Accepted May 25, 2023

Connie Cherry

Plan of Correction- Page 1

Facility Name: Thrive at Jones Farm (ALF)

Facility ID: D4548

Survey Exit Date: 01/26/2023

Administrator: Kelli Long

1. Cited Deficiency Number: 420-5-4-.03 (ID Prefix Tag A302)

   This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the governing authority failed to establish and implement a written policy to ensure residents were adequately monitored.

   THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

Findings:

The Alabama Department of Public Health received a complaint which alleged a resident of the facility sustained a fall and was left alone on the floor of their room for approximately nine hours on the night of January 16-17, 2023.

Review of facility policies on January 24, 2023, revealed there was no policy which specifically documented the frequency for conducting checks on each resident by designated facility staff; to ensure the resident was present, safe and resident care needs were met. On January 24, 2023, Employee Identifier (EI)#1 informed the surveyor there was no facility policy which addressed the required frequency for checking on each resident.

On January 24, 2023, the facility's camera footage was reviewed by the surveyor with EI#1 and EI#2. Two night shifts were reviewed, January 11-12, 2023 and January 16-17, 2023, between the hours of 10:00 PM and 6:00 AM. Resident Identifier (R/)#1's room was not entered by facility staff during the night shift on either date. The one doorway to RI#1's room could easily be viewed on the camera footage and staff did not attempt to open the door or enter RI#1's room during the entire eight hour shift for either date reviewed. E/#2 told the surveyor that EI#9, Care Associate (former employee) was assigned to care for RI#1 on both nights. During interviews with facility staff on January 24, 2023, six of six staff (EI#4, EI#5, EI#6, EI#?, EI#8 and E/#9) all reported they knew that residents should be checked on at least every two hours.
Only two of the six staff (EI#5 and EI#?) stated they had been trained by the facility to check on residents every two hours. The facility had no documented policy in place that directed staff to monitor residents within a specific time interval.

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2. Corrective Action(s) in response to resident/example identified in the statement of deficiencies:

   The administrator contacted the governing authority asking for a written policy which specifically documented the frequency for conducting checks on each resident by designated facility staff; to ensure the resident was present, safe, and resident care needs were met.

3. Corrective Action(s) the community will take to identify other residents or concerns not identified by the survey team that are related to those cited in your statement of deficiency:

   The new policy will be reviewed and signed by all staff members. Each staff member and resident will receive a copy of the written policy. This action will be completed by June 30th, 2023.

4. Measures/Changes put in place to ensure the same deficiency will not occur:
   Each staff member will review the policy by June 30th, 2023. The Administrator, Health & Wellness Director, Business Office Manager, or designee will sign as a witness that the policy review took place.

5. How we will monitor proposed corrective action:

   The Administrator, Health & Wellness Director, Business Office Manager, or Designee will utilize an Employee Roster to ensure all current employees reviewed and signed the new policy. New hires will sign the policy at orientation. The Plan of Correction and supporting documents will be located in the Plan of Correction Binder, located in the Administrator office.

Facility Name: Thrive at Jones Farm (ALF) Facility ID: D4548

Survey Exit Date: 1/26/2023 Administrator: Kelli Long

1. Cited Deficiency Number: 420-5-4-.03 (ID Prefix Tag A303)

This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility administrator failed to manage and direct staff activities to maintain an orderly and safe environment for all residents and failed to ensure adequate care was provided for the residents at all times.

THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

Findings:

The Alabama Department of Public Health received a complaint which alleged a resident of the facility sustained a fall and was left alone on the floor of their room for approximately nine hours on the night of January 16-17, 2023. The complainant reported that RI#1's sponsor had a camera installed in RI#1's room and the camera footage from RI#1's room revealed that RI#1 fell in RI#1's room at 9:21 PM on January 16, 2023. The sponsor was contacted by the facility around 6:40 AM on January 17, 2023 when RI#1 was found by facility staff on the floor in RI#1's room.

RI#1 was admitted to the facility on September 13, 2022, with diagnoses which included chronic kidney disease stage 2, ischemic heart disease, essential hypertension, type 2 diabetes mellitus with diabetic polyneuropathy and hyperlipidemia.

On January 24, 2023, the surveyor conducted an onsite investigation at the facility and interviewed the following staff who worked at the facility from 10:00 PM on January 16, 2023 until 6:00 AM on
January 17, 2023.

EI#9, Care Specialist (former employee), was employed by the facility from December 13, 2022 until January 19, 2023. EI#9's employment was terminated by the facility following an investigation of a fall sustained by RI#1 on the night of January 16-17, 2023. Review of the facility's incident investigation revealed EI#9 was assigned to care for RI#1 on the night of January 16-17, 2023. On January 17, 2023, EI#9 was asked by EI#2, why RI#1 was not checked on during the night shift of January 16-17, 2023. EI#9 replied she (EI#9) "checked on someone on 240 hall, I don't remember the room numbers".

