HERITAGE
ASSISTED LIVING & MEMORY CARE

POC Accepted 3.15.24
Connie Cherry
chg 03.26.24

March 15, 2024

Connie,

Per our conversation this morning here is the information you requested.

Attached is the POC for Heritage Assisted Living. I have signed and dated the POC.

All binders related to the survey will be kept in the Administrator's Office and will be available at any time for review.

Please let me know if you need any further information from us, we are glad to help.

Lori Moore
Executive Director
Heritage Assisted Living and Memory Care.

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Lori a Moore
3/15/24

Plan of Correction

Name of Provider	Street Address, City, State, Zip Code
Heritage Assisted Living	**11682 County Line Rd, Madison, AL 35656**
Provider Identification Number	Date Survey Completed
D4209	**8/10/2023**

1. **Cited Deficiency Number: 420-5-4-.03 (1) (a) (b) (c) (d) Administration**

A301 The Assisted Living Facility Governing Authority

a. **Corrective Action taken for each resident/ example identified in the SOD / frequency of action:**
Managing Director (EI#1) was terminated and replaced on 8/11/2023
Temporary administrator was hired on 8/3/2023
Management company was retained on 11/1/2023
Maintenance Director hired on 11/1/2023
Permanent administrator was hired on 12/4/2023
Permanent Registered Nurse hired on 12/4/2023
Consultant was hired on 12/4/2023

b. **Additional corrective actions for residents not identified or concerns/ frequency:**
Experienced administrator was hired for facility as well as experienced RN whom also holds a category II ALA license. Experienced consultant was hired at facility whom also holds a category II ALA license.

c. **Measures and changes put in place to ensure deficiency will not recur:**
Management company hired to ensure adherence to SBOH rules and regulations, additional staff hired (RN, consultant) whom also holds category II ALA license to ensure SBOH compliance. All managements contact numbers were posted at front desk, nurses station, and employee breakroom.

d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
Consultant to make weekly visits to ensure SBOH compliance, Management company to make monthly visits to ensure SBOH compliance.

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Name of Provider	Street Address, City, State, Zip Code
Heritage Memory Care	**11682 County Line Rd, Madison, AL 35656**
Provider Identification Number	Date Survey Completed
P4203	**8/10/2023**

1. **Cited Deficiency Number: 420-5-20-.03 – Administration**
   A301
   a. **Corrective Action taken for each resident/ example identified in the SOD / frequency of action:**
      Managing Director (EI#1) was terminated and replaced on 8/11/2023
      Temporary administrator was hired on 8/3/2023
      Management company was retained on 11/1/2023
      Maintenance Director hired on 11/1/2023
      Permanent administrator was hired on 12/4/2023
      Permanent Registered Nurse hired on 12/4/2023
      Consultant was hired on 12/4/2023
   b. **Additional corrective actions for residents not identified or concerns/ frequency:**
      An experienced administrator was hired for facility as well as experienced RN whom also holds a category II ALA license. Experienced consultant was hired at facility who also holds a category II ALA license.
   c. **Measures and changes put in place to ensure deficiency will not recur:**
      Management company hired to ensure adherence to SBOH rules and regulations, additional staff hired (RN, consultant) who also holds category II ALA license to ensure SBOH compliance. All managements contact numbers were posted at the front desk, nurses station, and employee breakroom.
   d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
      Consultant to make weekly visits to ensure SBOH compliance, Management company to make monthly visits to ensure SBOH compliance.

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1. **Cited Deficiency Number: 420-5-4-.03 (1) (a) (b) (c) (d) Administration**

A301 The Assisted Living Facility Governing Authority

a. **Corrective Action taken for each resident/ example identified in the SOD / frequency of action:**
   Managing Director (EI#1) was terminated and replaced on 8/11/2023
   Temporary administrator was hired on 8/3/2023
   Management company was retained on 11/1/2023
   Maintenance Director hired on 11/1/2023
   Permanent administrator was hired on 12/4/2023
   Permanent Registered Nurse hired on 12/4/2023
   Consultant was hired on 12/4/2023
b. **Additional corrective actions for residents not identified or concerns/ frequency:**
   Experienced administrator was hired for facility as well as experienced RN whom also holds a category II ALA license. Experienced consultant was hired at facility whom also holds a category II ALA license.
c. **Measures and changes put in place to ensure deficiency will not recur:**
   Management company hired to ensure adherence to SBOH rules and regulations, additional staff hired (RN, consultant) whom also holds category II ALA license to ensure SBOH compliance. All managements contact numbers were posted at front desk, nurses station, and employee breakroom.
d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
   Consultant to make weekly visits to ensure SBOH compliance, Management company to make monthly visits to ensure SBOH compliance.

