Accepted - 12/29/2021

PLAN OF CORRECTION

Facility Name: The Huntingdon **Facility ID #:** D0206

Survey Exit Date: 12/01/2021 **Administrator:** Wendi Bass-Bergeron

A 405 Deficiency Number: 420-5-4-.04 (6) Personnel

The facility failed to properly train all employees in fire safety.

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.**
   - Clarification to survey report: EI#7 activated the fire alarm and EI#5 was responsible to read the fire alarm panel and communicate the fire location to EI#9 on the B Wing. The surveyor and EI#7 observed that EI#5 misread the fire alarm panel and miscommunicated the fire location to EI#9. The surveyor and EI#7 observed residents independently going towards the dining room, instead of waiting in the common areas on their perspective wings for direction. EI#7 agreed that additional fire safety training was needed for EI#5 and EI#9.
   - EI#5 and EI#9 were in-serviced on 12/01/21 by EI#1 and EI#7 on importance of properly and accurately communicating location of fire location. Discussion took place on ways to improve communication during fire drills.
   - EI#1 was in-serviced by Maintenance Director of properly activating the Ansul Suppression system. EI#6 was in-serviced by EI#1, Administrator, on properly activating the Ansul Suppression system. This was completed on 12/13/21.

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#1 initiated all staff in-service on fire drills which included but not limited to: properly reading panel, properly communicating location of fire, performing a head count of all residents after residents have been evacuated from fire location, and importance of educating residents to stay on their perspective wings until direction is provided by staff. This training will be completed by 12/17/21.
   - On 12/13/21, EI#1 initiated all staff in-service on properly activating the Ansul Suppression system. This training will be completed by 12/17/21.

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.**
   - Two-way radios provided by community on 12/10/21 and all staff in-service initiated on community standard that each employee shall always keep a radio on their person to improve communication throughout the building, especially shall an

emergency develop such as a fire or other disaster. This training will be completed by 12/17/21.

- Resident meeting to be held by Administrator by 12/17/21 to educate all current residents on importance of remaining on their perspective wings until direction is provided by staff.
- Administrator will evaluate effectiveness of the implementation of the two-way radios during all fire drills and if it is determined to be ineffective by 01/17/22, the Administrator shall make immediate revisions and submit an amended Plan of Correction to the Alabama State Board of Health.
- Fire drills will be conducted weekly x 4 weeks by Maintenance Director to evaluate the effectiveness of communicating location of fire among staff and residents. If communication is effective, these drills will resume to per rules and regulations. This will be initiated on 12/20/21. If drills are deemed as ineffective, weekly fire drills will continue until Maintenance Director along with Administrator assesses staff response as acting appropriately, with approval of corporate personnel before these drills cease.
- Ansul Suppression system training was added to employee orientation on 12/13/21. The Administrator, or designee, is responsible to ensure staff complete this training and have sufficient knowledge of activating and operating the Ansul suppression system.

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.**
   - Administrator, or designee, and Executive Director will observe all weekly fire drills x 4 weeks, initiated on 12/20/21 to evaluate for effective communication among staff and residents. If concerns are identified, Administrator, or designee, and Executive Director will continue these weekly fire drill observations until staff perform properly with all important aspects of fire drills to include, but not limited to:
     - Proper reading of fire panel
     - Proper communication to all staff of fire location
     - Residents remain on their perspective wing until direction provided by staff
     - All residents properly evacuated from area of fire on other side of fire doors
     - Properly performing head count of all residents once evacuation takes place

PLAN OF CORRECTION

Facility Name: The Huntingdon **Facility ID #:** D0206

Survey Exit Date: 12/01/2021 **Administrator:** Wendi Bass-Bergeron

A 504 Deficiency Number: 420-5-4-.05(3)(d) Records and Reports

The facility failed to maintain all resident records in a confidential manner.

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.**
   - Once identified by EI #2 and EI#3, the clipboard in which contained RI#3 health notes, the clipboard was immediately turned over to prevent visibility to others.

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.**
   - Facility round was conducted by EI#3 on 11/30/21 to assess for other potential concerns regarding visible resident information to others. No other findings were 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.**
   - All staff in-service initiated on 12/10/21 with specific attention discussed regarding the following. This training will be completed by 12/17/22. Refresher training will be provided on an ongoing basis as needed as determined by Nurse, Administrator, or Sage Management:
     - All Resident Rights reviewed with specific attention and discussion regarding Resident Right #13: "Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file."
     - HIPPA/ Notice of Privacy Practices/ Our Duties in Protecting Health Information Policy
     - Care staff to keep all follow-up notes of each resident in the RCA office in binder labeled follow-up notes
     - Any resident health information is not to be placed on the medication/ computer cart and the EMAR screen shall always be minimized when walking away from the medication/ computer cart

- No health information shall be visible to visitors or others in common areas or other areas of the community. Areas within the community that are designated for health information storage shall be secured to prevent access from unauthorized persons.

