POC Accepted
July 1, 2022
Debbie Freeman, RN
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The following is the Plan of Correction for The Neighborhood at Sheffield Assisted Living regarding the Statement of Deficiencies dated 6/15/2022. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

PLAN OF CORRECTION

Facility Name: The Neighborhood at Sheffield - ALF Facility ID #: D1703

Survey Exit Date: 06/15/2022 Administrator: Kutana Mitchell

Deficiency Number: 420-5-4-.05 (3)(h) Records and Reports

A 508

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 6/14/2022, EI#1 reported RI#4's incident to the Online Reporting System.
    - On 6/14/2022, EI#2 updated RI#4's Care Plan to reflect incident and interventions.
    - On 6/14/2022, EI#3 and Clinical Support Specialist, re-trained EI#'s 1&2 on Incident Reporting Guidelines and Procedures.

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 or before 6/18/2022, EI#'s 1&2 will review all incidents to ensure that all have been reported to the Online Reporting System. No additional reports identified to be out-of-compliance.

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.

    - Effective immediately, EI#2 will report all incidents to EI#1 and EI#'s 1&2 will work together through the duration of the process to ensure timely reporting of all incidents.

- Effective immediately, all incidents will be reported to the Regional Director of Operations and Clinical Support Specialist, at the time of medical treatment.

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.

    - Effective immediately, the Regional Director of Operations and/or Clinical Support Specialist will review all State Reportables prior to submission to the Online Reporting System.

    - Effective 7/1/2022, during routine visits, a Phoenix Support representative will perform random audits of The State Reportable Binder to ensure the ORIS confirmation is attached, ongoing.

PLAN OF CORRECTION

Facility Name: The Neighborhood at Sheffield – ALF Facility ID #: D-1703

Survey Exit Date: 06/15/2022 Administrator: Kutana Mitchell

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

A601

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 #10 is no longer employed at the community.

    - EI#2 notified resident's physician and new orders obtained to hold Lantus on 6/15/2022.

    - EI#2 notified pharmacy to ensure delivery of the medication on 6/15/2022.

    - EI#1 retrained EI#2 on Medication Administration Policies and Procedures on 6/15/2022.

    - EI#'s 1&2 retrained all nurses on Medication Administration Policies and Procedures on 6/15/2022 and 6/20/2022.

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 performed medication cart audit to ensure all other medications were available. 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.

    - Effective immediately, EI#2 initiated a sign-off sheet for each nurse to verify that all medications are available at the end of their shifts.

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.

    - Effective 6/20/2022, Wellness Director and/or Administrator will perform weekly medication cart and MAR audits to ensure compliance with medication availability and that medications are given at the correct time on the MARs x 3 months and randomly thereafter.

    - Effective the week of 6/20/2022, Guardian Pharmacy will send a representative every other week to perform a medication cart audit for compliance with medications and availability x 2 months and monthly thereafter x 6 months.

    - Effective 7/5/2022, during routine visits, a Phoenix Senior Living representative will perform medication cart and MAR audits to ensure compliance with medication availability and that medications are given at the correct time on the MARs randomly, ongoing.

PLAN OF CORRECTION

Facility Name: The Neighborhood at Sheffield – ALF Facility ID #: D1703

Survey Exit Date: 06/15/2022 Administrator: Kutana Mitchell

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

A 611

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 #10 is no longer employed at the community.
    - EI#2 updated RI#6's Care Plan on 6/15/2022.
    - EI#1 retrained EI#2 on Medication Administration Policies and Procedures on 6/15/2022.
    - EI#'s 1&2 retrained all nurses on Medication Administration Policies and Procedures on 6/15/2022 and 6/20/2022.

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 will review all residents' care plans to ensure that they reflect the most current physician orders on or before 7/13/2022.

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.

    - Effective immediately, Wellness Director will update care plans, daily, to reflect new physician orders, ongoing.

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.

- Effective immediately, Administrator will review care plans weekly x one month and then randomly, ongoing, to ensure resident care plans reflect most current orders.

- Effective immediately, Wellness Director and/or Administrator will visually inspect resident apartment's following a med pass to ensure there is no evidence of medications being left in the apartments, randomly, ongoing.

- Effective 7/1/2022, a Phoenix Support Representative will randomly audit resident Care Plans to ensure that they are current to residents' needs.

- Effective 7/1/2022, a Phoenix Support Representative will randomly inspect resident apartments following a medication pass to ensure there is no evidence of medications being left in the apartments, ongoing.

PLAN OF CORRECTION

Facility Name: The Neighborhood at Sheffield Facility ID #: D1703

Survey Exit Date: 06/15/2022 Administrator: Kutana Mitchell

Deficiency Number: 420-5-4-.11 (1) Fire and Safety

A 1101

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 1/12/2022, EI#1 notified Fire Marshall of missing inspections and Fire Marshall came for a complete inspection and report for the community, to include photos of concerns.

    - All items to be found deficient, per the Fire Marshall's report, were rectified by the end of 2/2022.

    - On 6/15/2022, EI#1 retrained EI#12 on the State required semi-annual and annual Fire and Safety Inspections.

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.

    - N/A

3. Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.

    - Effective immediately, the Facilities Director will upload all inspection reports into the TELS system, ongoing.

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.

    - Effective immediately, the Administrator will perform routine checks of fire safety inspection tags, ongoing.

    - Effective immediately, the Administrator will run TELS history reports to ensure that fire/safety inspection reports are uploaded, ongoing.

    - Effective 7/1/2022, a Phoenix Senior Living support representative, during routine visits, will randomly audit TELS history reports and Fire Safety Inspection tags for compliance, ongoing.

NOTE: All Plan of Correction documentation will be in a binder, organized and filed by the Administrator. This binder will be stored in the Administrator's office.

Should any corrective action be determined as ineffective, the Administrator and Governing Authority shall make immediate revisions and submit an amended Plan of Correction to the Alabama State Board of Health.

Authorized Signature: _____ ***Date:*** 6/29/2022

Prepared by:
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