However, after review of the facility's camera footage for January 16-17, 2023, (the night that RI#1's fall occurred), EI#9 was not observed to enter RI#1's room between the hours of 10:00 PM and 6:00 AM. In fact, no one entered RI#1's room or even opened RI#1's door during the entire eight hour night shift.

When EI#9 was interviewed by phone on January 24, 2023, the surveyor explained that camera footage had been reviewed at the facility and no one entered RI#1's room during the night shift of January 16-17, 2023. EI#9 replied, "They say I didn't but I did. I check on my residents. I don't go in. I just stick my head in the door."

EI#5, Medication Technician, had been employed al the facility since January 5, 2022. EI#5 stated the Medication Technician was the person in charge on the night shift. The night shift usually consisted of one Medication Technician and two or three Care Specialists. EI#5 added that the residents were divided between the staff on duty, based on the hall where they resided. EI#5 carried a pager which received all of the resident calls through the call system. EI#5 also used a portable radio to call Care Specialists and to notify them when an assigned resident was in need of assistance.

The Care Specialist was required to "clear out" the resident call by entering the resident's room, which then notified EI#5 that the resident's call had been addressed. EI#5 stated she (EI#5) had worked with EI#9 previously and EI#9 would always "clear out" her calls. EI#5 stated she (EI#5) checked on assigned residents every two hours, but did not check on residents that were not assigned to (EI#5) prior to RI#1's fall on January 17, 2023. EI#5 added that she (EI#5) now tries to "lay eyes" on all the residents during her (EI#5's) shift, even the residents who are not assigned to her (EI#5). EI#5 stated "I had no idea she (EI#9) was not doing her job". When asked if staffing was adequate on the night shift, EI#5 staffed that staffing was adequate.

EI#7, Care Specialist, had been employed at the facility since October 4, 2022. EI#7 stated she (EI#7) was not assigned to care for RI#1 on the night of January 16-17, 2023 and added that EI#9 was assigned to RI#1 on that night. EI#7 was not aware that RI#1 had fallen until she (EI#7) received a call from the facility later in the morning on January 17, 2023. EI#7 stated she (EI#7) had worked with EI#9 two times previously but was not aware EI#9 was not checking on her (EI#9's) residents because they worked on different halls. EI#7 stated she (EI#7) was trained to check on residents every two hours. When asked about staffing on the night shift, EI#7 stated that staffing was adequate.

Review of the Thrive Senior Living Job Title: Care Specialist on January 24, 2023 revealed the following Duties and Responsibilities:

Verify individualized service plan (ISP) and ensure appropriate care is being provided to the correct resident, Recognize and respond to the needs of residents, Assure that Staff Call System is within easy reach at all times and answered promptly, Follow established safety precautions and observe, monitor and intervene or report unsafe conditions in the facility.

Review of the Thrive Senior Living Job Title: Experience Coordinator-Med Tech on January 24, 2023 revealed the following Essential Responsibilities: Recognize and respond to the needs of residents and team members Ensure all assigned tasks are handled in accordance with Community policies and procedures as instructed by supervisor. During an interview on January 25, 2023, RI#1's sponsor informed the surveyor that he/she had reported two times that RI#1's call pendant was missing. The first lime was January 15, 2023 and the report was made to a staff member on duty at the time (name and title unknown). The second time was January 16, 2023 and the report was made to the administrator, EI#1. When interviewed on January 26, 2023, EI#1 stated RI#1's sponsor had paid for RI#1 to have a pendant in addition to the pull cords already in place in RI#1's bedroom and bathroom. EI#1 also staled RI#1's sponsor had reported to her (EI#1), on January 16, 2023, that RI#1's pendant was missing. EI#1 stated she (EI#1) had a new pendant created that same day for RI#1 and ii was given to the Medication Technician to deliver to RI#1. The Medication Technician delivered the pendant to the wrong resident. EI#1 staled RI#1 did not receive the new pendant until after the fall occurred on January 17, 2023.

During an interview with EI#4, Licensed Practical Nurse (LPN), on January 24, 2023, EI#4 stated she (EI#4) assessed RI#1 following the fall on January 17, 2023. After assisting RI#1 to the chair, EI#4 then asked RI#1 if he/she (RI#1) had the call pendant. RI#1 held up the purple string which had previously been attached to the call pendant to allow RI#1 to wear the pendant around the neck. The pendant was missing. EI#4 stated she (EI#4) reported the missing pendant to management and a new one was provided that same day.

When interviewed on January 24, 2023, EI#1, Administrator, informed the surveyor EI#9 had been trained on facility policies as well as Slate Rules for Assisted Living Facilities.

