Accepted November 8, 2021

Connie Cherry

Legacy Woods III

Facility ID: P0504

Plan of Correction

Survey Exit Date: 10/20/2021

Administrator: Trina Cleveland

Trina Cleveland

11/6/2021

Legacy Woods III
Facility ID: P0504
Administrator: Trina Cleveland
Survey Exit Date: 10/20/2021

1. A302 420-5-20-.03 (e) Policies: The facility failed to follow its own Infection Control policies and procedures to prevent the spread of COVID-19.

2.. Each employee is to take his/her temperature and answer the screening questions prior to beginning his/her shift daily and document the screening results.

3. All employees will self-screen daily prior to beginning a shift. Any employee having a temperature of 100.4 or greater or any Covid-19 symptoms will return home until a negative Covid-19 test is obtained or the employee is symptom free for 24 hours without medication.

4. All employees have been retrained on the Infection Control Policy and Procedure to prevent the spread of COVID-19 by conducting daily health screenings prior to beginning a shift. New employees will also be trained. Documentation of the daily screenings will be placed in the Infection Control binder.

5. The Administrator/ Designee will review the screening documentation weekly for four weeks beginning 11/12/2021 and ending 12/3/2021 to make sure all employees are following the screening policy. Documentation of these audits will be placed in the POC binder located in the Administrator's office.

Legacy Woods III
Facility ID: P0504
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Survey Exit Date: 10/20/2021

1. A406 420-5-20-.04 (9) Personnel: The facility failed to ensure all staff received required training and ensure staffing at all times included one individual who had current certification in CPR.

2. The Administrator/Designee and the RN will ensure that all new employees receive required training upon hire and that staffing at all times will include one individual with current CPR certification.

3. All employees not having CPR certification will be certified in CPR by November 5. All employees not trained in diabetes and hospice have been trained. Employee schedules were amended ensuring that at least one staff member was certified in CPR at all times until training is completed.

4. The Administrator/Designee and the RN will ensure that new employees are trained in all required training. An audit of all employee files will be completed by November 15 to ensure that all staff has all required training. Documentation of the audit will be placed in the POC binder in the Administrator's office.

5. The Administrator/Designee will review employee files quarterly beginning 12/15/2021 and ending 6/15/2022 to ensure that all required training has been completed. Documentation of quarterly audits will be placed in the POC binder in the Administrator's office.

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Facility ID: P0504
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1. A504 420-5-20-.05 (3) (d) Records and Reports. The facility failed to adhere to Standards and Recommendations of CDC.

2.. Each employee is to take his/her temperature and answer the screening questions prior to beginning his/her shift daily and document the screening results.

3. All employees will self-screen daily prior to beginning a shift. Any employee having a temperature of 100.4 or greater or any Covid-19 symptoms will return home until a negative Covid-19 test is obtained or the employee is symptom free for 24 hours without medication.

4. All employees have been retrained on the standards and recommendations of the CDC and conducting daily health screenings prior to beginning a shift. New employees will also be trained. Documentation of the daily screenings will be placed in the Infection Control binder.

5. The Administrative Designee will review the screening documentation weekly for four weeks beginning 11/5/2021 and ending 11/26/2021 to make sure all employees are following the screening policy. Documentation of these audits will be placed in the POC binder located in the Administrator's office.

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Survey Exit Date: 10/20/2021

1. A504 420-5-20-.05 (3) (d) Records and Reports. The facility failed to post the most recent state survey and corrective action plan.

2. A copy of the most recent state survey will be posted with the corrective action plan.

3. The Administrator/Designee will ensure that the most recent state survey is posted with the corrective action plan.

4. The Administrator/Designee will check monthly to ensure that the most recent state survey is posted with the corrective action plan. The checking of the posting of the survey will be added to the monthly checklist.

5. The Administrator/Designee will complete the monthly checklist. The checklist will be placed in the POC binder located in the Administrator's office.

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Facility ID: P0504
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Survey Exit Date: 10/20/2021

1. A508 420-5-20-.05 (3) (h) Records and Reports. The facility failed to report an outbreak of a contagious disease to the Department's Online Incident Reporting System within 24 hours of the diagnosis (Code 420-4-1-.04).

2. All outbreaks of contagious disease will be reported to the Department's Online Incident Reporting System within 24 hours of the diagnosis.

3. The RN will ensure that all outbreaks of contagious disease are reported within 24 hours of the diagnosis. In the absence of the Director of Nursing, the Administrator will report an outbreak of a contagious disease to the OIRS.

4. The RN will ensure that all outbreaks of contagious disease are reported within 24 hours of the diagnosis and that a copy of the report is given to the Administrator.

5. Documentation of the disease report will be placed in the POC binder in the Administrator's office.

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1. A604 420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents. The facility failed to assess a resident for admission eligibility as required.

2. All residents will be assessed for admission eligibility as required.

3. The RN will ensure that all residents are assessed for eligibility and results of the assessments documented in the resident's chart.