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Provider Identification Number	Date Survey

302- The facility failed to follow its own policies and procedures.

a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**

Heritage's ADPH approved Policies and Procedure manual was copied and placed in memory Completed

D4209 **8/10/2023**

1. **Cited Deficiency Number: 420-5-4-.03 (1) (e) Administration**
   care facility. All staff will be retrained on the policy and procedure manual by February 29, 2024. Staff will be educated on the location of policies and procedure manual made easily accessible at nurse's station.

b. **Additional corrective actions for residents not identified or concerns / frequency:**
   Mandatory monthly employee in services will include continued education on policies and procedures.
   The mandatory staff meetings will take place on the 2nd Thursday of everything month at 2pm at Heritage Memory Care.

c. **Measures and changes put in place to ensure deficiency will not recur:**
   Employees who do not attend required training and inservices will be removed from schedule until training and education is completed.

d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
   Facility administrator will ensure all staff complete policy and procedure training by February 29, 2024.
   Facility administrator will ensure all staff attend mandatory in services and training.
   Facility administrator will track attendance of staff in training binder located in administrator's office.
   Facility consultant will attend monthly in services.
   Facility consultant will perform monthly checks on inservice binder to confirm employee compliance.

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2. **Cited Deficiency Number: 420-5-20-.03 (2) (a) – Administration**
   303- There was no administrative designee in writing.
   a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**
      Facility hired administrator on 12/4/2023.
      Facility hired full time Registered Nurse on 12/4/2023 that also holds a Category II Assisted Living Administrators license.
      Registered Nurse was placed as administrator designee on 12/4/2023.
      Required posted was placed at both nurses' stations, front desk, and facility break room.

   b. **Additional corrective actions for residents not identified or concerns / frequency:**
      All staff will be trained on administrator designee and location of phone numbers by January 31, 2024.

   c. **Measures and changes put in place to ensure deficiency will not recur:**
      Administrator designee documentation is placed at front desk, nurse's station, and employee breakroom throughout the facility.

   d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
      Administrator will ensure all required postings are present and in good condition at all times.
      Facility consultant will check monthly to ensure all required postings are present.
      In the event that the administrator or the administrator designee is not available, facility consultant will act as administrator designee.

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3. **Cited Deficiency Number: 420-5-4-.04 (1) (2) – Personnel**
   401-The facility was not staffed at all times by at least one individual certified in CPR.
   a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**
      Contract established with Go Rescue LLC to ensure all staff are CPR certified within 90 days of employment. Facility to complete employee file audit and ensure that all staff is CPR certified by March 31, 2024.

   b. **Additional corrective actions for residents not identified or concerns / frequency:**
      Monthly CPR class will be made available to any staff needed to be certified or recertified in CPR. All new staff will be CPR certified within 90 days of hire.
   c. **Measures and changes put in place to ensure deficiency will not recur:**
      All employee files will be audited with all required documentation and training in place by February 29, 2024. All new employee files will be signed on by administrator prior to first day of resident contact.
   d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
      Administrator will perform random monthly audit on 4 employee files to ensure all required documentation is in place.
      Consultant will perform monthly audit on 4 employee files to ensure all required documentation is in place.

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4. **Cited Deficiency Number: 420-5-20-.04 (3)– Personnel**
   402-Employees were not screened prior to hire and prior to resident contact.

a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**

All employee files will be audited and completed by February 29, 2024.

All employee screenings will be completed by February 29, 2024.

b. **Additional corrective actions for residents not identified or concerns / frequency:**
Prior to resident contact all new employee screenings will be completed and signed off by Administrator.

c. **Measures and changes put in place to ensure deficiency will not recur:**
Administrator will oversee all employee screenings to ensure they are completed and in file prior to resident contact.

d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**

The administrator will conduct random monthly audits on 4 employee files to ensure all screenings are present in file until next survey starting 3/1/2024.