Documentation of the training was provided. However, oversight of EI#9 was not provided to ensure EI#9 utilized the training provided and performed the essential duties of her (EI#9's) job. The administrator failed to manage staff activities in a manner that resulted in a safe environment and adequate care being provided at all times for RI#1. A functional call system was not available to RI#1 even though RI#1's sponsor had purchased an additional

method of utilizing the system for RI#1 (pendant) and had notified the administrator when the additional system (pendant) was no longer available. These failures resulted in actual harm to RI#1 and placed all residents of the facility at significant risk of harm.

2. Corrective Action(s) in response to resident/example identified in the statement of deficiencies:

   (a) The Administrator stayed with RI#1 at the hospital until the POA was able to transport RI#1 back to the facility. The Administrator provided a replacement pendant to the RI#1 upon arrival to the facility. The Administrator instructed the staff to complete frequent checks on RI#1.

   (b) Employee EI#9 who failed to complete frequent checks on the resident was suspended, pending investigation on January 17th, 2023. The Administrator reported the incident to ADPH and opened an internal investigation.

   (c) The facility provided 24/7 sitters for RI#1 starting on 1/24/2023. The facility utilized staff and Home Instead for sitter services until the resident was discharge to another IL/ALF/SCALF Facility.

3. Corrective Action(s) the community will take to identify other residents or concerns not identified by the survey team that are related to those cited in your statement of deficiency:

   (a) The Administrator, Health & Wellness Director, Business Office Manager, or Designee will audit the current resident files to ensure that each resident who purchased a pendant has one in their possession. The audit will be completed by June 30th, 2023.

   (b) Employee EI#9 was terminated once the internal investigation was complete.

   The Administrator, Health & Wellness Director, Business Office Manager, or Designee will complete an in-service with current Nurses, MedTechs, and Care Specialists to ensure each employee understands their job description and responsibilities. The in-service will be completed by June 30th , 2023.

(c)The Administrator, Health & Wellness Director, or Designee will audit current residents' fall history within the last 6 months. The audit will be completed by August 15th, 2023.

4. Measures/Changes put in place to ensure the same deficiency will not occur:

   (a) The Administrator, Health & Wellness Director, Business Office Manager, or Designee will audit the current resident files to ensure that each resident who purchased a pendant has one in their possession. A note will be added to the residents Care Plan if a pendant is in the resident's possession. The resident Care Plan notes will be completed by August 15th, 2023.

   (b) The Administrator, Health & Wellness Director, Business Office Manager, or Designee will complete an in-service with current Nurses, MedTechs, and Care Specialists to ensure each employee understands their job description and duties. All new hires will continue to review and sign their job descriptions and responsibilities at the time of hire. The in-service will be completed by June 30th, 2023.

   (c) The Administrator, Health & Wellness Director, or Designee will audit current residents fall history within the last 6 months to determine if additional safety measures need to be added to the resident's care plan. The resident Care Plan notes will be completed by August 15th, 2023.

5. How we will monitor proposed corrective action:

   (a) The residents who purchased and have a pendant in their possession will have a note located in their Care Plan. This will be monitored by the Administrator, Health & Wellness Director, or Designee. The Plan of Correction and supporting documents will be located in the Plan of Correction Binder, located in the Administrator office.

(b) The signed job descriptions and duties will be signed by the employee and will be located in their employee file. The in-service log for current employees will be located in the community in-service/training binder. The signed job descriptions, responsibilities, and in-service will be reviewed/completed by the Administrator, Health & Wellness Director, Business Office Director, or Designee by June 30th, 2023. The Plan of Correction and supporting documents will be located in the Plan of Correction Binder, located in the Administrator office.

(c) The Administrator, Health & Wellness Director, or Designee will review the falls and interventions at the monthly QA Meeting, this will be completed by August 15th, 2023. The Plan of Correction and supporting documents will be located in the Plan of Correction Binder, located in the Administrator office.

1. Cited Deficiency Number: 420-5-4.05 (3) (d) Records & Reports (ID Prefix Tag A504)

This Rule is not met as evidenced by: Based on record reviews and interviews, community standards of care were not followed for one resident's care by failure to perform periodic checks on the resident during an entire night hour shift.

THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

Findings:

The Alabama Department of Public Health received a complaint which alleged a resident of the facility sustained a fall and was left alone on the floor of their room for approximately nine hours on the night of January 16-17, 2023.

An incident investigation of the alleged fall was received by the Alabama Department of Public

Health, from the facility, prior to the onsite survey. The investigation conducted by the facility and interviews with facility staff during the onsite survey revealed the following timeline of events.

January 16, 2023
10:36 PM - EI#9 was seen on the camera passing down the 240 Hall. No residents' rooms were entered.
11:00 PM - EI#9 entered Resident Room 247 (not RI#1's room).