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.**
   - Nurse will check all medication/computer carts for any visible information. This will be completed daily x 2 weeks, weekly x 3 months, then quarterly x 2. This documentation will be stored in the Administrator's office. This will begin week of 12/13/21.
   - Administrator will conduct rounds of the community weekly x 1 month, then monthly x 3 months to ensure compliance is maintained with confidential information. This documentation will be stored in the Administrator's office. This will begin week of 12/13/21.
   - Executive Director will conduct random rounds of the community to ensure compliance with maintaining confidential information and will review the above documentation to ensure compliance with this plan of correction.
   - In addition, Sage Management will review this documentation and conduct random rounds when visiting the community, to ensure compliance with the above.

PLAN OF CORRECTION

Facility Name: The Huntingdon **Facility ID #:** D0206

Survey Exit Date: 12/01/2021 **Administrator:** Wendi Bass-Bergeron

A 601 Deficiency Number: 420-5-4-.06 (1) Care of Residents

The facility failed to have physician orders for medications managed by the resident.

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.**
   - 11/30/21, once this finding was identified and brought to EI#2's attention, the 3 medications without proper label were removed from the resident room. The sponsor was notified the same day and informed of facility policy regarding requiring a Physician order for all medications kept in the custody of RI# 1. On 12/01/21, RI#1's Physician was notified.
   - Investigation of the unlabeled medications was initiated by EI#1 on 12/02/21. It was identified that based on drugs.com website and the imprint code of the three medications, those medications were identified as the following: Advil, Benadryl, and Oxycodone. These medications were destroyed by EI#2 and documented in RI#1 resident record on 12/01/21.
   - EI#2 received a verbal order from physician on 12/1/2021 regarding RI#1 request for Ibuprofen, Daily vitamin, Benadryl and AZO. These medications were delivered and in the custody of RI#1 with proper labels on the medication bottles on 12/02/21.
   - EI#2 faxed physician verbal order for signature on 12/1/2021. Received signed order by physician on 12/2/2021 for implementation of the above requested orders by RI#1.
   - EI#2 conducted Self-Administration Assessment of RI#1 on 12/02/21 in which RI#1 passed assessment of current medications ordered.

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#2 initiated conduction of room rounds of all current residents to investigate whether any other residents were identified of having medications at bedside without a physician order. Any discrepancies identified, EI#2 immediately notified the resident's physician for instruction on further orders. This was completed on 12/10/21.

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#1 sent email reminder to all sponsors of current resident's residing at the community on 12/10/21 of medication policy that includes, but not limited to, the following (a copy of this was also provided to 100% of all current residents of the community):
  - The Administrator will be made aware of every medication, both prescribed and over the counter kept in the resident's room
  - Resident and/or sponsor agree to not purchase or have a friend or family member purchase on the resident's behalf any medication, both prescribed and over the counter without the Administrator's approval
  - Understand the Administrator or designee will occasionally check the resident's room for any medications not on the current medication list for the resident
  - Understand any medicines found in the resident's room or in possession of the resident that is not prescribed by the physician or not on the resident's approved medication list will be removed and disposed
  - Understand all medications must be kept under a single lock
  - Examples of over-the-counter medications provided
- Nurse will conduct room rounds of all current residents to investigate whether any other residents will be identified of having medications at bedside without a physician's order. This will be completed weekly x 3 months, then will document monthly x 3 months but will continue per community policy. This will start week of 12/13/21. This documentation will be kept on file in the Administrator's office.
- In-service to be held with all staff to review Medication Policy with review of importance of identifying medications at bedside without a physician order and staff responsibility of reporting these medications to Nurse and/or Administrator. This in-service was held by EI#1 on 12/07/21. EI#2 was also in-serviced by EI#1 12/08/21.

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.**
   - Administrator will conduct a random room round monthly x 6 months to identify any concerns with compliance with Physician orders for medications in the custody of any resident of the community. This will begin week of 01/01/22.
   - Executive Director will review this documentation to ensure compliance with this plan of correction, beginning week of 01/01/22.
   - In addition, Sage Management will review this documentation when visiting the community.

PLAN OF CORRECTION

Facility Name: The Huntingdon **Facility ID #:** D0206

Survey Exit Date: 12/01/2021 **Administrator:** Wendi Bass-Bergeron

A 602 Deficiency Number: 420-5-4-.06 (2) (a) (b) (c) Care of Residents

The facility failed to ensure that the initial physical medical examination for all residents was complete.