The Facility Consultant will conduct random monthly audits on 4 employee files to ensure all screenings are present in file until next survey starting 3/1/2024.

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5. **Deficiency Number: 420-5-4-.04 (6) – Personnel**
   405- Employees were not properly trained
   a. **Corrective action taken for each resident/example identified in the SOD / frequency of action:**
      Employee file audits will be completed by February 29, 2024.
      All staff will receive the required training and documentation by 2/29/2024.
   b. **Additional corrective actions for residents not identified or concerns / frequency:**
      Facility will conduct mandatory monthly inservices on the 2nd Thursday of every month. Facility administrator will ensure all staff complete and sign monthly inservice binder located in administrator's office. If employee does not complete mandatory monthly training, employee will be removed from schedule until training is complete.
      Administrator will perform a file audit on all new hired employees to ensure properly training and documentation is in place prior to resident contact.
   c. **Measures and changes put in place to ensure deficiency will not recur:**
      All employee files will be audited with all required documentation and training in place by 2/29/2024.
      All new employee files will be signed on by administrator prior to first day of resident contact.

   d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
      Administrator will perform random monthly employee file audits on 4 employee files to ensure all required documentation is in place until next survey.
      Consultant will perform monthly audit on 4 employee files to ensure all required documentation is in place until next survey.

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6. **Cited Deficiency Number: 420-5-4-.05 – (3) (d) Records and Reports**

   504- The facility failed to provide a safe and decent environment for residents at all times. Agency phone numbers and the most recent survey results were not cited.

   a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**
      Copies of agency phone numbers were placed at front desk and both nurses' stations. Copies of the most recent survey results were placed at front desk and both nurse's stations.
   b. **Additional corrective actions for residents not identified or concerns / frequency:**
      All staff will be in serviced by 1/31/2024 on location of Agency phone numbers and location of most recent survey.
   c. **Measures and changes put in place to ensure deficiency will not recur:**
      Additional copies of Agency numbers and most recent survey results were placed at the front desk and also in addition they were placed in binders at both nurse's stations, and label for everyone to be able to see at all times.
   d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
      The administrator will make monthly rounds to ensure all areas have required postings easily accessible for all residents, guests, and employees until next survey.
      Consultant will make monthly rounds to ensure all areas have required postings easily accessible for all residents, guest, and employees until next survey.

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7. **Cited Deficiency Number: 420-5-4-.05 – (3) (e) Records and Reports**

505- Financial Agreements were not completed for residents upon admission.

a. **Corrective action taken for each resident/example identified in the SOD / frequency of action:**
All financial agreements will be audited by March 1, 2024.
Missing financial agreements will be completed by March 31, 2024.

b. **Additional corrective actions for residents not identified or concerns / frequency:**
All financial agreements will be audited by March 1, 2024.
Any resident with a missing financial agreement will be completed by March 31, 2024.

c. **Measures and changes put in place to ensure deficiency will not recur:**
All financial agreements going forward will be completed prior to admission to facility and signed off by administrator.

d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
The administrator will complete a random monthly audit of 2 resident charts to ensure that all financial agreements are in place until next survey.
The consultant will complete monthly random audits of 2 resident charts to ensure that all financial agreements are in place until next survey.

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8. **Cited Deficiency Number: 420-5-4-.05 – (3) (f) Records and Reports**

506- Personal Effects Inventories were not completed upon admission of residents.

a. **Corrective action taken for each resident/example identified in the SOD / frequency of action:**
All personal effects inventories will be audited by March 1, 2024.
Missing personal effects inventories will be completed by March 1, 2024.

b. **Additional corrective actions for residents not identified or concerns / frequency:**
All personal effects inventories will be audited by March 1, 2024.
Any resident with a missing personal effects inventory sheet will be completed and signed by administrator and resident/sponsor by March 1, 2024.

c. **Measures and changes put in place to ensure deficiency will not recur:**
All financial agreements going forward will be completed prior to admission to the facility and signed off by the administrator.

d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
The administrator will complete a random monthly audit of 2 resident charts to ensure that all financial agreements are in place until next survey.
The consultant will complete monthly random audits of 2 resident charts to ensure that all financial agreements are in place until next survey.