January 17, 2023
12:25 AM - EI#9 was observed on the camera in the hallway. No resident rooms were

entered.
12:37 AM - EI#9 was observed pulling laundry from the 260 Hall.
2:57 AM - EI#9 was observed passing down the hallway. No resident rooms were entered.
4:57 AM - EI#9 was observed on the 240 Hall. No resident rooms were entered.
6:45AM -EI#6 entered RI#1's room and found RI#1 on the floor. EI#6 called EI#8 for assistance.
6:45 AM - EI#4 was called to RI#1's room by EI#6 and EI#8. EI#4 assessed RI#1 and found a dime size skin tear to the right lower leg and bruising to the right arm. EI#4 administered Tylenol to RI#1 and did not feel it was necessary to transport RI#1 to the hospital. EI#4 observed RI#1 did not have a call pendant and was unable to recall what happened.
7:07 AM - EI#4 left a message for RI#1's sponsor notified the sponsor of RI#1's fall.
8:00 AM - RI#1's physician was notified of the
fall.
8:00AM - EI#3, RN, was notified of RI#1's fall by EI#4.

9:30 AM - RI#1's sponsor contacted EI#1, Administrator, to report RI#1 had actually fallen at 9:21 PM on January 16, 2023 and no one came to check on RI#1 throughout the night. The sponsor reported RI#1 was on the floor the entire night and unable to get up alone. This information was reported based on camera footage from a camera in RI#1's room which was observed by RI#1's sponsor.
9:40 AM - A comprehensive assessment of RI#1 was completed by EI#3. EI#3 found no new injuries and RI#1 had no pain in the lower right leg. RI#1's blood pressure was low (94/78), blood sugar was elevated (233) and RI#1 was confused. Due to the low blood pressure, EI#3 elevated RI#1's feet and provided caffeine. EI#3 did not feel it was necessary to transport RI#1 to the hospital at that time.
11:15 AM -A follow-up comprehensive assessment of RI#1 was completed by EI#3. At the time of the assessment, EI#3 identified a developing hematoma on the top of RI#1's head as well as increased confusion. EI#3 and EI#1 sent RI#1 to the hospital for evaluation and treatment.

RI#1 was not checked on by any facility staff during the hours of 10:00 PM on January 16, 2023 and 6:00 AM on January 17, 2023. As noted in deficiencies 303 and 1203, RI#1 did not have available the call pendant that had been paid for by RI#1's sponsor. RI#1 was unable to get up or to reach the emergency pull chords in the bathroom and bedroom to call for assistance.
RI#1 was evaluated and treated at the hospital for a scalp contusion and a urinary tract infection on January 17, 2023.

During interviews with facility staff on January 24, 2023, six staff members (EI#4, EI#5, EI#6, EI#7, EI#8 and EI#9) all stated they knew residents should be checked on at least every two hours. Several staff members stated they had not been trained at the facility to perform every two hour resident checks but they just knew it to be an acceptable standard of care and the right thing to do. EI#9 failed to monitor RI#1's status at least every two hours and to ensure RI#1 had access to the call system, placing RI#1 in an unsafe environment which resulted in actual harm to RI#1. In spite of the facility's camera footage which confirmed EI#9 did not enter RI#1's room on the night of January 11-12 and 16-17, 2023, EI#9 stated she (EI#9) checked on her residents. EI#9 offered no explanation for her (EI#9's) failure to monitor RI#1 on the nights of January 11-12 and 16-17, 2023.

2. Corrective Action(s) in response to resident/example identified in the statement of deficiencies:

   The facility provided 24/7 sitters for RI#1 starting on 1/24/2023. The facility utilized staff and Home Instead for sitter services until the resident was discharge to another IL/ALF/SCALF Facility.

3. Corrective Action(s) the community will take to identify other residents or concerns not identified by the survey team that are related to those cited in your statement of deficiency:

   The Administrator, Health & Wellness Director, or Designee will create a rounds report to allow the team to document when rounds are competed on each resident. This will be completed by 5/15/2023.

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4. Measures/Changes put in place to ensure the same deficiency will not occur:

   The Administrator, Health & Wellness Director, or Designee will monitor the Round Report to confirm that rounds were completed each shift. If a resident requests not to receive rounds, the request will be notated in the resident care plan. The Nurses/MedTechs/Care Specialists will be in-serviced on the facilities Rounds Policy by June 1st, 2023. Future Employees will sign the Rounds Policy at the time of hire and will review the Rounds Report at orientation. The Rounds Report will be implemented on June 1st, 2023.

5. How we will monitor proposed corrective action:

   The Administrator, Health & Wellness Director, or Designee will monitor the Rounds Report weekly, through August 15th, 2023. The Plan of Correction and supporting documents will be located in the Plan of Correction Binder, located in the Administrator office.