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 #2 faxed RI#1 Physician Medical Exam dated 09/07/21 to the physician to complete the required statement regarding infectious diseases. This occurred on 12/02/21.
   - EI #2 faxed RI#2 Physician Medical Exam dated 09/28/21 to the physician to complete the required statement regarding infectious diseases. This occurred on 12/02/21.
   - Both Physician Medical Exams were returned to the community on 12/08/21 with the statement that both, R1#1 and RI#2, were free of communicable diseases.

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 initiated a review on 12/01/21 of all current Resident Admission Physician Medical Exams to identify any other missing free of communicable diseases statement and any other incomplete items.
   - EI#3 provided the audit review to EI#2 to follow-up with all current resident physicians if any other resident records were to have found as missing this communicable disease statement or other items, these items were faxed to the physician. This was completed on 12/03/2021.
   - Currently pending response from physician on other resident records. EI#2 is following up daily with a verbal phone call to the physician's office until all responses are received. If pending items remain week of 12/13/21, EI#2 will physically arrive to those doctor's office's to expedite these Admission Medical Exams to be complete.

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.**
   - Training was conducted by Director of Compliance/ Sage Management with EI#1 and EI#2 on importance of reviewing Admission Medical Exams prior to admission

of a resident to the community. This training included a review of the Physician Medical Exam form and importance of all required fields to be completed by the physician and if an item is noted to be missing on the form, prompt follow-up with the physician shall be initiated and a resident's admission shall be postponed until form is accurate and complete, if an item is missing on the form.

- The community Admission Medical Exam form was revised by Director of Compliance to better adjust visibility for physician of location of statement of communicable diseases to prevent potential overlook of this required item. This was completed on 12/05/21.

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.**
   - Nurse will review all Admission Medical Exams for each prospective resident prior to admission. This began immediately after survey exit date of 12/01/21.
   - Once nurse has completed review, the Administrator, in conjunction with the Executive Director will complete a review of the Admission Medical Exam. This began immediately after survey exit date of 12/01/21.
   - After all above staff have conducted reviews of the Admission Medical Exam, the Administrator or Executive Director will send the Admission Medical Exam to Sage Management for final review. This will be completed on each new prospective resident for 3 months, minimum. Shall on-going concerns be identified by Sage Management, this requirement of submitting these forms to the Sage Management may be extended. This began immediately after survey exit date of 12/01/21.

PLAN OF CORRECTION

Facility Name: The Huntingdon **Facility ID #:** D0206

Survey Exit Date: 12/01/2021 **Administrator:** Wendi Bass-Bergeron

A 616 Deficiency Number: 420-5-4-.06 (7) (k) (l) (m) (n) (o) Care of Residents

The facility failed to ensure that all resident medications were properly labeled.

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.**
   - 11/30/21, once this finding was identified and brought to EI#2's attention, the 3 medications without proper label were removed from the resident room. The sponsor was notified the same day and informed of facility policy regarding requiring a Physician order for all medications kept in the custody of RI#1. On 12/01/21, RI#1's Physician was notified.
   - Investigation of the unlabeled medications was initiated by EI#1 on 12/02/21. It was identified that based on drugs.com website and the imprint code of the three medications, those medications were identified as the following: Advil, Benadryl, and Oxycodone. These medications were destroyed by EI#2 and documented in RI#1 resident record on 12/01/21.
   - EI#2 received a verbal order from physician on 12/1/2021 regarding RI#1 request for Ibuprofen, Daily vitamin, Benadryl and AZO. These medications were delivered and in the custody of RI#1 with proper labels on the medication bottles on 12/02/21.
   - EI#2 faxed physician verbal order for signature on 12/1/2021. Received signed order by physician on 12/2/2021 for implementation of the above requested orders by RI#1.

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#2 conducted room rounds of all current residents to investigate whether any other residents were identified of having medications at bedside without proper labeling or omission of a physician's order. This was completed on 12/10/21.

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.**
   - Nurse will conduct room rounds of all current residents to investigate whether any other residents will be identified of having medications at bedside without a proper label. This will be completed weekly x 3 months, then will document monthly x 3

months but will continue per community policy. This will begin week of 12/13/21. This documentation will be kept on file in the Administrator's office.

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.**
   - Administrator will conduct a random room round monthly x 6 months to identify any concerns with compliance with labeling of medications in the custody of any resident of the community. This will begin week of 01/01/22.
   - Executive Director will review this documentation to ensure compliance with this plan of correction, beginning week of 01/01/22.
   - In addition, Sage Management will review this documentation when visiting the community.

