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 Memory Care. 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 A. Moore
Lori Moore
Executive Director
Heritage Assisted Living and Memory Care.

11682 COUNTY LINE ROAD, MADISON, AL 35756.
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Lori a Moore
3/15/24

Plan of Correction

Name of Provider

Heritage Memory Care

Provider Identification Number

P4203

Street Address, City, State, Zip Code

11682 County Line Rd, Madison, AL 35656

Date Survey Completed

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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2. **Cited Deficiency Number: 420-5-20-.03 – Administration**
   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 care facility. All staff will be retrained on policy and procedure manual by January 31, 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 in-services 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 8, 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.
      The facility consultant will perform monthly checks on in-service binder to confirm employee compliance.

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3. **Cited Deficiency Number: 420-5-20-.03 – 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 1/31/2024.

   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 always present and in good condition.
      The facility consultant will check monthly to ensure all required postings are present.
      If the administrator or the administrator designee is not available, facility consultant will act as administrator designee.

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4. **Cited Deficiency Number: 420-5-20-.04 – 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 classes will be made available to any staff needing 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 by administrator prior to first day of resident contact.
   d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
      The administrator will perform a random monthly audit on 4 employee files to ensure all required documentation is in place.
      The consultant will perform a monthly audit on 4 employee files to ensure all required documentation is in place.

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5. **Cited Deficiency Number: 420-5-20-.04 – 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 March 1, 2024.

All employee screenings will be completed by March 1, 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 the Administrator.

c. **Measures and changes put in place to ensure deficiency will not recur:**
The 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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6. **Deficiency Number: 420-5-20-.04 (6) (7) (8) – Personnel**
   405-There was no RN to devote adequate time to complete RN duties.
   a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**
      Full time facility RN hired on 12/4/2023.
      Full time facility RN also holds Category II Alabama Assisted Living Administrators License.
   b. **Additional corrective actions for residents not identified or concerns / frequency:**
      Facility hired management company on 11/1/2024. If RN is unable to complete RN duties, Vice President of Clinical Operations will assist in completing RN duties.
   c. **Measures and changes put in place to ensure deficiency will not recur:**
      The administrator will review SCALF assessments monthly to ensure that they are completed, and all residents are appropriate for continued stay.
   d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
      The monthly assessment will be completed on all residents' monthly and kept in the Director of Resident Service's office.
      The administrator will review 4 assessments completed by RN for 3 months and then will perform random audits of 1 residents' assessment per week until next survey.
      The administrator will review all residents' PSMS monthly.
      The consultant will review all assessments completed by RN monthly.
      Vice President of Clinical Operations will review 6 random resident's assessments completed by facility RN every 3 months until next survey, starting 3/1/2023.

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7. **Cited Deficiency Number: 420-5-20-.04 (9) – Personnel**
   406- 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 3/1/2024.
      All staff will receive required training and documentation by 03/01/2024.
   b. **Additional corrective actions for residents not identified or concerns / frequency:**
      The facility will conduct mandatory monthly in-services on the 2nd Thursday of every month.
      The facility administrator will ensure all staff complete and sign monthly in-service binder located in administrator's office. If an employee does not complete mandatory monthly training, the employee will be removed from schedule until training is complete.
      The administrator will perform a file audit on all newly 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 03/01/2024.
      All new employee files will be signed by administrator prior to first day of resident contact.
   d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
      The administrator will perform random monthly employee file audits on 4 employee files to ensure all required documentation is in place until next survey.
      The consultant will perform monthly audit on 4 employee files to ensure all required documentation is in place until next survey.

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8. **Cited Deficiency Number: 420-5-20-.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 the 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 the 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 labeled for everyone to be able to see at all times.
   d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
      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, guests, and employees until next survey.

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9. **Cited Deficiency Number: 420-5-20-.05 – 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 be in-serviced on incidents that are reportable to ADPH by 02/08/2024.
   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 02/08/2024 in notifying on call administration of any incidents related to residents.
   All staff will be trained by 02/08/2024 on completing 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:**
   The administrator will make rounds twice weekly and check communication log located at nurse's station for incidents and changes of condition until next survey.