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9. **Cited Deficiency Number: 420-5-4-.05 – (3) (g) Records and Reports**
   507- Residents' admission records were incomplete.
   a. **Corrective action taken for each resident/example identified in the SOD / frequency of action:**
      All resident admission records will be audited by March 1, 2024.
      Missing resident admission records will be completed by March 1, 2024.

   b. **Additional corrective actions for residents not identified or concerns / frequency:**
      All resident admission records will be audited by March 1, 2024.
      Any resident with a missing resident admission record will be completed by March 1, 2024.

   c. **Measures and changes put in place to ensure deficiency will not recur:**
      All resident admission records going forward will be completed prior to admission to the facility and signed off by administrator.

   d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
      The administrator will complete a random monthly audit of 2 resident charts to ensure that all resident admission records are in place before the next survey.
      The consultant will complete monthly random audits of 2 resident charts to ensure that all resident admission records are in place until next survey.

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10. **Cited Deficiency Number: 420.5.4-.05 (3)(h) – Records and Reports**
    508- Incidents were not reported to ADPH.

a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**
All staff will in serviced on incidents that are reportable to ADPH by February 8, 2024.
Administrator and facility RN will be responsible for submitting all ADPH reports.

b. **Additional corrective actions for residents not identified or concerns / frequency:**
All staff will be trained by February 8, 2024, on notifying on call administration of any incidents related to residents.
All staff will be trained by February 8, 2024, on completing a communication log located at the nurse's station to include any incidents that took place during shift.

c. **Measures and changes put in place to ensure deficiency will not recur:**
Administrator and facility RN are designated to complete all required incident reporting.

d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
Administrator and RN will communicate daily on incidents and change of conditions that are being logged in the communication notebook. Staff will be trained by February 8, 2024, on what to put into the incident logbook and how to write an incident report.

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11. **Cited Deficiency Number: 420-5-4-.06 (1) – Care of Residents**
    601- Physician's orders were not followed for the resident's medication administration.
    a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**
    Match back on all residents will be completed by February 29, 2024, to ensure all orders match the order, MAR, and medication label. The initial match back will be done by Guardian Pharmacy and then on a weekly basis by third shift nurses until next survey. RN will check monthly to make sure this is being completed properly.
    b. **Additional corrective actions for residents not identified or concerns / frequency:**
    Facility RN will receive a copy of all orders to ensure that they are recorded correctly to ensure all orders match with the physician order, medication administration log, and medication label.
    c. **Measures and changes put in place to ensure deficiency will not recur:**
    Facility RN will receive and review all orders to ensure all orders are properly recorded.
    d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
    Administrator will complete random match back on 4 residents per month for 4 months and then 2 per month until next survey. Consultant will complete 2 random match backs per month until next survey.

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

602- Residents' Medical Examinations were incomplete or not completed at all.

a. **Corrective action taken for each resident/example identified in the SOD / frequency of action:**
All resident medical examinations will be audited by January 31, 2024.
Missing medical examinations will be completed by January 31, 2024.

b. **Additional corrective actions for residents not identified or concerns / frequency:**
All resident medical examinations will be audited 1/31/2024.
Any resident with a missing resident medical examination will be completed by January 31, 2024.

c. **Measures and changes put in place to ensure deficiency will not recur:**
All resident medical examinations going forward will be completed prior to admission to the facility and signed off by administrator.

d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
The administrator will complete a random monthly audit of 2 resident charts to ensure that all resident medical examinations are in place until next survey.
The consultant will complete monthly random audits of 2 resident charts to ensure that all resident medical examinations are in place until next survey.

