What You Need to Know About Your Plan of Correction

Alabama Department of Public Health
Bureau of Health Provider Standards
Assisted Living Facilities Unit

Your Plan of Correction (POC) must contain the following information:

- ☑ Facility Name: Meadows of Jackson, The
- ☑ Facility Identification Number: D1302
- ☑ Name of Administrator: Anna Robinson
- ☑ Survey Exit Date: 12/12/23

Each deficiency in the statement of deficiencies (SOD) must be separately addressed and include the following five (5) elements:

1. The cited deficiency number from the SOD.

2. The POC must specify the corrective action(s) that you will take in response to each resident or example identified in the SOD.

3. The POC must explain the corrective action(s) that your facility will take to identify other residents or concerns not identified by the survey team that are related to those cited in your SOD. Be sure to include specific timetables and identify responsible facility staff. **DO NOT include resident rosters or any Protected Health Information (PHI) in the POC.** If PHI is included in the POC, corrections to remove that information will be requested.

4. The POC must describe the measures/changes you have put into place or made to ensure the same deficiency will not recur in your facility. Be sure to include specific timetables and identify responsible facility staff; staff training; policy changes; use of consultants; resident input; physical environment modifications; changes or expansion of staffing positions; increase in staff numbers; and improvement of staff qualifications.

5. The POC must explain how you will monitor your corrective action(s) to ensure that they are fully implemented; adequately address the identified problems; and are effective. The POC must also identify positions of staff that will accomplish the monitoring; when and how often the monitoring will take place; and where documentation of the monitoring will be kept. (Monitoring activities may include: oversight by the administrator or other supervisory personnel; ombudsman feedback; and interviews with residents and families.)

Your POC must be signed, dated, and returned by: Friday, February 16, 2024, at 5pm.

Return to:
Alabama Department of Public Health
Bureau of Health Provider Standards
alfcomplaints@adph.state.al.us

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

PLAN OF CORRECTION

Facility Name: The Meadows of Jackson **Facility ID #: D1302**

Survey Exit Date: 12/12/2023 **Administrator: Anna Robinson**

1. **Cited Deficiency Number from SOD.**

   A402 402-5-4-.04 (3) (a) (b) (c) (d) Personnel

   The facility did not include a physical examination certifying the employee was free of signs and symptoms of infectious skin lesions and transmissible diseases prior to hire.

2. E#1, E#2 and E#3 will have the Employee Physical Form completed by physician when/if re-instated by Alabama Department of Public Health.

3. All employee files have been audited. All employees hired post re-instatement of employee screening by Alabama Department of Public Health will have Employee Physical Form completed by a physician.

4. Since the date of this survey, the Employee screening is not required currently by the Alabama Department of Public Health. If the Alabama Department of Public Health re-instates the Employee screening of cited deficiency the facility will use physical form that is provided with plan of correction. E#1 and E#2 have been trained as of 2/7/2024 on Employee Physical Form by Regional Administrator.

5. E#1 and/or Administrator will review all new employees Employee Physical Form for physicians' signature prior to first date of employment when/if employee screening is re-instated by the Alabama Department of Public Health. Regional Administrator will audit new employee files for 3 months when/if re-instatement of employee screening by Alabama Department of Public Health. The audits will be kept in the administrator's office.

CHH _____ 2-7-24 _____

Administrator Date

STAFF ATTENDANCE RECORD

TOPIC Employee Physical DATE 2/7/2024 INSTRUCTORS: Beth Hurley

Signature	Print Name	Hours
VAL	Anna Robinson	20 min.
megan motes	Megan Motes	20 min.

ATTACH COPIES OF IN-SERVICE MATERIALS AND HANDOUTS.

EMPLOYEE PHYSICAL EXAMINATION

EMPLOYEE NAME: _____

I CERTIFY THAT I HAVE EXAMINED THE ABOVE PATIENT. HE/SHE IS FREE OF SIGNS AND SYMPTOMS OF INFECTIOUS SKIN LESIONS AND DISEASES THAT ARE CAPABLE OF TRANSMISSION TO RESIDENTS THROUGH NORMAL STAFF TO RESIDENT CONTACT.

_____ _____

Date Physician's Signature

_____

Physician's Telephone Number

ASSESSMENTS TO BE PERFORMED BY PHYSICIAN

Blood Pressure: _____

Weight _____

Temperature: _____

Pulse: _____

Respiration: _____

Flu Vaccine: _____ (October through February)

Date Administered

Chest X-Ray: _____ _____

(Chest X-Ray only required if TB Skin Test is positive or Past history of TB)

Date Result

TB Skin Test _____ _____ _____

Placement Date Initials

_____mm _____ _____

Results Date Read Initials