PLAN OF CORRECTION

Facility Name: The Huntingdon **Facility ID #:** D0206

Survey Exit Date: 12/01/2021 **Administrator:** Wendi Bass-Bergeron

A 803 Deficiency Number: 420-5-4-.08 (3) Physical Facilities

The facility failed to maintain resident care equipment in safe operating condition.

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 #3 identified the hand sanitizer stations to be emptied upon arrival to community and communicated to Director of Corporate Development who then relayed to Maintenance Director the need for refill containers for the hand sanitizer stations by the front entrance, dining room, and common living room on B wing.
   - Maintenance Director entered community moments later and refilled all hand sanitizer stations within the community.

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.**
   - All staff in-service initiated on 12/13/21 to demonstrate how to replace hand sanitizer pumps throughout the community, importance of promptly replacing hand sanitizing solution once exhausted, and location of extra hand sanitizer refills which is in housekeeping closet on A Wing of community. This in-service also includes Infection Control Policy with specific attention discussed regarding hand hygiene. This will be completed by 12/17/21.

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.**
   - Administrator or designee will conduct community rounds each morning to assess the need for refill replacements of all hand sanitizer stations within the community. Shall a hand sanitizer station be empty, the Administrator or designee will immediately refill with sanitizing solution. This check of the hand sanitizer stations will be documented as done daily, on a weekly basis x 1 month, then monthly x 3 months. This will begin on 12/13/21.

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.**

- Executive Director will review this documentation to ensure compliance with this plan of correction and will conduct random checks of all hand sanitizing stations, as needed.
- In addition, Sage Management will review this documentation when visiting the community and conduct random checks of all hand sanitizing stations, as needed.

PLAN OF CORRECTION

Facility Name: The Huntingdon **Facility ID #:** D0206

Survey Exit Date: 12/01/2021 **Administrator:** Wendi Bass-Bergeron

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

The facility failed to ensure that the kitchen/dining equipment and serving areas were properly maintained and sanitary.

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 12/06/21 Maintenance Director removed the screen door between the kitchen and porch exit. On 12/21/21, Maintenance Director replaced with a new screen door.
   - EI#1 spoke to Executive Director and Maintenance Director on 12/02/21 regarding need of replacing dining room drink station cabinet. Plans to coordinate this replacement when dining room gets completely repainted, as the repainting was part of a previously planned update to the community. On 12/03/21 measurements were obtained by Maintenance personnel. On 12/06/21 the replacement cabinet was ordered by Maintenance Director. Tentative date scheduled for completion after new cabinet delivered and installed is 01/10/22.
   - On 11/30/21 upon identification of standing water in ice machine, Director of Corporate Development immediately cleaned the drip tray. Later that afternoon, a staff RCA then cleaned the drip tray again as well.
   - On 12/02/21 EI#3 cleaned the drip tray and identified that the ice machine was constantly dripping water in the drip tray. EI#1 completed Maintenance request on 12/02/21 to investigate cause.
   - On 12/07/21 Maintenance Director repaired ice machine. Currently ice machine is functioning properly without a constant drip.
   - On 12/01/21 Maintenance Director completed repair of ceiling above the drink station, eliminating the peeling paint and exposed drywall between the sprinkler head and the side wall.

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 12/06/21 Maintenance Director removed the screen door between the kitchen and porch exit. On 12/21/21, Maintenance Director replaced with a new screen door.
   - EI#1 spoke to Executive Director and Maintenance Director on 12/02/21 regarding need of replacing dining room drink station cabinet. Plans to coordinate this

replacement when dining room gets completely repainted, as the repainting was part of previously planned update to the community. On 12/03/21 measurements were obtained by Maintenance personnel. On 12/06/21 the replacement cabinet was ordered by Maintenance Director. Tentative date scheduled for completion after new cabinet installed after delivery is 01/10/21.

- On 12/07/21 Maintenance Director repaired ice machine. Currently ice machine is functioning properly without a constant drip.
- On 12/01/21 Maintenance Director completed repair of ceiling above the drink station, eliminating the peeling paint and exposed drywall between the sprinkler head and the side wall.

