Regency Retirement Village

D3777

Administrator: Rachelle Gillespie

Survey Date: 12/08/2021

Plan of Correction

1. A401 420-5-4-04(1)(2) Personnel

1.Facility was not always staffed with at least one individual who was currently certified in cardiopulmonary resuscitation (CPR)

2. By evidence of E#12 audits to be conducted for each employee at time of hire for current CPR. December 14,2021 CPR classes held to bring staff current for CPR meeting compliance

3. Upon Hire staff will bring current CPR cards for record or placed in the next CPR training provided to meet requirements for one individual who is currently certified in cardiopulmonary resuscitation (CPR) on shift in community

4. Audited monthly by Business Office Manager, DON and or Designee beginning 1/03/22. Monthly for 3 months'

5.Monthly audits by Business Office Manager, DON and or Designee findings to be placed in Plan of Correction Book and reported to QAPI and DON or designee

2. A402 420-5-4-04 (3) Personnel

1. Employees files were reviewed with E#6, for supporting documentation all staff had received the required screening as noted above.
2. E#2 Documentation for hire dates and for TB screenings must be completed and documented prior to hire dates
3. Ongoing Plan of Correction: E#2, E#3, E#15 each staff prior to hire will have all examinations completed and paperwork signed and filed prior to orientation and resident contact. Beginning 12/10/21 and ongoing as a practice of hire for staff. Business office manager to audit prior to each start date.
4. Current Employee Records to be audited and completed by Business Office Manger 02/15/22 for compliance and Employee records up to date. New Hire Employee records to be Audited by Administrator or designee beginning 02/16/22 for the next 4 weeks, 2x the next 4 weeks, findings kept in Plan of Correction Book and reported to QAPI by Administrator

3. A617 420-5-4-06(8) Care of Residents

1.By evidence of R#4 medication disposition was incomplete, Inservice all nurses for procedure at time of hire in orientation for Medication's disposition. Inservice nurses for proper medication Disposition. Processes implemented and in service as 12/20/21. Orientation training for medication disposition at time of hire for all nursing staff by DON, audit to be conducted at time of resident discharge for medication and appropriate paperwork upon discharge from the community. 1. As Evidence of R#4 record of medication disposition facility will complete correct forms for medications leaving the facility at discharge or transfer of residents with proper signatures of medications released from the facility. Inservice provided by nurses as to proper medication disposition all new hire nurses to complete and regulations met A617(A) in orientation and in services to meet state regulations and company policies

2. By evidence of R#4 medication disposition was incomplete, Inservice all nurses for procedure at time of hire in orientation for Medication's disposition. Inservice nurses for proper medication Disposition. Processes implemented and in service as 12/20/21. Orientation training for medication disposition at time of hire for all nursing staff by DON, audit to be conducted at time of resident discharge for medication and appropriate paperwork upon discharge from the community by designee.

3. Medication Disposition to be audited by shift nurse according to policy and procedure at time of resident discharge and noted in Disposition Binder

4. Medication Disposition will be audited by DON, Administrator or designee for each discharge for 2 months beginning 02/01/22 and place findings in the Plan of Correction Binder reported to QAPI and DON or designee.

4.A1101 420-5-4-11(1) Fire & Safety

1.Facility failed to document Monthly Fire Drills

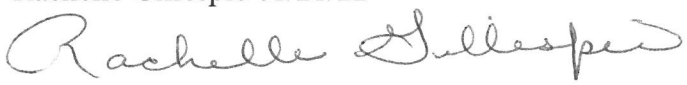
2.Maintenance Director educated on Fire Drill Documentation by Surveyor 12/07/21

3.Maintenance Director to complete Fire Drills in accordance with Policy and Procedure for Both ALF & SCALF and documentation for each for every fire drill beginning 1/2022

4. 12/20/21 Documentation procedures implemented for Fire drills performed on 12/07/21 as witnessed by Surveyors completed and ongoing for compliance for Fire & Safety

5. Audit Fire Drill Documentation for the next 3 months beginning January 2022, by the Administrator or designee, findings kept in the Plan of Correction Book and reported to QAPI by DON or designee.

Rachelle Gillespie 01/21/22



Plan of Correction Book located in DON Office

accepted 1.24.22

Connie Cherry

Regency Retirement Village

P3277

Administrator: Rachelle Gillespie

Exit Survey Date: 12/08/21

Plan of Correction

1. A-402 420-5-20-04 Personal

1.Every new hire, ongoing will have tuberculosis testing prior to orientation and or resident contact

2.Plan of Correction: each staff prior to hire will have all examinations completed and paperwork signed and filed prior to orientation and resident contact. Beginning 12/10/21 and ongoing as a practice of hire for staff. Business office manager to audit prior to each start date.

3.Current Employee Files to be Audited by Business Office Manager by 02/15/22 to assure that all Employee files are accurate and in compliance

4.Administrator to audit employee files 1 time for 2 months beginning 01/01/22 and all new employee files. audit, to be placed in the Plan of Correction and reported to the QAPI and the DON or designee

2. A406 420-5-20-4 Personal

1. EL#3 named in this deficiency was corrected as of December 10,2021 with Inservice and completed Pharmacological Management of Dementia training and Dementia Assessment training.