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13. **Cited Deficiency Number: 420-5-4-.06 (3) (a) (b) Care of Residents**
    604- Health supervision and assessments of residents were inadequate.
    a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**
    Facility RN was hired on 12/4/2024 whom also holds a Category II Alabama Assisted Living License.
    Facility hired RN consultant to complete PSMS during time of survey with three residents being inappropriate for continued stay. All three inappropriate residents were given 30 day discharge notices and were discharged from facility.
    The dietician will review all weights and care plans during scheduled visit in February 2024. Dietician will make quarterly visits to facility starting February2024 and will return to facility quarterly. If resident has a weight change or change of condition, facility dietician will be available via phone and email.
    All staff will be trained by 02/08/24 on completing the communication log located at the nurse's station to include any incidents that took place during shift.

    b. **Additional corrective actions for residents not identified or concerns / frequency:**
    All residents will receive a base line weight by 1/18/2024.
    The dietician will review all weights and care plans during a scheduled visit in February 2024. The Dietician will make quarterly visits to the facility starting in February 2024 and will return to facility quarterly. If resident has a weight change or change of condition, facility dietician will be available via phone and email.
    c. **Measures and changes put in place to ensure deficiency will not recur:**
    Communication logs were put in place at nurse's station for staff to communicate any changes of condition with facility RN checking communication log at the beginning of every shift.
    d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
    The administrator will review 4 assessments monthly completed by facility RN for 3 months starting on 2/1/2024, after 3 months Administrator will review 2 assessments per month until next survey.

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14. **Cited Deficiency Number: 420-5-4-.06 (4) (a) (b) Care of Residents**
    611- Residents' care plans were not current or non-existent.
    a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**
    All residents will have appropriate care plan to details residents' specific needs by January 31, 2024.
    b. **Additional corrective actions for residents not identified or concerns / frequency:**
    All care plans will be reviewed and revised by facility RN to ensure all residents have specific care plan for their needs by February 23, 2024.
    c. **Measures and changes put in place to ensure deficiency will not recur:**
    Facility RN will check orders, and communication log on Tuesdays and Thursdays to ensure all orders and resident's needs are placed on care plan.
    d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
    Administrator will complete random care plan audits on 4 residents per month for 4 months and then 2 per month until next survey.
    Consultant will complete 2 random care plan audits per month until next survey.

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15. **Cited Deficiency Number: 420-5-4-.06 (5) (a) (b) (c) (d) (e) Care of Residents**

613-A resident who was unable to protect himself/herself from a medication error was not promptly discharged. No licensed nurse was provided to administer medications to a resident who could not protect himself/herself froma medication error.

a. **Corrective action taken for each resident/example identified in the SOD / frequency of action:**
All residents will be assessed for appropriateness by facility RN by 1/31/2024.
Anyone found to be unable to protect him/herself from a medication will be given a 30-day discharge notice and have medication administered by licensed nurse until resident is discharged.

b. **Additional corrective actions for residents not identified or concerns / frequency:**
All residents will be assessed for appropriateness by facility RN by 1/31/2024.
Anyone found to be unable to protect him/herself from a medication will be given a 30-day discharge notice and have medication administered by licensed nurse until resident is discharged.

c. **Measures and changes put in place to ensure deficiency will not recur:**
Staff nurses will perform all monthly medication awareness testing. Facility RN to take med cart once monthly to check awareness of resident's medication awareness.
All nurse's/medication assistance will be trained in medication awareness testing by February 16, 2024.

d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
Facility administrator will perform 4 monthly medication awareness testing per month until the next survey.
Facility consultant will perform 4 monthly medication awareness testing per month until the next survey.

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16. Cited Deficiency Number: 420-5-4-.06 (5) (f) (g) (6) (7) (a)-(i) Care of Residents

614- Residents were not given the opportunity to identify their medications.

a. **Corrective action taken for each resident/example identified in the SOD / frequency of action:**
All Nurse's/Medication Assistance will be trained by facility RN on medication assistance by 2/16/2024.

b. **Additional corrective actions for residents not identified or concerns / frequency:**
All Nurse's/Medication Assistance will be trained by facility RN on medication assistance by 02/16/2024.
All Nurse's/Medication Assistance will be able to demonstrate proper medication assisting by 2/16/2024.

c. **Measures and changes put in place to ensure deficiency will not recur:**
Facility RN will observe medication assisting at least once weekly until next survey to ensure staff and resident compliance.
The administrator will observe medication assisting at least once monthly until next survey.

d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
Facility RN will observe medication assisting weekly until next survey to ensure staff and resident compliance.
The administrator will observe medication assisting monthly until next survey.
Consultant will observe medication assisting monthly until next survey.