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 in-service initiated on 11/30/21 by Director of Corporate Development to all staff stating their responsibility to ensure that all drip trays are properly cleaned immediately after serving of all three meals per day. EI#1 will complete this in-service with all staff by 12/17/21.
   - Maintenance Director will conduct a community round weekly x 4 weeks, then monthly x 3 months to identify any concerns with proper closure of screen door between the kitchen and porch exit, assess drink station cabinet to identify any maintenance needs to keep cabinet in proper working order, assess ice machine for any malfunctions, and complete a community round to identify any concerns with community ceilings. This will begin week of 12/20/21. This documentation will be kept on file in the Administrator's office.
   - Administrator or designee will conduct a community round weekly x 4 weeks, monthly x 3 months, then quarterly x 2 of drink station area to ensure station is properly cleaned and omission of dust, spills, or stains of the drink station exterior, interior, drawers, and toe kick. This will begin week of 12/20/21. This documentation will be kept on file in the Administrator's office.

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.**
   - Executive Director will review this documentation to ensure compliance with this plan of correction. This will begin week of 12/20/21.
   - Executive Director will conduct random checks of screen door between kitchen and porch, drink station cabinet, ice machine, and ceilings throughout community, as needed.
   - In addition, Sage Management will review this documentation when visiting the community and conduct random checks of the above items, as needed.

PLAN OF CORRECTION

Facility Name: The Huntingdon **Facility ID #:** D0206

Survey Exit Date: 12/01/2021 **Administrator:** Wendi Bass-Bergeron

A1001 Deficiency Number: 420-5-4-.10 (1) Sanitation and Housekeeping

The facility failed to ensure that cardboard boxes and waste were promptly disposed of so as to not attract unwanted pests.

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 11/30/21, the scheduled night shift security guard removed all boxes and then disposed of all garbage in the trash can as this had recently (prior to survey) been initiated by the community as an assigned duty for the security guard to complete nightly. The surveyor verified on 12/01/21 that the area had been cleaned up, which was noted within the survey report. EI#1 also verified this as done on 12/01/21.

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.**
   - Community rounds conducted by EI#1 on 12/01/21 to identify any other unwanted trash on the grounds that needed disposing. No other concerns 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.**
   - Once the food truck sends automatic email to Administrator or designee to notify truck is in route, Administrator or designee is to alert community Maintenance Director. Then once food items are delivered and stored properly within the kitchen, Administrator or designee shall notify Maintenance Director at that time that the empty boxes and/or additional trash need promptly removing from the grounds of the community. This will be documented daily x 1-week, weekly x 4, then monthly x 3 months. This will begin on 12/13/21. This documentation will be kept on file in the Administrator's office.

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.**

- Executive Director will review this documentation to ensure compliance with this plan of correction and will conduct random checks of porch outside of the kitchen., as needed. This review of documentation will begin on 12/13/21.
- In addition, Sage Management will review this documentation when visiting the community and conduct random checks of porch outside of the kitchen, as needed.

PLAN OF CORRECTION

Facility Name: The Huntingdon **Facility ID #:** D0206

Survey Exit Date: 12/01/2021 **Administrator:** Wendi Bass-Bergeron

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

The facility failed to ensure that chemicals were properly secured or supervised at all times. The facility also stored flammable chemicals within the facility.

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 11/30/21 once identified, EI#3 immediately removed the Nail Dryer aerosol spray by disposing in community dumpster and Clorox spray with bleach and Clorox wipes were properly secured.
   - On 11/30/21 another employee had removed the Clorox bottle that was sitting on the table in the common area on A Wing prior to EI#3 identifying the item during community round which occurred upon arrival to community approximately, 12:00pm this day.

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 11/30/21 EI#3 immediately conducted a community round to ensure all other chemicals were secured properly.
   - On 11/30/21 an in-service with EI #1 and EI#2 was conducted by EI#3 on ADPH rules and regulations regarding facility cleaning supplies and poisons shall be always attended or shall be kept in a secure area and flammable materials shall not be store in 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.**
   - On 12/02/21 all staff in-service initiated by EI#1 on ADPH rules and regulations regarding facility cleaning supplies and poisons shall be always attended or shall be kept in a secure area and flammable materials shall not be store in the facility. This in-service will be completed by 12/17/21.
   - Administrator will conduct rounds daily x 1 -week, weekly x 4, then monthly x 3 months. This began on 12/06/21. This documentation will be kept on file in the Administrator's office.

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.**
   - Executive Director will review this documentation to ensure compliance with this plan of correction and will conduct random community rounds., as needed. This review will begin week of 01/01/22.
   - In addition, Sage Management will review this documentation when visiting the community and conduct random community rounds for specific observation of unsecured chemicals or flammable items stored within the community, as needed.

If it is determined the Plan of Correction is ineffective, then a revised Plan of Correction will be submitted to ADPH.

Plan of correction documentation will be maintained and filed by the facility administrator in the administrator's office.

Prepared by:
Nikki Kelley
251-656-7660

Administrator: Wendi BamBerg **Date:** 12-27-21