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10. **Cited Deficiency Number: 420-5-20-.06 – 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:**
    e. 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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11. **Cited Deficiency Number: 420-5-20-.06 – Administration(3) (a) (b) (c) (d) € 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 the facility.
    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 a resident has a weight change or change of condition, facility dietician will be available via phone and email.
    All staff will be trained by 02/08/2024 on completing 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 a 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 each day.

    d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
    Administrator will review all assessments 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.
    The administrator will review all residents monthly PSMS and Behavior Screening each month until next survey.

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12. **Cited Deficiency Number: 420-5-20-.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 an appropriate care plan to detail 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 January 31, 2024.
    c. **Measures and changes put in place to ensure deficiency will not recur:**
    Facility RN will check orders, and communication log on Tuesday's 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:**
    The 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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13. **Cited Deficiency Number: 420-5-20-.06 (5) (i) (j) (K) (l) (m) – Care of Residents**
616- The facility failed to maintain a system to account for controlled substances in its possession.

a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**
All staff will be in-serviced on controlled substances and designated staff accountable for controlled substances by 1/31/2024.
The narcotic count log form was supplied by pharmacy and is being used by nursing staff to ensure proper controlled substance count.

b. **Additional corrective actions for residents not identified or concerns / frequency:**
All staff will be in-serviced on controlled substances and designated staff accountable for controlled substances by 1/31/2024.
The narcotic count log form was supplied by pharmacy and is being used by nursing staff to ensure proper controlled substance count.

c. **Measures and changes put in place to ensure deficiency will not recur:**
Facility RN will review all controlled substances logs daily to ensure they are completed, and a designated staff member was in possession of controlled substances during shift.

d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
The administrator will review controlled substance possession logs weekly for 3 months and then monthly until next survey.
Facility consultant will review controlled substance possession logs monthly until next survey.

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14. **Cited Deficiency Number: 420-5-20-.06 (6) – Care of Residents**
617- Medication disposition was not adequately documented following discharge of residents. Medications of a resident who had been discharged were not destroyed timely.
    a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**
    All nursing staff will be in serviced on medication disposition by 1/31/2024.
    The medication disposition form was supplied by pharmacy and is being used by nursing staff to ensure all medications are properly disposed with 30 days of resident discharge or order change.
    b. **Additional corrective actions for residents not identified or concerns / frequency:**
    All nursing staff will be in serviced on medication disposition by 1/31/2024.
    The medication disposition form was supplied by pharmacy and is being used by nursing staff to ensure all medications are properly disposed with 30 days of resident discharge or order change.

    c. **Measures and changes put in place to ensure deficiency will not recur:**
    Facility RN will receive all medications that need to be disposed of by nursing staff once the order has been changed or resident is discharged.
    Medications will be properly disposed of and recorded within 30 days of medication change or discharge of resident.
    d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
    The administrator will review medication disposition records monthly until next survey.
    Facility consultant will review medication disposition records monthly until next survey.

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15. **Cited Deficiency Number: 420-5-20-.06 (9) (b) – Care of Residents**
621- Residents were retained at the facility who did not meet the requirements for residents of a SCALF.
    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.
    All staff will be trained upon hire in the continued stay criteria by 1/31/2024.
    All staff will be trained by 1/31/2024 on completing a communication log located at the nurse's station to include any incidents and changes of condition that took place during shift.
    All staff will be in serviced on admission and continued stay by 1/31/2024.
    b. **Additional corrective actions for residents not identified or concerns / frequency:**
    Facility hired RN consultant to complete PSMS on all residents to ensure they were still eligible for continued stay during survey.
    Facility hired full time Registered Nurse who also holds a Category II Assisted Living License.
    c. **Measures and changes put in place to ensure deficiency will not recur:**
    Additional PSMS will be completed on all residents by 1/31/2024 by facility RN.
    Facility shall not retain a resident that has a PSMS score greater than 23 or a score of five in feeding, dressing, grooming, bathing or a score of four or five in physical ambulation.
    d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
    Facility RN to complete PSMS and BS on all residents by 1/31/2024.
    Facility will perform quarterly PSMS and BS screenings until next survey.
    Administrator will review all PSMS and BS screenings once completed by 1/31/2024.
    Administrator will review PSMS and BS screenings once quarterly once completed by Facility RN.
    Nurse Consultant will review all PSMS and BS screenings every quarter once completed by Facility RN.