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

616- A system was not maintained to account for controlled substances in the facility's possession.

a. **Corrective action taken for each resident/example identified in the SOD / frequency of action:**
Facility acquired controlled substances possession log from Guardian pharmacy.
All nurse's/medication assistance will be trained on controlled substance possession and counting by facility RN by 1/12/2024.

b. **Additional corrective actions for residents not identified or concerns / frequency:**
Facility acquired controlled substances possession log from Guardian pharmacy.
All nurse's/medication assistance will be trained on controlled substance possession and counting by facility RN by 1/12/2024.

c. **Measures and changes put in place to ensure deficiency will not recur:**
Facility acquired controlled substances possession log from Guardian pharmacy.
All nurse's/medication assistance will be trained on controlled substance possession and counting by facility RN by 1/12/2024.
Facility RN will observe a change of shift, controlled substance possession count weekly until next survey.
Facility RN will review all medication possession logs weekly for staff compliance.

d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
Facility RN will observe a change of shift, controlled substance possession counts weekly until next survey.
Facility RN will review all medication possession logs weekly for staff compliance.
Administrator will review all medication possession logs monthly for staff compliance until next survey.

The administrator will observe change of shift, controlled substance possession count monthly until next survey.
The consultant will review all medication possession logs monthly for staff compliance until next survey.
Consultant will observe a change of shift, controlled substance possession counts monthly until next survey.

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18. **Cited Deficiency Number: 420-5-4-.06 (11) (b) Care of Residents**
621- The facility retained a resident who was unable to direct his/her own care and required skilled nursing care to administer medications.

    a. **Corrective action taken for each resident/example identified in the SOD / frequency of action:**
    All residents will be assessed for appropriateness by facility RN by 1/31/2024.
    Anyone found to be unable to direct his/her own care will be given a 30-day discharge notice and have medication administered by a licensed nurse until the resident is discharged.

    b. **Additional corrective actions for residents not identified or concerns / frequency:**
    All residents will be assessed for appropriateness by facility RN by 1/31/2024.
    Anyone found to be unable d will be given a 30-day discharge notice direct his/her own care and have medication administered by licensed nurse until resident is discharged.

    c. **Measures and changes put in place to ensure deficiency will not recur:**
    Facility RN will assess all residents monthly to ensure all residents are able to direct his/her own care if resident is unable to direct his/her own care they will be given a 30-day discharge notice and medications will be administered by licensed nurse.
    All nurse's/medication assistants will be trained in medication awareness testing by facility RN by 1/31/2024.

    d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
    Facility RN will observe medication assisting weekly until next survey to ensure staff and resident compliance.
    Administrator will observe medication assisting weekly until next survey.
    Consultant will observe medication assisting weekly until next survey.
    Administrator will review monthly assessments to ensure resident appropriateness until next survey.
    Consultant will review monthly assessments to ensure resident appropriateness until next survey.

Plan of Correction

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Heritage Assisted Living	**11682 County Line Rd, Madison, AL 35656**
Provider Identification Number	Date Survey Completed
D4209	**8/10/2023**

19. **Cited Deficiency Number: 420-5-4-.07 (3) – Food Services**
703- The facility's food supply was inadequate resulting in weight loss to four residents. Portions of food served to residents were inadequate. Snacks were not provided to residents. Weekly menu and meal times were not posted.

a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**

Experienced Food Services Director was hired on 7/24/2023.

Food vendor WoodFruitcher started providing services on 7/26/2023 with deliveries twice per week.

Dietician will review all portion sizes to ensure adequate amounts.

The dietician will review all weights and care plans during scheduled visit in February 2024.

Dietician will make quarterly visits to facility starting in February 2024 and will return to facility quarterly. If resident has a weight change or change of condition, facility dietician will be available via phone and email.
Snacks have been made available and accessible to all residents.
All staff will be educated on ensuring snacks are stocked prior to leaving shift by 1/31/2024.
The weekly menu and mealtimes were posted in the dining room.

b. **Additional corrective actions for residents not identified or concerns / frequency:**
The dietician will review all weights and care plans during scheduled visit in February 2024.
Dietician will make quarterly visits to facility starting in February 2024, and will return to facility quarterly. If resident has a weight change or change of condition, facility dietician will be available via phone and email.
Snacks have been made available and accessible to all residents.
All staff will be educated on ensuring snacks are stocked prior to leaving shift by 1/31/2024.
Weekly menu and meal times were posted in dining room.

c. **Measures and changes put in place to ensure deficiency will not recur:**
Administrator will make daily rounds in dining room to ensure portion sizes are adequate.

