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POC accepted 3.21.22

Connie Cherry

PLAN OF CORRECTION

FACILITY NAME: BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER-SCALF

FACILITY ID: P3701

SURVEY EXIT DATE: 3/10/2022 ADMINISTRATOR: SONJA EDWARDS

DEFICIENCY NUMBER: 420-5-20-.06(1) Care of Residents

A302 Facility failed to follow its own policies and procedures for employee personal appearance

1. Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.
   - All staff were in-serviced during the survey 3/9/2022 by the Administrator on policy and procedure related to dress code and appearance, page 40 of the handbook.

2. Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems like those listed in each example. Include specific timetables and the title of staff responsible.
   - All residents have the potential to be affected.

3. Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.
   - All new hires will be in-serviced on dress code during new hire orientation by the Administrator or designee.
   - All employees not in compliance will be given 72 hours to remove all false nails according to the facility handbook policy.

4. Explain how you will monitor your proposed corrective actions to ensure that they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.

   - The HSD or designee will monitor for employees daily for adherence to policy during rounds. Any employee not in compliance will receive the appropriate disciplinary action.
   - The Administrator will review new hire paperwork monthly to ensure compliance with the education on the handbook.

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SURVEY EXIT DATE: 3/10/2022 ADMINISTRATOR: SONJA EDWARDS

DEFICIENCY NUMBER: 420-5-20-.06(1) Care of Residents

A601 Facility failed to follow physician's orders for a resident's care

1. Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.
   - All nurses were in-serviced on correct procedure to follow with a new medication order on 3/14/2022. Any new medication orders will be called into the pharmacy to receive medication from back-up. The nurse receiving the medication from the back-up pharmacy will administer the first dose.
   - Resident #2 has a follow-up appointment with cardiologist scheduled for 3/23/22.

2. Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems like those listed in each example. Include specific timetables and the title of staff responsible.
   - All residents have the potential to be affected.

3. Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.
   - The HSD or designee will check 24-hour report sheets daily and round with the physician weekly to ensure any new physician orders are addressed timely. This in-service was performed 3/14/2022 with nurse managers.
   - The HSD or designee will check care suites daily to ensure documentation is completed in the emar system. This in-service was also completed on 3/14/2022.
   - The HSD or designee will ensure all follow-up appointments have been scheduled per physician orders.

4. Explain how you will monitor your proposed corrective actions to ensure that they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.

   - The Administrator will audit 10% of charts to ensure all new orders are completed and the appropriate follow-up is completed monthly x6 months then quarterly.

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FACILITY ID: P3701

SURVEY EXIT DATE: 3/10/2022 ADMINISTRATOR: SONJA EDWARDS

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

A604 The RN failed to perform a required assessment of a prospective resident for eligibility

1. Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.
   - Both nurse managers were in-serviced on the assessment process and requirements for eligibility for admission and the documentation required by SBOH on 3/9/2022 by the Administrator.

2. Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems like those listed in each example. Include specific timetables and the title of staff responsible.
   - All residents have the potential to be affected.

3. Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.
   - The HSD director or designee will ensure all residents are assessed and appropriate for admission and have all documentation required by the SBOH on the chart prior to admission.
   -The lead nurse manager will perform a second inspection to ensure all documentation required by the state is on the chart prior to the day of admission and complete any missing documentation.

4. Explain how you will monitor your proposed corrective actions to ensure that they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.
   - Beginning 3/14/2022 the Administrator or designee will audit all new admission charts for the comprehensive screen, psms and behavior screen prior to admission x 90 days. Then 10% of charts audited monthly for 6 months then 10% quarterly for 6 months.

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SURVEY EXIT DATE: 3/10/2022 ADMINISTRATOR: SONJA EDWARDS

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

A618 The facility failed to document oxygen usage

1. Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and the title of staff who will accomplish the corrective action.
   - All nurses were in-serviced on oxygen use and documentation on 3/14/22 by the Administrator.
   - Resident physician orders were corrected on 3/11/2022 for the two residents currently on oxygen therapy.

2. Specify how you will identify other residents or concerns, not identified by the survey team, who may have problems like those listed in each example. Include specific timetables and the title of staff responsible.
   - All residents have the potential to be affected.

3. Describe the measures you have put into place or the systemic changes you have made, or both, to ensure the same deficiency will not recur in your facility.
   - The HSD or designee director will ensure all resident's receiving oxygen has an order for usage by 3/15/2022 as well as all care plans updated.
   - The HSD or designee will check any new orders for oxygen therapy as part of their daily routine and ensure documentation is present in the emar system.

4. Explain how you will monitor your proposed corrective actions to ensure that they are implemented and that the corrective actions adequately address the identified problems. Include specific timetables and the titles of staff who will be conducting the monitoring.
   - Beginning 3/14/2022 the Administrator or designee will audit charts of all residents receiving oxygen therapy weekly to ensure the documentation is present in emar x 90 days.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intent that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Kayne Anderson Management

Plan of correction completed by Sonja Edwards Administrator of Briar Glen 03/15/2022

Signature Sonja Edwards 3/21/22