1. Cited Deficiency Number: 420-5-4-.06 (4) (a) (b) Care of Residents (ID Prefix Tag 611)

   This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain a care plan for a resident which addressed the residents current care needs with appropriate fall interventions to meet the care and safety needs of the resident.

   THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

   Findings:

The Alabama Department of Public Health received a complaint which alleged a resident of the facility fell and remained on the floor for approximately nine hours without being checked on by facility staff.Review of facility records for RI#1 on January 24, 2023, revealed the following information. RI#1 had resided at the facility since September 13, 2022. A 30-day discharge notice was issued to RI#1 on January 10, 2023 due to "severely cognitively impaired", "not able to

identify his/her medications, is a possible elopement risk or is not able to make good safety decisions". RI#1 sustained numerous falls at the facility on the following dates: September 22, 2022, found on the floor, no injury; September 29, 2022, found on the floor, hit head and sent to emergency department; October 5, 2022, found on floor, no injury; November 1, 2022, resident reported a fall, no injury; November 3, 2022, found on floor, skin tear to arm; November 20, 2022, found on floor, small cut to finger; December 24, 2022, slid out of lift chair, no injury, was confused at time of fall; December 25, 2022, found on floor in bathroom, no injury; January 17, 2023, found on floor, hematoma to head. RI#1's facility Care Service Plan was dated September 9, 2022. An initial entry on RI#1's Care Service Plan under Fall Precautions read "Educate resident to call for assistance". The Care Service Plan documented updates after the following falls under Fall Precautions: "9/22/22-slid off sofa.

Extra cushions removed for safety; 9/30/22-unwitnessed fall in suite. Resident stated...hit...head. Sent to er for evaluation; 10/5/22-unwitnessed fall. Lost balance opening door. Reminded to call for assistance with daily tasks; 11/1/22-resident self reported fall in suite. Resident teaching to use call pendent when incidents occur; 11/3/22-Unwitnessed fall in suite. Slid from lift recliner chair. Skin tear to left arm. Education provided on use of lift recliner chairs; 11/21/22-lost balance in hallway attempting to unlock door. Team to ensure resident has room key...when out of suite; 12/24/22-slid from lift chair. Education on proper use of lift chair for safety; 12/25/22-unwitnessed fall in bathroom.
Education for team to ensure resident has personal items close at hand; 1/17/23-fall in suite. Unwitnessed. Sent to er later the same day due to complaint of pain in neck and low B/P. Resident unable to recall how fall occurred". The interventions on October 5, 2022, November 1,
2022 and December 24, 2022 were repetitive. No new interventions were developed at the time of these falls to prevent recurrence.

When RI#1 was found on the floor January 17, 2023, RI#1's sponsor reported RI#1 had been on the floor for approximately nine hours and no facility staff had entered the room during the nine hours to assist RI#1. Although RI#1's facility care plan instructed staff to teach RI#1 to call for assistance, the staff failed to ensure RI#1 had a functional call system in place. In fact, at the time of the fall on January 17, 2023, RI#1 did not have a call pendant which had been paid for by RI#1's sponsor and had been reported missing two days before the fall. Following RI#1's fall on January 17, 2023, no additional interventions were

documented on RI#1's Care Service Plan to prevent additional falls and to keep RI#1 safe.

RI#1 had sustained nine falls during the four months he/she resided at the facility and RI#1 had confusion which limited RI#1's ability to make safe decisions. The facility staff had not implemented necessary measures to prevent additional falls for RI#1. On January 24, 2023, the surveyor requested a plan of action from EI#1 to keep RI#1 safe until discharged from the facility. EI#1 provided the plan which implemented 24-hour sitters for RI#1 until discharge.

2. Corrective Action(s) in response to resident/example identified in the statement of deficiencies:

   The facility provided 24/7 sitters for RI#1 starting on 1/24/2023. The facility utilized staff and Home Instead for sitter services until the resident was discharge to another IL/ALF/SCALF Facility.

3. Corrective Action(s) the community will take to identify other residents or concerns not identified by the survey team that are related to those cited in your statement of deficiency:

   The Administrator, Health & Wellness Director, or Designee will review each current resident's care plan to determine if appropriate, non-repetitive fall interventions are in place. The Administrator, Health & Wellness Director, or Designee will review each current resident's care plan to add appropriate interventions. This action will be completed by August 15th, 2023.

4. Measures/Changes put in place to ensure the same deficiency will not occur:

   The Administrator, Health & Wellness Director, or Designee will review each current resident's care plan to determine if appropriate, non-repetitive fall interventions are in place. The Administrator, Health & Wellness Director, or Designee will review each current resident's care plan to add appropriate interventions. The current resident care plan review will be completed by August 15th, 2023.