All staff will be in serviced on portion sizes and snack availability by 1/31/2024.

d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
Administrator will ensure that all weekly food deliveries arrive on time and are accurate portions for the number of residents in facility.
The administrator will make twice weekly random checks to ensure snacks are readily available and easily assessable to all residents until next survey.
Consultant will make weekly check to ensure snacks are readily available and easily assessable to all resident until next survey.

Plan of Correction

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20. **Cited Deficiency Number: 420-5-4-.08 (4) – Physical Facilities**
    804- A refrigerator was not properly maintained.
    a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**
    Refrigerator was defrosted.
    Refrigerator log placed in protective sleeve and adhered to refrigerator.
    Maintenance Director will perform weekly refrigerator checks and will defrost if found with excessive ice/frost build up.
    First shift will be responsible for ensuring refrigerator temperatures and checked and recorded daily.
    All staff will be in serviced on completing refrigerator logs during shift by 2/8/2024.
    b. **Additional corrective actions for residents not identified or concerns / frequency:**
    Maintenance Director will make weekly checks to ensure that staff is properly recording refrigerator temperature.
    c. **Measures and changes put in place to ensure deficiency will not recur:**
    Second shift will also check refrigerator temperature and document only if first shift failed to do so.
    All staff to be in serviced by 2/8/2024 on refrigerator logs and notifying maintenance if any problem associated with refrigerators.
    d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
    The administrator will make twice weekly rounds to check refrigerator temperature log for completion and accuracy for 30 days and then will make weekly checks until next survey.
    Consultant will make weekly checks of all refrigerators and refrigerator logs until next survey.

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D4209	**8/10/2023**

21. **Cited Deficiency Number: 420-5-4-.11 (1) – Fire and Safety**
    1101- Fire drills were not conducted as required.
    a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**
    Starting August 2023, fire drills began being conducted monthly by maintenance director and will alternate between shifts with each shift having a fire drill conducted quarterly.
    b. **Additional corrective actions for residents not identified or concerns / frequency:**
    All staff will be trained in fire evacuation and be able to demonstrate proficient knowledge of resident egress during fire drills by 02/08/2024.
    c. **Measures and changes put in place to ensure deficiency will not recur:**
    Administrator will be present at all monthly fire drills to ensure staff have proficient knowledge and residents can egress to safety. If maintenance director is not available to conduct monthly drill administrator will conduct fire drill.
    d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
    The administrator will be present at all monthly fire drills for 3 months to ensure staff have proficient knowledge and residents can egress to safety until next survey.
    Monthly fire drill documentation will be completed by maintenance director monthly at the time of fire drill.
    All fire drill documentation will be placed in fire safety binder kept in administrators' office.
    Administrator will check all documentation at the time of drill to ensure it is completed in its entirety.
    Consultant will check monthly to ensure all fire drill completed as well as documented until next survey.

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D4209	**8/10/2023**

22. **Cited Deficiency Number: 420-5-4-.12 (5) – Physical Environment**
    1203- Fire extinguishers were not checked monthly.

    a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**
    Facility hired maintenance director on 11/1/2023 to complete monthly fire extinguisher checks.
    On 11/1/2023 maintenance director completed fire extinguisher checks and will continue to complete monthly.

    b. **Additional corrective actions for residents not identified or concerns / frequency:**
    Administrator will perform monthly checks on all fire extinguisher.

    c. **Measures and changes put in place to ensure deficiency will not recur:**
    Both administrator and maintenance director will ensure all fire extinguishers are checked monthly and recorded on attached tag. If the tag becomes detached or fire extinguisher is not in compliance, facility will contact Global Fire and have a replacement delivered immediately.

    d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
    Administrator and Maintenance Director will both document all fire extinguisher checks on the log attached to the fire extinguisher.
    Consultant will make random monthly checks to ensure all fire extinguishers are checked and documented until next survey.