Name: Monark Grove Madison

Facility ID: P4204

Survey Exit Date: August 8th, 2024

Administrator: Julie Campbell

Deficiency: A 1205

Deficiency: A 1205 420-5-20-.12 (7) Physical Environment

During a fire drill, on the morning of August 7, 2024, the surveyor noted that the fire doors separating the kitchen and dining area had a visible gap under the bottom edge. During an interview that same morning, both EI#2 and EI#7 concurred with the surveyor's observation.

Corrective Action:

- The facility has ordered door sweeps for all doors with gaps underneath.

Systemic changes implemented to ensure the same deficiency will not reoccur.

- Door sweeps arrived 9/6/24 and are being installed.

Monitoring of proposed corrective action:

- The administrator will conduct random walk throughs to verify sweeps remain in place no less than weekly for two months, then monthly for two months for compliance.
- A representative of the governing authority will visit the facility no less than monthly for the next four months to conduct random walk throughs to verify sweeps remain in place and to ensure continued compliance with the facilities plan of correction
- A record of the governing authority's visits will be maintained in the office of the administrator.
- Any identified concerns may result in additional education and/or continued monitoring.

Administrator: Julie Campbell **Date:** 9/18/24