Accepted September 1, 2022
Connie Cherry

Plan of Correction (POC): Page 1
Facility Name: Peachtree Assisted Living
Facility Identification Number: D3772
Name of Administrator: Kelley Self
Survey Exit Date: 8/17/2022

1. **Cited deficiency number: 420-5-4-.04 (3) Personnel (ID Prefix Tag A 402)**

   This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to screen potential employees for abuse prior to hire.

   Review of employee files on August 16, 2022 revealed the following employees were not screened through the Alabama Department of Public Health Nurse Aide Abuse Registry prior to hire. Employee Identifier (EI)#2 was hired at the facility on May 20, 2022 and screened for abuse on May 26, 2022. EI#8 was hired at the facility on July 12, 2022 and screened for abuse on July 15, 2022. EI#1 agreed the abuse screenings had not been completed prior to hire of the employees

2. **Corrective action(s) in response to each resident or example identified in the SOD:**

   All potential employees, ongoing will be screened for abuse prior to hire.

3. **Corrective action(s) the facility will take to identify other residents or concerns not identified by the survey team that are related to those cited in SOD:**

   Current employee files to be audited by Administrator/designee or HSD by 9/5/2022 to ensure all employee files are accurate and in compliance.

4. **Measures/Changes put into place to ensure the same deficiency will not recur:**

   Administrator/designee will perform random audits on new hire employee files to check that employees are checked against the abuse registry prior to hire, times 3 months, starting 8/26/2022.

5. **How corrective action(s) will be monitored to ensure that they are fully implemented; adequately address the identified problems; and are effective:**

   The Administrator/designee or HSD will monitor quarterly on-going. Any discrepancies will be addressed by Administrator/designee immediately. Documentation will be kept in Administrator's office in POC binder.

Plan of Correction (POC): Page 2
Facility Name: Peachtree Assisted Living
Facility Identification Number: D3772
Name of Administrator: Kelley Self
Survey Exit Date: 8/17/2022

1. Cited deficiency number: 420-5-4-.06 (3) (a) (b) Care of Residents. (ID Prefix Tag A 604)

   This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to assess each resident at least monthly to identify changes in the resident's status and assess the resident's ability to protect self from medication errors.

Resident Identifier (RI)#1 was admitted to the facility on June 3, 2020 and had diagnoses which included rheumatoid arthritis, dementia and major cognitive disorder. In the year 2022, only one monthly assessment had been documented for RI#1 (April 2022).

RI#2 was admitted to the facility on February 5, 2021 and had diagnoses which included chronic hypertension and chronic kidney disease. In the year 2022, only one monthly assessment had been documented for RI#2 (April 2022).

RI#5 was admitted to the facility on July 9, 2021 and had diagnoses which included history of transischemic attacks, anxiety, Parkinson's disease, diabetes mellitus type II, hypertension, hyperlipidemia, hypothyroidism, atherosclerotic cardiovascular disease and gastroesophageal reflux disorder. In the year 2022, only three monthly assessments had been documented for RI#5 (April, June and July 2022).

RI#6 was admitted to the facility on April 15, 2021 and had diagnoses which included diabetes mellitus type II, vascular dementia and congestive heart failure. Refer to deficiency 611 for additional information on RI#6. No monthly assessments had been documented for RI#6 during the year 2022.

RI#7 was admitted to the facility on October 28, 2020 and had diagnoses which included chronic kidney disease, sciatica, metabolic encephalopathy, insomnia, situational depression, bipolar disorder, diabetes mellitus type II, hypertension, gastroesophageal disorder, hypothyroidism, congestive heart failure, dementia and convulsions. No monthly assessments had been documented for RI#7 during the year 2022.

RI#8 was admitted to the facility on October 28, 2014 and had diagnoses which included chronic obstructive pulmonary disease, dementia, insomnia, depression, osteoarthritis, weakness, hypothyroidism, urinary retention, chronic kidney disease stage 3, hyperlipidemia and osteoporosis. Refer to deficiencies 606, 611, 613 and 614 for additional information on RI#8. During the year 2022, only three monthly assessments had been documented for RI#8 (April, June and July 2022). In addition, no weights were documented for RI#8 in April and May 2022. A note on the Monthly Resident Evaluation for RI#8, dated April 18, 2022, read "unable to obtain weight". Also, RI#8 was not assessed in January, February, March, April and May 2022 to determine RI#8's ability to protect self from medication errors. When tested on August 16, 2022 by EI#1, EI#8 could not correctly identify medications and was unable to protect self from a medication error, substantiating the complaint received. On August 17, 2022, the surveyor discussed monthly assessments with EI#1, Administrator. EI#1 stated she (EI#1) knew the assessments had been completed and documented but she (EI#1) was unable to locate the documentation. EI#1 agreed RI#8 had not been properly assessed to determine RI#8's ability to direct medication assistance.