5. How we will monitor proposed corrective action:

   The Administrator, Health & Wellness Director, or Designee will confirm each current resident's care plan is updated with appropriate fall interventions and will be kept in the resident medical chart at completion. The Plan of Correction and supporting documents will be located in the Plan of Correction Binder, located in the Administrator office.

1. Cited Deficiency Number: 420-5-4-.06 (11) (b) Care of Residents (ID Prefix Tag A621)

   This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide all care needs and maintain a safe environment for the resident who was cognitively impaired and had been issued a 30 day notice.

   THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

   Findings:

RI#1 had resided at the facility since September 13, 2022. RI#1 sustained nine falls during the four months of residency at the facility. RI#1's Monthly Wellness Reviews contained documentation of the following changes. In September 2022, RI#1 refused activities of daily living and getting up from bed. In October 2022, physical therapy and occupational therapy were ordered for RI#1 but the therapy was refused by RI#1's sponsor. In November 2022, RI#1's cognitive status declined and behavioral health was ordered due to signs and symptoms of depression. In December 2022, RI#1 was unable to recognize his/her name on the medication packages and failed the medication awareness test. The December 2022 monthly review also documented RI#1's cognitive status had declined and RI#1 refused community activities. On January 10, 2023 a 30-day discharge notice was issued to RI#1 and sponsor due to RI#1 being "severely cognitively impaired...not able to identify his/her medications, is a possible elopement risk or is not able to make good safety decisions".

On the morning of January 24, 2023, the surveyor observed RI#1 ambulate a short distance in his/her room using a walker. RI#1's gait was slow and unsteady and RI#1 had some difficulty maneuvering the walker causing the walker to catch on furniture. RI#1 was wearing a call pendant on a string around the neck but did not remember the pendant was

available until asked by the surveyor. On the afternoon of January 24, 2023, the surveyor observed medication awareness testing of RI#1 by EI#2. RI#1 was presented with two medication packets and asked if the packets contained his/her name.

RI#1 quickly responded that he/she was unable to read the packets. Glasses and a magnifier were offered to RI#1 but RI#1 stated it "won't help". RI#1 added "I always just tell them to give them to me". When questioned about insulin injections RI#1 was unable to state how often insulin injections were given. RI#1 became very suspicious and agitated during the medication testing and asked why he/she was being questioned since the doctor had ordered his/her medications,

During interviews on January 24, 2023, multiple staff members reported RI#1 was frequently confused and was not safe to be alone, Staff reported RI#1 may not remember to call for assistance if needed. Staff also reported RI#1 had a history of hallucinations and had wandered into the wrong room at times when attempting to find his/her own room.

Following issuance of the 30-day discharge notice, no additional interventions were added to RI#1's facility care plan until a fall occurred on January 17, 2023, Refer to deficiency 611 for additional information on RI#1's care plan, Following RI#1's fall, a complaint was received by the Alabama Department of Public Health which alleged RI#1 had actually fallen on the night of January 16, 2023 and remained on the floor about nine hours without any staff entering RI#1's room or assisting RI#1 until the morning of January 17, 2023. Interviews with staff also revealed RI#1 did not have in his/her possession, at the time of the fall, the call pendant which had been paid for by RI#1's sponsor and had been reported missing by RI#1's sponsor two days before the fall. Refer to deficiency 1203 for additional information on RI#1's call pendant. The facility failed to take necessary steps to ensure that care needed by RI#1 was provided to keep RI#1 safe until discharge from the facility, At the request of the surveyor, a written plan of action was received from EI#1 during the onsite survey and 24 hour sitters were placed with RI#1 until discharge.

2. Corrective Action(s) in response to resident/example identified in the statement of deficiencies:

The facility provided 24/7 sitters for RI#1 starting on 1/24/2023. The facility utilized staff and Home Instead for sitter services until the resident was discharge to another IL/ALF/SCALF Facility.

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3. Corrective Action(s) the community will take to identify other residents or concerns not identified by the survey team that are related to those cited in your statement of deficiency:

   The Administrator, Health & Wellness Director, or Designee will review each Resident Care Plan/Assessment who is on a 30-Day notice to determine if appropriate interventions are in place. Facility to review each 30-day notice, through the August 15th, 2023, completion date.

4. Measures/Changes put in place to ensure the same deficiency will not occur:

   The Administrator, Health & Wellness Director, or Designee will review each Resident Care Plan/Assessment who is on a 30-Day notice to determine if appropriate interventions are in place. If additional interventions are needed the facility will add to the Care Plan at that time. Facility to review each 30-day notice, through the August 15th, 2023, completion date.

5. How we will monitor proposed corrective action:

   Resident care and 30-Day notices given will be discussed on the Weekly Corporate Conference Call. The Plan of Correction and supporting documents will be located in the Plan of Correction Binder, located in the Administrator office.

