June 10, 2024

Plan of Correction
for
Facility Name: Specialty Care at Danberry at Inverness
Facility Identification Number: P3724
Name of Administrator: Jaclyn Gardner
Survey Exit Date: 05/01/2024

Deficiency 1

Cited deficiency: A 508

1. The corrective action(s) that community will take in response to deficiency A 508 includes but is not limited to in servicing of Directors and staff on State Regulations of reporting of reportable incidents to AL Department of Public Health within twenty-four hours of incident.

2. As a result of the cited deficiency A 508, the facility designee, conducted an in-service on 5/28/2024 to all Directors regarding twenty-four-hour state regulation reporting of incidents to ADPH.

3. The administrator or designee will monitor the progress of the procedures during the months of June, July, and August of 2024. A quarterly review will be conducted for two quarters beginning November 2024 to ensure that the corrective actions have been fully implemented and are adequately addressing the cited deficiency and it is an effective process. This monitoring will take place by the Director of Healthcare Services or designee.

4. Monitoring will be maintained in notebook in the Director of Healthcare Services Office.

Deficiency 2

Cited deficiency: A 605

1. The Director of Healthcare Services contacted the podiatrist of RI#5 on 4/30 for documentation of resident visit of 4/24/2024. Also, the Director of Healthcare Services notified the podiatrist that blister on heel had opened, causing a stage 2 pressure ulcer and requested an order for Home health to provide wound care, which was received. Home Health was immediately started for wound care. RI #5 was care planned for wound care of stage 2 pressure ulcer on heel, including any change to be reported immediately to nurse.

2. The corrective action(s) that community will take in response to deficiency A 605 includes but is not limited to Executive Director sending letters to all the sponsors by 5/31/2024 regarding taking the facility form "MD Visit Summary" any time they are taking a resident for a physician visit, including a Podiatrist or Dental visit and returning it to the nurse upon return to the community. A mandatory in-service was conducted with staff on 5/8/2024 regarding the importance of reporting any changes of status to the nurse. Staff also reeducated on importance of giving family MD Visit Summary form when resident is going to doctor, including Podiatrist and Dentist.

3. As a result of the cited deficiency A 605 a system will be put in place with one specific area and folder for any incoming documentation from MD by 5/31/2024. Weekly audits will be conducted to ensure oversite of completion of "MD Visit Summary" form by the Unit Coordinator or his or her designee.

4. The community will take corrective action to identify other concerns related to deficiency A 605 not identified by the surveyor by assuring that forms are being completed, brought back to community, and care planned as needed. A copy will be made of forms and given to the Director of Healthcare Services to assure each is completed and care planned (if applicable). This action will be monitored for three months by the Director of Healthcare Services or designee for June, July and August. Then quarterly for two quarters by the DOHS or designee as part of the community's quality assurance processes for determining regulatory compliance of processes and medical oversite of resident care.

5. Monitoring will be maintained in notebook in the Director of Healthcare Services Office.

Deficiency 3

Cited deficiency: A 611

1. The corrective action(s) that the community will take in response to deficiency A 611 RI2 includes but is not limited to updating care plan to include the use of weighted utensils and care associated with tremors. This was accomplished on 05/03/24by the Director of Healthcare Services.

2. The corrective action(s) that community will take in response to deficiency A 611 RI3 includes but is not limited to updating care plan to

include the risk of elopement. This was accomplished on 05/03/24 by the Director of Healthcare Services.

3. The community will take corrective action to identify other concerns related to deficiency A 611 not identified by the surveyor by performing an internal audit of all resident care plans to ensure that all care plans include items identified on medical plan of care has been addressed in resident care plan and update any that have deficiencies. This will be accomplished by 7/19/2024 by the Director of Healthcare Services and/or designee. All new admission care plans will be audited by the Director of Healthcare Services and/or designee for the following six months as part of the community's quality assurance processes to ensure that the corrective actions have been fully implemented and are adequately addressing the cited deficiency and it is an effective process.

4. Monitoring will be maintained in notebook in the Director of Healthcare Services Office.

Deficiency 4

1. Cited deficiency: A 802

2. The corrective action(s) that the community will take in response to deficiency A 802 includes but is not limited to staff education on requirements of assuring medication rooms are locked at all times which was in-serviced on 05/08/2024 by Director of Healthcare Services. New automatic locking locks have been ordered on 5/24/2024 and will be installed by maintenance upon their arrival to the community.

3. The community will monitor the progress of the procedures during its monthly quality assurance audits conducted by staff member as assigned by the Director of Healthcare Services (DOHS) or by the Director of Healthcare Services and/or his or herself to ensure that the corrective actions have been fully implemented and are adequately addressing the cited deficiency and it is an effective process. This monitoring will take place by staff assigned by the Director of Healthcare by assuring medication rooms are locked during a quality assurance process monthly or more frequently as needed for the following three months.

4. Evidence of medication room door checks will be maintained in notebook in the Director of Healthcare Services Office.

Deficiency 5

Cited deficiency: A 1001

1. The corrective action(s) that community has taken in response to deficiency A 1001 includes but is not limited to a verbal coaching session by Administrator Designee to the Director of Maintenance on 4/31/2024. A new policy outlining a log be maintained on a weekly basis of water temperature checks was instituted on 05/01/2024.

2. The community will take corrective action to identify other concerns related to deficiency A 1001 not identified by the surveyor by performing an internal audit of the log to assure water temperatures are being monitored and corrected as needed by the Director of Maintenance and/or designee on a monthly basis for the month of June, then quarterly for two quarters. The monitoring will be part of the community's quality assurance processes for determining regulatory compliance of processes.

3. Monitoring will be maintained in notebook in the Director of Healthcare Services Office.

Submitted By:

Jaclyn Gardner – Executive Director – Danberry at Inverness

Jaclyn Gardner 5/31/24

Executive Director