2. **Corrective action(s) in response to each resident or example identified in the SOD:** The HSD that was responsible for monthly assessments, medication assessments, weights, is no longer employed at Peachtree. Documentation updated 8/22/2022 to reflect RI#1, RI#2, RI#5, RI#6, RI#7, RI#8 were all appropriately assessed and have records to be audited.
3. **Corrective action(s) the facility will take to identify other residents or concerns not identified by the survey team that are related to those cited in SOD:** Administrator/Designee will audit all resident assessments completed by HSD 1 time a month for 3 months starting August 2022.
4. **Measures/Changes put into place to ensure the same deficiency will not recur:** On-going random audits of resident assessments completed by Administrator/Designee or HSD.
5. **How corrective action(s) will be monitored to ensure that they are fully implemented; adequately address the identified problems; and are effective:** Administrator/Designee or HSD will perform quarterly audits to ensure all resident assessment documentation is completed. Audit documentation will be kept in POC binder in Administrator's office.

Plan of Correction (POC): Page 3
Facility Name: Peachtree Assisted Living
Facility Identification Number: D3772
Name of Administrator: Kelley Self
Survey Exit Date: 8/17/2022

1. **Cited deficiency number: 420-5-4-.06 (3) (D) Care of Residents. (ID Prefix Tag A 606)**

   This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to promptly discharge or transfer a resident who required care beyond the capabilities of the assisted living facility.

   RI#8 had resided at the facility since October 28, 2014. Refer to deficiencies 604, 611, 613 and 614 and for additional information on RI#8. Observations of RI#8 during the onsite survey revealed RI#8 was bed to chair bound, requiring one or two person assistance with transfers, was unable to ambulate, required assistance/encouragement for turning when in bed, required oxygen use which was managed by facility staff, required meal set-up and was totally dependent on facility staff for personal care. RI#8 slept most of the time but would arouse when spoken to and would sit in wheelchair if placed in the chair by facility staff. RI#8 was currently receiving hospice services at the facility.

   On August 17, 2022, the surveyor observed three attempts by facility staff to allow RI#8 to utilize the unit dose packaging system. RI#8 was unable to identify medications and protect self from a medication error on all three attempts. Review of RI#8's facility record revealed RI#8 was also unsuccessful in identifying medications in June 2022 and July 2022. RI#8's inability to utilize the unit dose packaging system is further described in deficiency 614. RI#8 also required skilled care to administer medications and was noted to have coughing episodes after drinking and would chew up medications. Refer to deficiency 614.

   Review of RI#8's Resident Service Plan on August 17, 2022 revealed the following information. RI#8 required 2 person assistance to get up from chair, bed or on/off toilet and in/out of showers. RI#8 was resistive to bathing at times. RI#8 was not oriented to day, month and year. RI#8 was not oriented to city, state and place of residency. RI#8 was not able to utilize the call light system. RI#8 did not understand how to lock their door and use a key to unlock their door. RI#8 was unable to recall any of five objects listed (apple, pen, tie, house, cat). RI#8 would pick up items that may not belong to them and place the items in "special" areas that were difficult to find. RI#8 would pick up items from other resident's plates and put them in his/her mouth. RI#8 had a tendency to wander without regards to safety of purpose. RI#8 was requiring more assistance with transfers due to not being able to stand and assist staff during transfers. RI#8 was becoming more resistive to care and had episodes of kicking and cursing when staff attempted to provide incontinence care. RI#8 had a severe cognitive impairment. RI#8 was at risk of falls due to decline in ability to stand and to assist with transfers. RI#8 was at risk of elopement due to cognitive impairment. RI#8 was at risk of skin breakdown due to decline in mobility status. This was the most recent Resident Service Plan for RI#8 and was dated July 5, 2022. Staff reported to the surveyor that RI#8 had declined during the past 1-2 months.

   No 30-day discharge notice had been issued to RI#8 at the time of the onsite survey. EI#1 stated she (EI#1) had been working with a social worker through the Department of Human Resources as well as a social worker through hospice to locate a higher level of care facility for RI#8 but she (EI#1) was unsure how long the process would take.