1. Cited Deficiency Number: 420-5-4-.12 (5) Physical Plant (ID Prefix Tag A1203)

   This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility allowed a portable heater in the room of a resident who was cognitively impaired. In addition, the facility failed to maintain a functional call system at all times for this resident.

Facility Name: Thrive at Jones Farm (ALF) Facility ID: D4548

Survey Exit Date: 01/26/2023 Administrator: Kelli Long

THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

Findings:

Portable Heater

On the morning of January 24, 2023, the surveyor entered RI#1's room at the facility. The room was *very* warm. RI#1 was seated in a chair in the living area of the room. A portable heater was in use in the room and was placed approximately 8-10 feet from RI#1. That same morning the surveyor discussed RI#1's use of the portable heater with EI#1 and the heater was *removed.*

Call System

The Alabama Department of Public Health received a complaint which alleged a resident fell and

remained on the floor for about nine hours without staff entering the room or assisting the resident. During the investigation of this complaint, the surveyor found an additional deficient practice affecting the resident's call system.

RI#1 had resided at the facility since September 13, 2022 and had been issued a 30-day discharge notice due to cognitive decline and inability to protect self from a medication error. In addition, RI#1 sustained nine falls while residing at the facility.

On January 24, 2023 EI#1 explained to the surveyor that all residents were provided with emergency pull cords located in the bedroom and bathroom of each apartment which the residents were instructed to pull if immediate assistance was needed. In addition, a call pendant could be purchased by the resident. The pendant was placed on a cord which could be worn around the neck and was available for the resident to push as needed wherever the resident was in the facility. Once the call system was activated by a resident, the calls were received by the person in charge on that shift via a pager. The person in charge was then responsible for notifying that resident's assigned caregiver to check on the resident. Once the caregiver went to the resident, the call system (pull cord or pendant) was reset by the caregiver to notify the person in charge that the call had been answered. EI#1 slated RI#1's sponsor had purchased a call pendant for RI#1 and the pendant had not been provided to RI#1.

During an interview with RI#1's sponsor on January 25, 2023, the sponsor stated that he/she had visited RI#1 on January 15 and was unable to locate the pendant at the time of the visit.

RI#1's sponsor stated he/she notified a staff member on duty at the time (name unknown) of the need for a replacement pendant for RI#1. RI#1's sponsor also stated he/she met with EI#1 on the afternoon of January 16, 2023 and notified EI#1 of the need for a new pendant at that time. When interviewed, EI#1 acknowledged she (EI#1) had been informed the pendant was missing and had immediately requested a new pendant be created. EI#1 stated the new pendant was given to the Medication Technician to deliver to RI#1 on January 16, 2023. However, the Medication Technician had delivered the call pendant to the wrong resident. RI#1's sponsor reported RI#1 had a camera in his/her room which could be monitored at the sponsor's home. The sponsor stated RI#1 had fallen around 9:20 PM on the night of January 16, 2023 and remained on the floor until around 6:40 AM on January 17, 2023 before anyone entered the room to check on RI#1. Surveyor review of the video footage from the facility's camera system confirmed no facility staff had entered RI#1's room on the night of January 16-17, 2023, between 10:00 PM and 6:00 AM.

During an interview on January 24, 2023, E1#4 reported she (E1#4) was notified of RI#1's fall by Care Specialists on the morning of January 17, 2023. EI#4 and Care Specialists assisted RI#1 from the floor to a chair. At that lime, EI#4 asked RI#1 about the call pendant and RI#1 picked up the

cord for the pendant from the table beside the chair but no pendant was on the cord. A pendant could not be located. EI#4 added a new pendant was provided to RI#1 on the morning of January 17, 2023, following RI#1's fall.

Although an additional device had been purchased to ensure RI#1 had a method of calling for assistance, the facility failed to ensure this device was available to the resident at all times. As a result, RI#1 had no way to call for assistance on the night of January 17, 2023. The surveyor and EI#2 checked RI#1's pendant as well as the two emergency pull cords on January 24, 2023 and ensured all were functional at that time.

2. Corrective Action(s) in response to resident/example identified in the statement of deficiencies:

(a) The Administrator provided a replacement pendant to RI#1 on 1/17/2023 and communicated to staff that frequent rounds were required.
(b) The portable heater was removed by the Administrator on 1/24/2023, the residents POA was notified.

Facility Name: Thrive at Jones Farm (ALF) Facility ID: D4548

Survey Exit Date: 01/26/2023 Administrator: Kelli Long

3. Corrective Action(s) the community will take to identify other residents or concerns not identified by the survey team that are related to those cited in your statement of deficiency:

   (a) The Administrator, Health & Wellness Director, Business Office Manager, or Designee will audit the current resident files to ensure that each resident who purchased a pendant has one in their possession. A note will be added to the residents Care Plan if a pendant is in the resident's possession. The audit will be completed by June 30th , 2023.