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16. **Cited Deficiency Number: 420-5-20-.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.

The dietician will review all portion sizes to ensure adequate amounts.

The dietician will review all weights and care plans during a scheduled visit in 02/2024.

The Dietician will make quarterly visits to the facility starting 02/2024 and will return to facility quarterly. If a resident has a weight change or change of condition, facility dietician will be available via phone and email.
Snacks were made available at all times and accessible to all residents.
All staff will be educated on ensuring snacks are stocked prior to leaving shift by 02/08/2024.
Weekly menu and mealtimes were posted in dining room.

b. **Additional corrective actions for residents not identified or concerns / frequency:**
The dietician will review all weights and care plans during a scheduled visit in 02/2024.
The Dietician will make quarterly visits to the facility starting 02/2024 and will return to facility quarterly. If a resident has a weight change or change of condition, facility dietician will be available via phone and email.
Snacks were made available at all times 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 mealtimes were posted in dining room.

c. **Measures and changes put in place to ensure deficiency will not recur:**
The 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 02/08/2024.

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

The administrator will ensure that all weekly food deliveries arrive on time and are accurate portions for the number of residents in the facility.

The administrator will make 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.

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17. **Cited Deficiency Number: 420-5-20-.08 – Physical Facilities**
    804- A refrigerator was not properly maintained.
    a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**
    The refrigerator was defrosted.
    Refrigerator log placed in protective sleeve and adhered to refrigerator.
    The Maintenance Director will perform weekly refrigerator checks and will defrost if found with excessive ice/frost build up.
    The 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 1/31/2024.
    b. **Additional corrective actions for residents not identified or concerns / frequency:**
    The 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 2/08/2024 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:**
    Administrator will make daily 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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18. **Cited Deficiency Number: 420-5-20-.11 – 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 1/31/2024.
    c. **Measures and changes put in place to ensure deficiency will not recur:**
    The administrator will be present at all monthly fire drills to ensure staff have proficient knowledge and residents can egress to safety. If the 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 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 the fire safety binder kept in administrators' office.
    The 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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19. **Cited Deficiency Number: 420-5-20-.12 – Physical Enviroment**
    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:**
    The 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 extinguisher 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.

Plan of Correction

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**

20. **Cited Deficiency Number: 420-5-20-.12 – Physical Environment**
    1206- Exit door locks did not release automatically upon activation of the fire alarm system.
    a. **Corrective Action taken for each resident/example identified in the SOD / frequency of action:**
    Global Fire evaluated the issue with exit door locks not releasing on 1/4/2024 and they stated that issue was related to access control panel.
    Access Control Solutions and Building Systems Technologies were contacted and will evaluate and repair issues by 2/29/2024 or sooner if all parts and supplies are readily available for installation.
    b. **Additional corrective actions for residents not identified or concerns / frequency:**
    Global Fire evaluated the issue with exit door locks not releasing on 1/4/2024 and they stated that issue was related to access control panel.
    Access Control Solutions and Building Systems Technologies were contacted and will evaluate and repair issues by 2/29/2024 or sooner if all parts and supplies are readily available for installation.

    c. **Measures and changes put in place to ensure deficiency will not recur:**
    The Maintenance Director will check all egress doors during monthly fire drill.
    d. **Monitoring of corrective actions and staff accountable/ frequency and location of logs:**
    The administrator will check all egress doors during monthly fire drill.
    The consultant will check all egress doors and documentation monthly.