2. **Corrective action(s) in response to each resident or example identified in the SOD:** Administrator contacted Ombudsman for guidance, and he came to facility to meet Administrator on 8/19/2022 to assist with discharge plan.

   30-day discharge issued to RI#8 and mailed to DHR social worker on 8/19/2022.

3. **Corrective action(s) the facility will take to identify other residents or concerns not identified by the survey team that are related to those cited in SOD:** HSD or Administrator/Designee will assess all residents once a month to confirm they remain appropriate.

4. **Measures/Changes put into place to ensure the same deficiency will not recur:** Administrator/Designee will monitor all completed resident assessments monthly times 3 months to ensure resident appropriateness.

5. **How corrective action(s) will be monitored to ensure that they are fully implemented; adequately address the identified problems; and are effective:** To be monitored by HSD or Administrator/Designee monthly on-going. Any resident beyond the capability of assisted living will be appropriately discharged or transferred by Administrator. Documentation will be kept in Administrator's office in POC binder.

Plan of Correction (POC): Page 4
Facility Name: Peachtree Assisted Living
Facility Identification Number: D3772
Name of Administrator: Kelley Self
Survey Exit Date: 8/17/2022

1. **Cited deficiency number: 420-5-4-.06 (a) (b) Care of Residents. (ID Prefix Tag A 611)**

   This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to maintain resident care plans which were current and contained appropriate interventions to meet the care needs of the residents. In addition, proper nail care was not provided for a resident.

   Findings: Care Plans RI#3 was admitted to the facility on August 31, 2021 and had diagnoses which included diabetes mellitus type II, dementia, hypertension, hypothyroidism, osteoporosis and hyperlipidemia. Review of RI#3's facility record on August 17, 2022 revealed RI#3 had sustained at least nine falls at the facility since January 2022. Although a new entry was documented on RI#3's care plan for each fall, the interventions for each fall were identical. No new interventions had been developed and implemented to prevent recurrence of the falls and protect RI#3 from injury.

   RI#6 had resided at the facility since April 15, 2021. Refer to deficiency 604 for additional information on RI#6. Review of RI#6's facility record on August 17, 2022 revealed RI#6 had sustained at least four falls at the facility from January 2022 through June 2022. Although a new entry was documented on RI#3's care plan for each fall, the interventions for each fall were identical. No new interventions had been developed and implemented to prevent recurrence of the falls and protect RI#6 from injury.

   RI#14 was admitted to the facility on November 24, 2021 and had diagnoses which included benign prostatic hypertrophy and hypothyroidism. RI#14 passed away at the facility on July 21, 2022. Review of RI#14's facility record on August 17, 2022 revealed RI#14 sustained seven falls at the facility from December 23, 2021 through July 5, 2022. RI#14's Resident Service Plan indicated RI#14 was legally blind and required assistance to ambulate due to blindness but refused to utilize the call system to obtain assistance when ambulating. Although a new entry was documented on RI#14's care plan for each fall, the interventions for each fall were identical. No new interventions had been developed and implemented to prevent recurrence of the falls and protect RI#14 from injury.

   Nail Care

   On the morning of August 16, 2022, the surveyor and EI#7 observed RI#8 in the bed. RI#8's fingernails were long and contained brown residue underneath all nails. EI#1 immediately sent EI#5 to trim and clean RI#8's fingernails.

2. **Corrective action(s) in response to each resident or example identified in the SOD:** RI#3, RI#6 Care plans updated 8/30/2022 to reflect new interventions.

   Staff in-service on care plan interventions scheduled for 9/9/2022.

3. **Corrective action(s) the facility will take to identify other residents or concerns not identified by the survey team that are related to those cited in SOD:** Audit of all resident care plans to check for discrepancies to be completed by HSD or Administrator/Designee by 9/10/2022.
4. **Measures/Changes put into place to ensure the same deficiency will not recur:** Quarterly audits to be completed by HSD or Administrator/Designee.
5. **How corrective action(s) will be monitored to ensure that they are fully implemented; adequately address the identified problems; and are effective:** To be monitored by HSD or Administrator/Designee on-going. Any discrepancies will be corrected immediately. Audits will be kept in POC binder in Administrator's office.

Facility Name: Peachtree Assisted Living
Facility Identification Number: D3772
Name of Administrator: Kelley Self
Survey Exit Date: 8/17/2022

1. **Cited deficiency number: 420-5-4-.06 (5) (a) (b) (c) (d) (e) Care of Residents. (ID Prefix Tag A 613)**

   This Rule is not met as evidenced by: Based on observations, interview and record review, the facility failed to provide licensed personnel (physician, Registered Nurse or Licensed Practical Nurse) to administer medications to a resident who was unable to protect self from a medication error.