2. All Nursing hire employees will complete and be signed off in orientation for the Pharmacological Management of Dementia training and Dementia Assessment Training during orientation and before resident contact or support, Orientation to be conducted by DON or designee by DON for each new hire.

3. Business office Manager to audit all current employee files any training not completed shall be set for completion by February 28, 2022. oversite all paperwork completed upon hire prior to staff having contact with residents in the community by Business Office Manager

4.Audit to be completed for trainings of new hire nurses weekly for 1 month, by Administrator, DON or Designee Documentation to be placed in the Plan of Correction book and reported to QAPI or DON or designee

3. A508 420-5-20-05(3)(h) Records & Reports

Rule not met by notifiable health condition was not reported and investigated as

1.Beginning December 11, 2021, all change of condition will be reported by nurse on shift to DON, Administrator or Designee, verbally to make sure any reportable information is handled upon receipt. Confirmed by written statement to DON, Administrator or Designee at time of communication. DON, Administrator or Designee to report to appropriate reporting agency for compliance.

2. Inservice to be completed by DON for the education of caregiver and nursing staff as to reportable health conditions on or before 02/28/22

3. Reportable Health Conditions to be documented and reported based on State Regulations by Don, Administrator, or designee

4. 24 Hour Communication Log audited by DON or Administrator or designee,3 times a week for 4weeks, 2 times a week for 4 weeks,1 time a week for 4 weeks beginning 02/01/22 and audits will be documented and placed in the Plan of Correction and reported to QAPI by DON or Administrator or designee

4. A602 420-5-20-6 Care of Residents

1. Residents upon admission will have Medical Examination Records Completed

2. By evidence R#4, R#6 New resident admissions will have all proper information completed upon arrival for admission Audits to be completed prior to new resident admission and upon admission for all information completed as necessary following State guidelines and Company Policies. Ongoing for each new admission.

3. By evidence R#5 Residents will have update annual Physical Examinations records to be audited. Residents will receive annual Physical examinations as well as a change of condition to meet State Regulations and company policies ongoing for each resident of record.

4. R#4, R#5 paperwork has been corrected as of 12/15/21, Resident charts have been audited and corrected as of 12/31/21. Moving forward paperwork to be checked and approved prior to resident move in and annual physical examination by DON Corrections placed in Plan of Correction Book and reported to QAPI and Administrator or designee.

5. A604 420-5-20-06 (3)(a)(b)(c)(d)(e) Care of Residents

1. By Evidence R#3, R#4, R#11, R#7 Resident chart audits will be to assure that all information stays in the resident records from date of admission based on state regulations and company policies from date of current Survey and moving forward 12/08/21

2. Resident R#3, R#4 R#11R#7, are all current and up to date as January 3rd, 2022, Audits on all charts to be completed and brought current by January 31,2022 Audits conducted by DON and designees with DON oversite. All records to be current by February 1,2022 to remain in compliance on going.

3. For admission assessment and PSMS to be completed not more than 30 days prior to admission and an audit to be completed prior to resident admission and upon change of conditions

4.Resident chart audits to be completed by the DON or designee 1 time a month for 3 months beginning 2/01/22 and audit to be placed in Plan of Correction Book and reported to QAPI by Administrator, DON or designee

6. A611 420-5-20-6 (4)(a)(b) Resident Care

1.The Facility shall provide care and services consistent with community standards, RN failed to develop Plan of Care to address the currents needs of residents

2. RN will develop appropriate and current care plans on all residents & be always available for care staff to perform and meet the care for all residents each day based on current plans of care.

3. By evidence R#3 Plan of Care completed and 30-day notice given to family per the conversation of surveyor for additional 30days to heal said wound on left foot. Wound checks completed 3x a week for 2 weeks 2X a week for 2 weeks to meet deadline for healing. Care plan to reflect current resident needs and treatment on going by Home Care company for treatment of this resident.

Resident moved as of 01/10/22 to inpatient for wound care will be reevaluated to return if appropriate.

By Evidence R#11 Care Plan is current and oxygen needs are being met. Resident weight concerns are a result of additional need for Lasix added to her medications while at rehab. Care plan to reflect and weight monitored biweekly for 2 months and steps taken if necessary to address weight changes based on state regulation and company policies. December 10,2021 Care Plan updated, and MAR reflects O2 checks by nursing staff on each shift on going based on Plan of Care and RX for Oxygen us.

R#11 Date set for Dietitian for eval for weight concerns.01/10/22. Care Plan updated with Dietician recommendations, Weights to be checked 1x weekly for 4 weeks.2x a month until weight is stabilized, checks to go to monthly beginning March 1, 2022.

