POC Accepted 12.17.24

Connie Cherry

Plan of Correction

Facility Name:	Heritage SCALF
Facility ID Number:	P4203
Name of Administrator:	Lori Moore
Survey Exit Date:	11/20/2024

1. **Cited Deficiency Number: 420-5-20-.05 (3)(d) Records and Reports – Person Centered Care- A504**

2. **Corrective action taken for each Resident/example identified in the SOD/frequency of action:**
   Three times daily and four times daily medications have been scheduled for specific times effective 11/21/24. Three times daily= 8:00am, 2:00pm, 8:00pm and four times daily= 8:00am, 12:00pm, 4:00pm and 8:00pm. This was put in place on 11/21/24 by the Director of Resident Services and Guardian Pharmacy Representative, Samone Miller. The medication times were fixed in the EMAR to reflect the changes above.

3. **Additional corrective action(s) that the facility will take to identify other residents or concerns:**
   All nurses and medication technicians were retrained on the new medication times on 11/21/24 by Samone Miller of Guardian Pharmacy.

4. **Measures and changes put in place to ensure deficiency will not recur.**
   All pharmacy orders will have the new scheduled medication times in place when the facility receives medications from Guardian Pharmacy. This went into effect on 11/21/24.

5. **Monitoring of corrective actions and staff accountability/frequency and location of logs:**
   The Director of Resident Services (DORS) or her representative will review all new orders to verify correct times. The third shift nurse will check all incoming meds for correctness nightly against what the EMAR says. The EMAR will be checked weekly by the DORS or her representative to make sure all medications are given correctly. If there is an error that has occurred, the staff member making the error will be taken off the schedule until they can be reeducated by proper procedure. A random audit of 5 residents will be performed by the DORS monthly for 9 months to ensure TID and QID medications are at scheduled times. After the 9-month period the DORS and the ED will evaluate that the corrective actions put in place are effective, and if determined effective will no longer record random audits. The nightly audits and weekly EMARS will continue but no longer be recorded after the nine (9) month period.

Lori A Moore
Executive Director
12/14/24

Plan of Correction

Facility Name:	Heritage SCALF
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Name of Administrator:	Lori Moore
Survey Exit Date:	11/20/2024

1. **Cited Deficiency Number: 420-5-20-.06 (2)(a)(b)(c)- Care of Residents – Medical Examination Record – A602**

2. **Corrective action taken for each Resident/example identified in the SOD/frequency of action:**
   Vital signs and weight were in the EMAR from annual physical and were transferred to Medical Plan of Care Form upon finding by surveyors.

3. **Additional corrective action(s) that the facility will take to identify other residents or concerns:**
   All Medical Plans of Care will be reviewed by Director of Resident Services upon admission and on annual physicals.

4. **Measures and changes put in place to ensure deficiency will not recur.**
   All Medical Plan of Cares for new residents or returning residents or annual physicals will be verified by the Director of Resident Services or her representative before the resident may enter the community.

5. **Monitoring of corrective actions and staff accountability/frequency and location of logs:**
   The Director of Resident Services (DORS) or her representative will check all Medical Plan of Cares to make sure that all required information is complete and dated. The DORS will audit 4 charts monthly for correctness of the Medical Plan of Care. The Administrator will review the documents monthly for 12 months then quarterly after that.

Lori a Moore
Executive Director
12.14.24

Plan of Correction

Facility Name:	Heritage SCALF
Facility ID Number:	P4203
Name of Administrator:	Lori Moore
Survey Exit Date:	11/20/2024

1. **Cited Deficiency Number: 420-5-20-.07 (1)- Food Service – A701**

2. **Corrective action taken for each Resident/example identified in the SOD/frequency of action:**
   The Dietary Manager has been registered for a Serve Safe class on January 14, 2025, in Athens, AL with TSC Associates LLC.

3. **Additional corrective action(s) that the facility will take to identify other residents or concerns:**
   The Dietary Manager will do semiannual checks on kitchen employee certifications.

4. **Measures and changes put in place to ensure deficiency will not recur.**
   The kitchen employees will be registered for a renewal class at least 30 days before the certification expires to make sure the employee is current.

5. **Monitoring of corrective actions and staff accountability/frequency and location of logs:**
   The Executive Director will check the postings in the dining room semiannually to ensure compliance. The Executive Director will have a calendar reminder set for 2 months prior to Serve Safe expirations to ensure compliance.

Lori A Moore
Executive Director
12.14.24

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Survey Exit Date:	11/20/2024

1. **Cited Deficiency Number: 420-5-20-.07(3) – Food Service – A703**

2. **Corrective action taken for each Resident/example identified in the SOD/frequency of action:**
   Additional potable water was purchased on 11/20/24 by the President of SRI Midsouth, Rick Sweeney. This rectified the shortage of water on site.

3. **Additional corrective action(s) that the facility will take to identify other residents or concerns:**
   Water will be placed in the kitchen food storage area and will be locked up to prevent the water from being used for other purposes.

4. **Measures and changes put in place to ensure deficiency will not recur.**
   As new residents move in, the Dietary Manager (DM) will order new water to ensure compliance.

5. **Monitoring of corrective actions and staff accountability/frequency and location of logs:**
   The Executive Director will make monthly checks for 6 months and then quarterly checks on emergency water to ensure compliance.

Lori A Moore
Executive Director
12.14.24