   Findings: RI#8 had resided at the facility since October 28, 2014. Refer to deficiencies 604, 606, 611 and 614 for additional information on RI#8. As described in deficiency 614, RI#8 was incapable of understanding and utilizing the facility unit dose medication system and did not have the ability to protect self from a medication error. RI#8 required medication administration by licensed personnel to safely and accurately receive medications. RI#8 had been unable to utilize the unit dose medication system for at least two months prior to the onsite survey. Review of RI#8's Medication Assistance Record (MAR) revealed unlicensed Medication Technicians had provided medications to RI#8. RI#8's medications were not administered by licensed personnel, placing RI#8 at increased risk of medication errors.

2. **Corrective action(s) in response to each resident or example identified in the SOD:** Staff in-service completed on 8/19/2022. Licensed personnel were put into place on 8/17/2022 to administer all RI#8 medications until DHR transfers her to higher level of care.
3. **Corrective action(s) the facility will take to identify other residents or concerns not identified by the survey team that are related to those cited in SOD:** Medication assessments were completed on all residents by Administrator on 8/26/2022 to ensure all residents could protect themselves from medication errors.
4. **Measures/Changes put into place to ensure the same deficiency will not recur:** HSD or Administrator/Designee will observe unlicensed staff during scheduled medication assistance times 2 times a month for 3 months.
5. **How corrective action(s) will be monitored to ensure that they are fully implemented; adequately address the identified problems; and are effective:** On-going medication assistance monitoring and staff training on medication assistance. All documentation will be kept in POC binder in Administrator's office.

Plan of Correction (POC): Page 6
Facility Name: Peachtree Assisted Living
Facility Identification Number: D3772
Name of Administrator: Kelley Self
Survey Exit Date: 8/17/2022

1. **Cited deficiency number: 420-5-4-.06 (5)(f)(g)(6)(7)(a)-(i) Care of Residents. (ID Prefix Tag A 614)**
   This Rule is not met as evidenced by: Based on observations, interviews and record review, a resident was unable to utilize the unit dose packaging system to protect self from medication errors.
   THIS DEFICIENCY WAS CITED AS A RESULT OF COMPLAINT INVESTIGATIONS.

   Findings:
   The Alabama Department of Public Health received a complaint which alleged residents were unable to recognize their name on medications. An additional complaint received by the Alabama Department of Public Health alleged the facility had ineligible residents. The surveyor was able to substantiate these complaints during the onsite survey.

   RI#8 had resided at the facility since October 28, 2014. Refer to deficiencies 604, 606, 611 and 613 for additional information on RI#8. On the morning of August 17, 2022, EI#7 attempted to assist RI#8 with medications. RI#8 was unable to stay awake and alert enough to identify medications. EI#7 called EI#2, Licensed Practical Nurse, to administer RI#8's medications. It was noted that RI#8 coughed repeatedly after drinking water and would chew up all medications. Later during the morning of August 17, 2022, EI#1 attempted to perform medication awareness testing on RI#8, at the request of the surveyor. RI#8 was asleep in the bed and was again unable to stay awake and alert enough to answer questions and identify medications. EI#1 instructed facility caregivers to transfer RI#8 to the wheelchair. The transfer was completed by EI#9 and EI#10. RI#8 attempted to assist with pulling up pants and holding to staff but was unable to stand and provided very little assistance with the transfer. RI#8 remained in the wheelchair for 3-4 hours and it was again noted RI#8 had prolonged episodes of coughing after drinking liquids. RI#8 ate lunch while seated in the wheelchair. After lunch, EI#1 attempted medication awareness testing with RI#8. RI#8 was able to state name and read false name "Sunshine Ray" on a medication packet. However, when asked if Sunshine Ray was RI#8's name, RI#8 repeatedly stated "yes". After multiple attempts, RI#8 remained unable to identify medications and protect self from a medication error. RI#8's coughing episodes were discussed with EI#1 on August 17, 2022. EI#1 stated RI#8 had coughing spells since RI#8 had been at the facility but stated RI#8's physician would be notified to evaluate.
   Review of RI#8's Self Medication Evaluation form, on August 17, 2022, revealed the following. No evaluations were documented for the months of January, February, March, April and May 2022. The evaluations documented for June and July 2022 contained "no" answers to the following questions: "Is the resident aware of the day, date, season and current year?" and "Does the resident have a lay person's understanding of the unit dose packaging system, if needed?". RI#8 had been unable to protect self from a medication error and in need of skilled services for at least 2 months and likely longer. On August 17, 2022, EI#1 stated no 30-day discharge notice had been issued to RI#8. However, EI#1 stated RI#8's case worker had been working on nursing home placement for RI#8 but she (EI#1) was unsure how long the process would take.
2. **Corrective action(s) in response to each resident or example identified in the SOD:** The HSD employed at the time no assessments were completed is no longer employed at Peachtree. A 30-day discharge was issued to RI#8 and DHR case worker on 8/19/2022.
3. **Corrective action(s) the facility will take to identify other residents or concerns not identified by the survey team that are related to those cited in SOD:** Administrator/Designee will audit all resident assessments completed by HSD 1 time a month for 3 months starting August 2022.
4. **Measures/Changes put into place to ensure the same deficiency will not recur:** On-going random audits of resident assessments completed by Administrator/Designee or HSD.
5. **How corrective action(s) will be monitored to ensure that they are fully implemented; adequately address the identified problems; and are effective:** Administrator/Designee or HSD will perform quarterly audits to ensure all resident assessment documentation is completed. Audit documentation will be kept in POC binder in Administrator's office.