4. Audit for all current residents and updated care plans to be completed and reviewed by DON by 2/01/22 Audit to be reviewed by Administrator or designee for 3 months beginning February 1, 2022, and placed in The Plan of Correction Book and reported to the QAPI or DON or designee

7. A617 420-5-20-06 Care of Residents

1. As Evidence of R#12 record of medication disposition facility will complete correct forms for medications leaving the facility at discharge or transfer of residents with proper signatures of medications released from the facility. Inservice provided by nurses as to proper medication disposition all new hire nurses to complete and regulations met A617(A) in orientation and in services to meet state regulations and company policies

2. By evidence of R#12 medication disposition was incomplete, Inservice all nurses for procedure at time of hire in orientation for Medication's disposition. Inservice nurses for proper medication Disposition. Processes implemented and in service as 12/20/21. Orientation training for medication disposition at time of hire for all nursing staff by DON, audit to be conducted at time of resident discharge for medication and appropriate paperwork upon discharge from the community.

3. Medication Disposition to be audited by shift nurse according to policy and procedure at time of resident discharge and noted in Disposition Binder

4. Medication Disposition will be audited by DON, Administrator or designee for each discharge for 2 months beginning 02/01/22 and place findings in the Plan of Correction Binder, reported to QAPI and DON or designee.

8. A618 420-5-20-06(7) Care of Residents

1. By evidence based on R#11 Plan of Care did not reflect RX for oxygen frequency. RX was retrieved from Oxygen company and Care Plan updated on 12/9/21.

2.Care plan updated and current in resident record as of 12/9/21.

3.By Evidence R#11 Care Plan is current and oxygen needs are being met. Resident weight concerns are a result of additional need for Lasix added to her medications while at rehab. Dietitian visit scheduled 01/10/22 Care plan to reflect increased opportunities for calorie building snacks between meals and weight monitored weekly for 4weeks and steps taken if necessary to address weight changes based on state regulation and company policies. Plan of Care updated. 01/10/22. Inservice's completed for nurses on Care Plan for O2 and weight updates on R#11 1/10/22 December 10,2021 Care Plan updated, and MAR reflects O2 checks by nursing staff on each shift, ongoing based on Plan of Care and RX for Oxygen use

4. Resident Plan of care to be Audited weekly for 4 weeks, 2 times second four weeks beginning 01/10/22 for resolution of weight concerns and O2 monitoring, Audits to be placed in Plan of Correction Book and reported to QAPI and DON or designee

9. Deficiency number A621 420-5-20-06 (9)(b) Resident Retention

1. By Evidence of R#2 30-day notice was issued and hospital met with DON and stated resident did not meet criteria, resident will not return to community notice issued to R#2 sponsor. 12/10/21 And hospital that resident would not be returning to community based on criteria not being met for readmission.

2. By evidence R#3 has been given 30-day notice to family 12/9/21. By evidence pf R#3 By evidence R#3 Plan of Care completed and 30-day notice given to family per the conversation of surveyor for additional 30days to heal said wound on left foot. Wound checks completed 3x a week for 2 weeks 2X a week for 2 weeks to meet deadline for healing. Care plan to reflect current resident needs and treatment on going by Home Care company for treatment of this resident. Resident will be moved to higher care with notice if wound does not meet state regulations for resident care and company policy Resident moved as of 01/10/22 to inpatient for wound care will

be re-evaluated when wound is healed to return to community if resident meets criteria

3.DON or designated nurse will complete assessments on all residents based on State Regulations and company policy to confirm residents who remain appropriate for our SCALF setting Assessments to be completed by2/1/22 on all current residents.
4.Resident and audits to be placed assessments will be monitored for 2 months beginning 2/15/22 and reviewed by DON or Administrator or designee and placed in the plan of correction book and reported to the QAPI by the Administrator or designee

10. A1001 Sanitation & Housekeeping

1. Based on observation that the facility was not free of objectional odors.

2. By evidence based on R#1to evaluate for incontinence support. Family meeting set for discussion of furniture replacement, Care Plan to reflect toileting schedules to aid in control of odors. Family meeting held 12/20/21 Discussed the need for furniture replacement family will purchase and bring to community, implemented and updated Plan of Care 12/20/21

3. Implemented and updated Plan of Care toileting schedule as of 12/28/21 family has replaced furnishings, apartment audits to be completed weekly for 4 weeks by nurse each shift to keep apartment free of objectional odors.

4.Inservice for care team for apartment cleaning and Policy and procedures for odor control Inservice for Nurses and Care team 12/29/21

5. Administrator or designee to audit apartments for odors based on weekly audits and Plan of correction results placed in the Plan of Correction Book and reported to the QAPI or Administrator or Designee

11. A1101 420-5-20-11 Fire & Safety

1.Facility failed to document Monthly Fire Drills per SCALF & ALF
2.Maintenance Director educated on Fire Drill Documentation by Surveyor 12/07/21

3.Maintenance Director to complete Fire Drills in accordance with Policy and Procedure for Both ALF & SCALF and documentation for each for every fire drill beginning 1/2022

4.12/20/21 Documentation procedures implemented for Fire drills performed on 12/07/21 as witnessed by Surveyors completed and ongoing for compliance for Fire & Safety

5.Audit Fire Drills each month for the next 3 months. Beginning January 2022 Documentation will be kept in the Plan of Correction Book and Reported to the QAPI by the DON or designee

Rachelle Gillespie 01/21/22

Rachelle Gillespie

Plan of Correction Book to be kept in DON office