   (b) The Administrator, Health & Wellness Director, or Designee will complete Monthly Room Sweeps to ensure portable heaters are not located in the resident suites. This plan will be completed on August 15th, 2023.

4. Measures/Changes put in place to ensure the same deficiency will not occur:

   (a) The Administrator, Health & Wellness Director, Business Office Manager, or Designee will audit the current resident files to ensure that each resident who purchased a pendant has one in their possession. A note will be added to the residents Care Plan if a pendant is in the resident's possession. The resident care plans will be updated by August 15th, 2023.

   (b) The Administrator, Health & Wellness Director, or Designee will complete Monthly Room Sweeps to ensure portable heaters are not located in the resident suites. This plan will be completed by August 15th, 2023.

5 How we will monitor proposed corrective action:

   (a) The residents who purchased and have a pendant in their possession will have a note located in their Care Plan. This will be monitored by the Administrator, Health & Wellness Director, or Designee will complete this action by August 15th, 2023. The Plan of Correction and supporting documents will be located in the Plan of Correction Binder, located in the Administrator office.

(b) The Administrator, Health & Wellness Director, or Designee will complete Monthly Room Sweeps to ensure portable heaters are not located in the resident suites. This will be monitored and completed by August 15th, 2023. The Plan of Correction and supporting documents will be located in the Plan of Correction Binder, located in the Administrator office.

The Plan of Correction and the supporting documents will be located in the Plan of Correction Binder. The Plan of Correction Binder will be located in the Administrator's Office.

Kelli Long

Administrator

Thrive at Jones Farm-ALF

Facility Number: D4548

Survey Exit Date: 1/26/2023

Thrive at Jones Farm Plan of Correction. If you have any questions regarding the Plan of Correction, please contact me at 256-429-3008 or kelli.long@thriveatjonesfarm.com.

Thank you,

Kelli Long

Kelli Long, Administrator

Thrive at Jones Farm Community Rounding Policy

Date: May 9th, 2023

Purpose:

Regular rounding with residents is a critical component of high-quality care at our Alabama assisted living community. By making it a policy to round with residents at least twice per shift, we aim to improve communication, identify potential problems early on, increase resident satisfaction, and boost staff morale. Our goal is to ensure that all residents receive the best possible care and that staff members have a clear expectation of what is required of them.

Benefits:

1. Improved communication: Regular rounding promotes open communication between staff and residents, which leads to better care and stronger relationships.

2. Early problem identification: By checking in with residents regularly, staff members can identify potential problems or concerns early on, which helps prevent complications and improves outcomes for residents.

3. Increased resident satisfaction: Rounding allows staff members to address residents' needs and preferences in real-time, which leads to increased resident satisfaction and retention.

4. Improved staff morale: When staff members feel that they are providing high-quality care, they are more likely to feel motivated and engaged in their work, which leads to better outcomes for everyone.

Policy:

We require all staff members to round with residents at least twice per shift. During each round, staff members should check in with residents, ask about their needs and preferences, and offer assistance or support as needed. Staff members should also take note of any changes in residents' conditions or behavior and report them to the appropriate supervisor or healthcare provider. Each resident will be evaluated individually using our EHR System to determine if additional rounds are needed. If a resident requires additional rounds, it will be reflected in the resident's individual care plan and assigned task list.

We expect all staff members to make rounding a priority in their daily work and to adhere to this policy at all times. By doing so, we can ensure that our residents receive the highest quality care possible.

Month:	1st Shift Rounds- Hall Assignments	Care Specialist #1 Initials	Care Specialist #2 Initials	Care Specialist #3 Initials
Example:	Hall 150- 200, Hall 201-240, Hall 241-265	150-200 KL	Hall 201-240 KL	Hall 241-265 KL
1				
2				
3				
4				
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By Initialing your assigned shift, you are stating you followed the Rounds Policy and Completed the required Rounds during your shift.

Month:	2nd Shift Rounds- Hall Assignments	Care Specialist #1 Initials	Care Specialist #2 Initials	Care Specialist #3 Initials
Example:	Hall 150- 200, Hall 201-240, Hall 241-265	150-200 KL	Hall 201-240 KL	Hall 241-265 KL
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By Initialing your assigned shift, you are stating you followed the Rounds Policy and Completed the required Rounds during your shift.

Month:	3rd Shift Rounds- Hall Assignments	Care Specialist #1 Initials	Care Specialist #2 Initials	Care Specialist #3 Initials
Example:	Hall 150- 200, Hall 201-240, Hall 241-265	150-200 KL	Hall 201-240 KL	Hall 241-265 KL
1				
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3				
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By Initialing your assigned shift, you are stating you followed the Rounds Policy and Completed the required Rounds during your shift.