Facility Name: Peachtree Assisted Living
Facility Identification Number: D3772
Name of Administrator: Kelley Self
Survey Exit Date: 8/17/2022

1. **Cited deficiency number: 420-5-4-.06 (7) (j) Care of Residents. (ID Prefix Tag A 615)**

   This Rule is not met as evidenced by: Based on observation, interview and record review, documentation of a resident's medication assistance was incomplete.

   Findings:
   RI#5 had resided at the facility since July 9, 2021. Refer to deficiency 604 for additional information on RI#5. On the morning of August 16, 2022, the surveyor observed EI#6 assist RI#5 with an Exelon patch. The patch was applied to RI#5's upper back. Medication assistance of the Exelon patch was documented on RI#5's MAR but did not include the site of the application. EI#1 agreed the site should have been documented.

2. **Corrective action(s) in response to each resident or example identified in the SOD:** RI#5's order in MAR was updated 8/22/2022 to reflect the site in which the Exelon patch is applied.

3. **Corrective action(s) the facility will take to identify other residents or concerns not identified by the survey team that are related to those cited in SOD:** Administrator completed audit of all resident MARs on 8/22/2022 to check any orders requiring to note body site had the proper documentation.

4. **Measures/Changes put into place to ensure the same deficiency will not recur:** HSD or Administrator/Designee will complete monthly audit of all resident MARs to check for proper documentation if body site is required for any resident orders. This audit will start 9/1/2022 and occur 1 time per month times 3 months.

5. **How corrective action(s) will be monitored to ensure that they are fully implemented; adequately address the identified problems; and are effective:** On-going MAR monitoring to ensure orders requiring site location are properly documented. All documentation will be kept in POC binder in Administrator's office.

Plan of Correction (POC): Page 8
Facility Name: Peachtree Assisted Living
Facility Identification Number: D3772
Name of Administrator: Kelley Self
Survey Exit Date: 8/17/2022

1. **Cited deficiency number: 420-5-4-.06 (7) (k) (l) (m) (n) (o) Care of Residents. (ID Prefix Tag A 616)**

   This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an accurate system to account for all controlled substances in its possession.

   Findings:
   On the morning of August 16, 2022, the surveyor observed EI#6 and EI#7 count controlled substances. A card containing Lacosamide 200 milligram tablets for RI#2 was counted by EI#6 and EI#7 with a total number of 28 tablets. At the request of the surveyor, the card was again reviewed by EI#6 and EI#7 with a count of 27 tablets. One space on the card had been sealed but did not contain a Lacosamide tablet, making the count incorrect. EI#2 contacted the pharmacy and a replacement tablet was sent.

2. **Corrective action(s) in response to each resident or example identified in the SOD:** EI#6 and EI#7 were retrained on counting controlled substances. Pharmacy was also notified regarding the incorrect count of the medication not matching the proper documentation. Pharmacy sent a corrected count sheet.

3. **Corrective action(s) the facility will take to identify other residents or concerns not identified by the survey team that are related to those cited in SOD:** All employees that assist with medication will be retrained by 9/15/2022 by HSD or Administrator/Designee on how to properly count controlled medications.

