accepted November 8, 2021

Connie Cherry

Legacy Woods II

Facility ID: P0501

Plan of Correction

Survey Exit Date: 10/20/2021

Administrator: Trina Cleveland



11/4/2021

Legacy Woods II
Facility ID: P0501
Administrator: Trina Cleveland
Survey Exit Date: 10/20/2021

1. A302 420-5-20-.03 (e) Administration Policies: The facility failed to follow its own Infection Control policies and procedures to prevent the spread of COVID-19.

2.. Each employee is to take his/her temperature and answer the screening questions prior to beginning his/her shift daily and document the screening results.

3. All employees will self-screen daily prior to beginning a shift. Any employee having a temperature of 100.4 or greater or any Covid-19 symptoms will return home until a negative Covid-19 test is obtained or the employee is symptom free for 24 hours without medication.

4. All employees have been retrained on the Infection Control Policy and Procedure to prevent the spread of COVID-19 by conducting daily health screenings prior to beginning a shift. New employees will also be trained upon hire. Documentation of the daily screenings will be placed in the Infection Control binder.

5. The Administrative Designee will review the screening documentation weekly for four weeks beginning 11/12/2021 and ending 12/3/2021 to ensure all employees are following the screening policy. Documentation of these audits will be placed in the POC binder located in the Administrator's office.

Legacy Woods II
Facility ID: P0501
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Survey Exit Date: 10/20/2021

1. A406 420-5-20-.04 (9) Personnel: The facility failed to ensure all staff received required training and ensure staffing at all times included one individual who had current certification in CPR.

2. The Administrator/Designee and the RN will ensure that all new employees receive required training upon hire and that staffing at all times will include one individual with current CPR certification.

3. All employees not having CPR certification will be certified in CPR by November 5. All employees not trained in diabetes and hospice have been trained. Employee schedules were amended ensuring that at least one staff member was certified in CPR at all times until training is completed.

4. The Administrator/Designee and the RN will ensure that new employees are trained in all required training. An audit of all employee files will be completed by November 15 to ensure that all staff has all required training. Documentation of the audit will be placed in the POC binder in the Administrator's office.

5. The Administrator/Designee will review employee files quarterly beginning 12/15/2021 and ending 6/15/2022 to ensure that all required training has been completed. Documentation of quarterly audits will be placed in the POC binder in the Administrator's office.

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1. A504 420-5-20-.05 (3) (d) Records and Reports. The facility failed to adhere to Standards and Recommendations of CDC.

2.. Each employee is to take his/her temperature and answer the screening questions prior to beginning his/her shift daily and document the screening results.

3. All employees will self-screen daily prior to beginning a shift. Any employee having a temperature of 100.4 or greater or any Covid-19 symptoms will return home until a negative Covid-19 test is obtained or the employee is symptom free for 24 hours without medication.

4. All employees have been retrained on the standards and recommendations of the CDC and conducting daily health screenings prior to beginning a shift. New employees will also be trained. Documentation of the daily screenings will be placed in the Infection Control binder.

5. The Administrative Designee will review the screening documentation weekly for four weeks beginning 11/12/2021 and ending 12/3/2021 to make sure all employees are following the screening policy. Documentation of these audits will be placed in the POC binder located in the Administrator's office.

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1. A618 420-5-20-.06 (7) Care of Residents. The facility failed to document a resident's oxygen use on the Medication Administration Record (MAR).

2. All residents requiring the use of oxygen will have it documented on the MAR as ordered by his/her physician.

3. The RN will ensure that all residents requiring oxygen will have the date, time, rate and proper function of the equipment documented on the MAR on each shift.

4. The RN will identify all resident requiring the use of oxygen and ensure that the physician's order and the date, time, rate and proper function is documented on the MAR on each shift by 11/10/2021. Results of the audit will be documented in the POC binder.

5. Beginning 12/15/2021 and ending 6/15/2022, the RN will audit the MAR of any resident requiring the use of oxygen quarterly to ensure that the date, time, rate and proper function is documented on the resident's MAR on each shift. Documentation of the audits will be placed in the POC binder in the Administrator's office.

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1. A702 420-5-20-.07 (2) Food Handling Procedures (a) Dish and Utensils Washing, Disinfection, and Storage. The facility failed to monitor and document the parts per million (PPM) of the sanitizing solution (chlorine) for utensils and dishes.

2. Chlorine concentrations (PPM) will be monitored using a test strip and documented to ensure dishes and utensils are properly sanitized.

3. The Dietary Lead will ensure that chlorine concentrations are monitored and documented daily and kept in a binder in the kitchen. The dietary lead will also ensure that the kitchen has test strips available at all times.

4. The Administrator/Designee will audit the logs monthly to ensure that concentrations are being monitored and recorded. The audit will be added to the monthly facility checklist.

5. Beginning 11/12/2021 and ending 12/3/2022, the Administrator/Designee will audit the logs weekly to ensure concentrations are being monitored and recorded and monthly after that. Documentation of the audits will be placed in the POC binder in the Administrator's office.

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1. A1001 420-5-20-.10(1) Sanitation and Housekeeping (a) Water Supply The facility failed to ensure that hot water accessible to all residents did not exceed the allowed temperature.

2. Water temperatures will not exceed the allowed temperature of 110 degrees Fahrenheit.

3. The Care Team supervisor will ensure that water temperatures for all water accessible to residents is checked and documented on the 15th and 30th of each month.

4. The Administrator/Designee will audit the documentation on the monthly facility checklist to ensure that it is being completed.

5. Documentation of the audit will be placed in the POC binder in the Administrator's office.

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1. A1101 420-5-20-.11(1) Fire Safety The facility failed to perform and document fire drills as required.

2. All fire drills will be conducted and the date and time will be documented with noting AM or PM. Fire drills will be conducted quarterly on each shift.

3. The Administrator/Designee will ensure that fire drills are conducted quarterly on each shift and documented with AM or PM noted and the shift.

4. The Administrator/Designee will ensure that all fire drills are conducted and documented for date, time, and effectiveness of the drills.

5. Documentation of all drills will be will be placed in the fire drill binder and the POC binder in the Administrator's office.

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1. A1203 420-5-20-.12 (5) Physical Environment The facility failed to maintain documentation of a visual inspection to each fire extinguisher monthly.

2. All fire extinguishers will be visually inspected and documented monthly.

3. The Care Team supervisor will visually inspect all fire extinguishers in the building and document the inspection monthly on the tag located on the extinguisher.

4. The Administrator/Designee will audit the documentation quarterly to ensure that it is being completed.

5. Documentation of the audit will be placed in the POC binder in the Administrator's office.