4. The Administrator/Designee and the RN will audit all resident charts by 12/1/2021 to ensure all assessments have been completed. The results of the audit will be documented in the POC binder.

5. The Administrator/Designee and the RN will audit resident charts quarterly beginning 1/2022 and ending 6/2022 to ensure that all assessments are completed and documented. Documentation of the audits will be placed in the POC binder in the Administrator's office.

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1. A618 420-5-20-.06 (7) Care of Residents. The facility failed to document a resident's oxygen use on the Medication Administration Record (MAR).

2. All residents requiring the use of oxygen will have it documented on the MAR as ordered by his/her physician.

3. The RN will ensure that all residents requiring oxygen will have the date, time, rate and proper function of the equipment documented on the MAR on each shift.

4. Oxygen has been added to the Medical Examination Plan of Care for all new residents, those residents returning from a hospital stay, and the annual Plan of Care update. Documentation of the updated MEPOC will be placed in the POC binder in the Administrator's office.

5. Beginning January 2022 and ending June 2022, the Administrator/Designee will audit quarterly the MARs of all residents requiring oxygen to ensure that the use of oxygen is documented on the MAR.

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1. A621 420-5-20-.06 (9) (b) Care of Residents. The facility allowed a resident to return to the facility from a higher level of care in need of skilled care.

2. All residents returning from a higher level of care will be assessed by the RN prior to returning to the facility.

3. The RN will ensure that all residents returning to the facility from a higher level of care will be eligible for return by ensuring that they do not need a level of care that exceeds the level of care a specialty care assisted living facility is licensed to provide.

4. The RN will assess residents returning to the facility from a higher level of care. If the resident requires a level of care that exceeds the level of care provided by the specialty care assisted living facility, the resident will not be allowed to return to the facility at that time. Assessments will be completed and documented and documentation placed in the resident's chart.

5. The Administrator/Designee will audit resident charts quarterly beginning 12/15/2021 and ending 6/15/2022 to ensure that assessments are completed and documented. Results of the audits will be placed in the POC binder in the Administrator's office.

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Facility ID: P0504
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Survey Exit Date: 10/20/2021

1. A702 420-5-20-.07 (2) (a) Food Service. The facility failed to monitor and document dish water temperatures and chlorine concentrations to ensure dishes were properly sanitized.

2. Dishwasher temperatures and chlorine concentrations will be monitored and documented to ensure dishes are properly sanitized.

3. The Dietary Lead will ensure that chlorine concentrations and dishwasher temperatures are monitored and documented daily and kept in a binder in the kitchen.

4. The Administrator/Designee will audit the logs monthly to ensure that temperatures and concentrations are being monitored and recorded. The audit will be added to the monthly facility checklist.

5. Beginning 11/12/2021 and ending 12/3/2021, the Administrator/Designee will audit the logs weekly to ensure concentrations are being monitored and recorded Beginning January 2022 and ending December 2022, the Administrator/Designee will audit the logs monthly to ensure that concentrations are monitored and recorded. Documentation of the audits will be placed in the POC binder in the Administrator's office.

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1. A702 420-5-20-.07 (2) (c)(5) Food Service. The facility failed to label and date leftover foods with a "use by date."

2. All leftovers will be labeled and have a "use by date" which is within three (3) days of the preparation date.

3. The Dietary Lead will ensure that all leftovers are labeled with a "use by date" within three (3) days of preparation and any food items without a "use by date" will be discarded and not given to residents.

4. The Administrator/Designee will ensure that all employees who cook or serve food to residents will be trained/retrained on the dating of food items with a "use by date" by 11/10/2021.

5. Beginning January 2022 and ending June 2022, all employees who cook or serve food will have quarterly training on the dating of food items with a "use by date." Documentation of the training will be placed in the employee's file and the POC binder in the Administrator's office.

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1. A702 420-5-20-.07 (2)(f) Food Service. The facility staff failed to wear a clean covering over their clothing when handling and serving food.

2. All staff members will wear a clean apron over their clothing when handling and serving food.

3. All staff who cook or serve food will be trained/retrained on the importance of wearing an apron over clothing when handling food or serving food.

4. The Administrator/Designee will ensure that all employees who cook or serve food to residents will be trained/retrained on the wearing of aprons while cooking or serving food by 11/10/2021.

5. Beginning January 2022 and ending June 2022, all employees who cook or serve food will have quarterly training on the wearing of aprons while cooking or serving food. Documentation of the training will be placed in the employee's file and the POC binder in the Administrator's office.

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1. A1101 420-5-20-.11(1) Fire Safety The facility failed to perform and document fire drills as required.

2. All fire drills will be conducted and the date and time will be documented with noting AM or PM. Fire drills will be conducted quarterly on each shift.

3. The Administrator/Designee will ensure that fire drills are conducted quarterly on each shift and documented with AM or PM noted and the shift.

4. The Administrator/Designee will ensure that all fire drills are conducted and documented for date, time, and effectiveness of the drills.

5. Documentation of all drills will be will be placed in the fire drill binder and the POC binder in the Administrator's office.