4. **Measures/Changes put into place to ensure the same deficiency will not recur:** HSD or Administrator/Designee will audit the controlled count medications 1 time per month times 3 months starting 9/1/2022.

5. **How corrective action(s) will be monitored to ensure that they are fully implemented; adequately address the identified problems; and are effective:** Audits will be completed randomly going forward. Any discrepancies will be addressed immediately by HSD or Administrator/Designee. Documentation of audits will be kept in POC binder in Administrator's office.

Plan of Correction (POC): Page 9
Facility Name: Peachtree Assisted Living
Facility Identification Number: D3772
Name of Administrator: Kelley Self
Survey Exit Date: 8/17/2022

1. **Cited deficiency number: 420-5-4-.06 (11) (b) Care of Residents. (ID Prefix Tag A 621)**

   This Rule is not met as evidenced by: Based on record review and interview, the facility retained a resident in need of hospice services for a terminal diagnosis of dementia.

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

   Findings:
   The Alabama Department of Public Health received a complaint which alleged the facility had ineligible residents. The surveyor was able to substantiate this complaint during the onsite survey.

   RI#13 was admitted to the facility on December 18, 2019 and had diagnoses which included encephalopathy, muscle weakness, insomnia, dysphagia, hypertension, hypothyroidism, dementia without behaviors, Alzheimer's disease, heart failure and repeated falls. RI#13 passed away at the facility on August 9, 2022. RI#13 had received hospice services at the facility since February 4, 2021 until the time of death. Review of the Plan of Care for hospice revealed the primary Terminal Diagnosis for RI#13 was Alzheimer's disease with a Comorbidity of dementia without behavioral disturbance. RI#13 had been retained at the facility for 18 months in need of hospice services for a terminal diagnosis of dementia. When interviewed on August 17, 2022, EI#1 stated no discharge notice was issued to RI#13 and agreed RI#13 had not been appropriately discharged.

2. **Corrective action(s) in response to each resident or example identified in the SOD:** RI#13 is no longer residing in facility as of 8/9/2022.

3. **Corrective action(s) the facility will take to identify other residents or concerns not identified by the survey team that are related to those cited in SOD: No other resident is currently admitted onto hospice services with primary terminal diagnosis of Alzheimer's disease or Dementia.** HSD or Administrator/Designee will monitor the admitting diagnosis for all residents that we receive an order for hospice services.

4. **Measures/Changes put into place to ensure the same deficiency will not recur:** HSD or Administrator/Designee will monitor the admitting diagnosis for all residents going forward that facility receives an order for, for hospice services.

5. **How corrective action(s) will be monitored to ensure that they are fully implemented; adequately address the identified problems; and are effective:** Documentation of audits on all hospice admits will be kept in POC binder in Administrator's office.

Plan of Correction (POC): Page 10
Facility Name: Peachtree Assisted Living
Facility Identification Number: D3772
Name of Administrator: Kelley Self
Survey Exit Date: 8/17/2022

1. **Cited deficiency number: 420-5-4-.10 (2) Sanitation and Housekeeping. (ID Prefix Tag A 1002)**

   This Rule is not met as evidenced by: Based on observations and interview, the facility failed to maintain a safe and decent environment for residents.

Findings:

During a tour of the facility on August 16, 2022 with EI#6 and EI#7, the surveyor noted multiple resident rooms which contained stained, dirty carpet. In addition, the carpet in multiple resident rooms was frayed and torn at the entrance to the rooms, with loose strands of carpet, creating a fall hazard to the residents. During an interview on August 16, 2022, EI#1 stated the carpet in residents' rooms had been cleaned. However, the stained areas remained.

2. **Corrective action(s) in response to each resident or example identified in the SOD:** On 8/19/2022 ESD recleaned all carpets.

3. **Corrective action(s) the facility will take to identify other residents or concerns not identified by the survey team that are related to those cited in SOD:** ESD started obtaining quotes on 8/29/2022 to replace carpet with flooring.

4. **Measures/Changes put into place to ensure the same deficiency will not recur:** ESD/Designee will complete monthly audits on all carpets in resident rooms times 3 months and quarterly ongoing, until carpet replaced. Start date to replace carpet is 12/01/2022.

5. **How corrective action(s) will be monitored to ensure that they are fully implemented; adequately address the identified problems; and are effective:** Audits will be monitored by Administrator/Designee. All documentation will be kept in POC binder in Administrator's office.

Administrator's Signature: Kelley Self

Date: 8/30/2022