POC Approved
June 27, 2022
Debbie Freeman, RN
Debra Freeman, RN

PLAN OF CORRECTION – June 17, 2022
Truewood by Merrill, Riverchase SCALF
Facility Identification Number: P3725
Name of Administrator: Charles Cook
Survey Exit Date: 06/02/2022

1. **(A403) 420-5-20-.04 (4) Personnel**
2. On June 9, 2022, the Business Office Director updated EI#4 and EI#7's personnel record to reflect the date of initial resident contact.
3. By June 9, 2022, the Business Office Director reviewed all employee personnel records to ensure that the date of initial resident contact was noted in individual employee's record.
4. By June 24, 2022, the Administrator / Designee will in-service all managing directors regarding the required information in an employee record, to include the date of initial resident contact.
5. Beginning June 9, 2022, the Administrator / Designee will review all new hire employee records to ensure that the date of initial resident contact is noted in the employee record. This review will be conducted at the end of the newly hired employee's training for three weeks. At the end of three weeks, The Administrator /Designee will review 10% of new hire personnel records for two months. The Administrator / Designee will be responsible for additional corrective action, if needed. Results of monitoring and documentation of corrective action, if needed will be maintained in the POC notebook in the office of the Administrator.

1. **(A406) 420-5-20-.04 (9) Personnel**
2. On June 23, 2022, EI#2 provided EI#7 with the required CPR training. The current certification has been placed in EI#7's personnel record.
3. By June 30, 2022, the Business Office Director shall audit all employee records to identify, if any, newly hired employees, or employees who are due for recertification. CPR class is scheduled for June 30, 2022, for all employees who need certification or recertification. Any employee who has not completed the required CPR training by June 30, 2022, will be removed from the schedule and will not be allowed to return to work until the training is complete.
4. By June 22, 2022, the Administrator / Designee will in-service all employee on CPR certification requirement.
5. Beginning June 24, 2022, the Administrator /Designee will review all newly hired employee records every other week to ensure that CPR training and certification has been completed. This review will be conducted for one month. At the end of one month, the Administrator/Designee will review 10% of new personnel records monthly for two months. The Administrator / Designee will be responsible for additional corrective action, if needed. Results of monitoring and documentation of corrective action, if needed will be maintained in the POC notebook in the office of the Administrator.

1. **(A508) 420-5-20-.05 (3) (h) Records and Reports**
2. No residents were identified in this deficiency.
3. Beginning June 3, 2022, the Administrator /Designee shall report the outbreak to the ALF OIRS within 24 hours of the positive test results. On June 15, 2022, the Administrator/Designee demonstrated their understanding of this rule by submitting a report within 24-hours of a positive test result to the ALF OIRS.
4. By June 22, 2022, the Administrator / Designee will in-service all direct care staff to immediately report a resident's positive test result to the Administrator or Designee.
5. Beginning June 24, 2022, the Administrator / Designee will review all positive test results to ensure that a report has been submitted to the ALF OIRS. The review will be conducted every other week for two months. The Administrator / Designee will be responsible for additional corrective action, if needed. Results of monitoring and documentation of corrective action, if needed will be maintained in the POC notebook in the office of the Administrator.

1. **(A602) 420-5-20-.06 (2) (a) (b) (c) Care of Residents**
2. On June 13, 2022, the Garden House Director (RN), updated RI#3's initial Medical Health Statement to include "This resident if free from signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact."
3. Beginning June 13, 2022,the Garden House Director (RN) / Designee reviewed all recent resident admission Medical Health Statements and obtained a physician's statement regarding infectious skin lesions or diseases. The Medical Health Statement has been updated to reflect "☐ Yes ☐ No This resident is free from signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact."
4. By June 17, 2022, the Administrator / Designee will in-service the Garden House Director (RN), Community Relations Director, and direct care staff on the updated Medical Health Statement.
5. Beginning June 17, 2022, the Administrator / Designee will review all new admission Medical Health Statements to ensure that the physician's statement regarding infections skin lesions or diseases is completed. This review will take place for a period of three weeks. At the end of three weeks, the Administrator / Designee will review 10% of new admission Medical Health statements monthly for two months. The Administrator / Designee will be responsible for additional corrective action, if needed. Results of monitoring and documentation of corrective action, if needed will be maintained in the POC notebook in the office of the Administrator.

1. **(A612) 420-5-20-.06 (4) (c) (d) (e) (f) Care of Residents**
2. On June 9, 2022, the Garden House Director (RN) updated RI#3's care plan with scheduled activities that are of interest to the resident to manage his/her wandering behavior.
3. By June 17, 2022, the Garden House Director (RN) / Designee reviewed all resident records to ensure that no other resident exhibited wandering behaviors and that any resident who had wandering behaviors had an appropriate activity plan in place to address those behaviors. A monthly activity calendar shall be posted, and appropriate staff shall be responsible for conducting the planned activities.
4. By June 22, 2022, the Administrator / Designee will in-service all direct care staff, including activity staff, regarding monitoring for, recognizing and appropriately responding to residents with wandering behaviors. Any direct care staff, including activity staff, who has not completed the required training by June 22, 2022, will be removed from the schedule and will not be allowed to return to work until the training is complete.
5. Beginning June 17, 2022, the Administrator / Designee will review the care plans for all residents exhibiting wandering behaviors. This review will be conducted daily for three weeks. At the end of three weeks, the Administrator / Designee will review 10% of care plans of residents who are experiencing wandering behaviors monthly for two months. The Administrator / Designee will be responsible for additional corrective actions, if needed. Results of monitoring and documentation of corrective actions, if needed, will be maintained in the POC notebook in the office of the Administrator.

1. **(A617) 420-5-20-.06 Care of Residents**
2. As noted during the survey, RI#6 was discharged from the facility on February 20, 2022.
3. No residents were affected by this deficiency. By June 9, 2022, the Garden House Director / Designee reviewed medication destruction records for the required witness signature.
4. By June 25, 2022, the Garden House Director (RN) will in-service all direct care staff that when medications are destroyed on the premises of the specialty care assisted living facility, the medication destruction record shall include a witness signature. Any direct care staff who has not completed the required training by June 25, 2022, will be removed from the schedule and will not be allowed to return to work until the training is completed.
5. Beginning June 9, 2022, the Administrator / Designee will audit all medication destruction records for witness signatures. This review will be conducted daily for three weeks. At the end of three weeks, the Administrator / Designee will review 10% of the medication destruction records monthly for two months. The Administrator / Designee will be responsible for additional corrective actions, if needed. Results of monitoring and documentation of corrective actions, if needed, will be maintained in the POC notebook in the office of the Administrator.

Charles A. Cook Jr. 6-17-22