POC Accepted 3/25/24
Connie Cherry chg 03.26.2024

PLAN OF CORRECTION

Facility Name: The Harbor of Opelika Facility ID #: P4103

Survey Exit Date: 03/07/2024 Administrator: Sharon Lee

The following is the Plan of Correction for The Harbor of Opelika regarding the Statement of Deficiencies dated March 7,2024. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.

1. **Deficiency Number: 420-5-20-.04 (4) Personnel. A 403**
   - The facility failed to ensure prospective employees were not listed on the Alabama Department of Public Health Nurse Aide Abuse Registry for employees E#1, E#6 and E#7.

2. **Corrective Action:**
   - EI#1, EI#6 and EI#7 were re-screened on the Alabama Department of Public Health Nurse Aide Abuse Registry on 3/18/24.

3. **Steps taken to identify other concerns**
   - In response to the deficiency cited, all current employee records were reviewed by Administrator/Designee on 3/18/24 to verify that abuse registry was performed on employees prior to hire date, no further concerns identified.

4. **Measures, systems or changes put in place to ensure this deficiency will not reoccur:**
   - An in-service was performed with Business Office Manager on 3/15/24 that all prospective employees must have abuse registry cleared prior to hire date.
   - On 3/18/24 the facility enhanced and modified the protocol for Employee Hiring to ensure proper steps are taken to verify new employees meet hiring criteria prior to orientation and date of hire.
     - The procedure has been modified in which a position will be offered by phone/in person pending all pre-hire records are appropriate. The potential employee will then be instructed to obtain all pre-hire documents. During this time the Business Office Manager will check the Alabama Department of Public Health Nurse Aide Abuse Registry as well as the other pre hire checks needed. Dates will be completed on the Team Member Face-sheet. (SEE ATTACHMENT A).
     - Once pre-hire checks are completed, the Administrator will review and approve the pre-hire documents and sign the new hire face sheet for potential employee. The Business Office Manager will then contact the potential employee and schedule the orientation date.

5. **Monitoring of proposed corrective actions to ensure implementation:**
   - Copies of all new hire Face Sheets and the accompanied Abuse Registry Checks will be placed in the Plan of Correction binder for compliance review for a period of six (6) months.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team.

1. **Deficiency Number: 420-5-20-.06(1) Care of Residents A 601**
   - The facility failed to follow physician orders for the resident's oxygen administration for residents RI#4 and RI#8.

2. **Corrective Action**

   - In response to the deficiency cited, RI#4, physician was contacted for clarification on Oxygen order. On 3/7/2024, a clarification order was received for oxygen saturations to be checked daily and was transcribed correctly on the MAR.
   - RI#8 physician was contacted for clarification on Oxygen order. On 3/7/2024, a clarification order was received for oxygen saturations to be checked daily and was transcribed correctly on the MAR.

3. **Steps taken to identify other concerns.**

   - RN audited all current oxygen orders for all residents on 3/21/24 utilizing oxygen to ensure orders are appropriate and reflected as such on MAR. No further concerns identified.

4. **Measures, systems, or changes put in place to ensure this deficiency will not reoccur:**

   - An in-service was performed on 3/13/24 by Administrator with nursing staff regarding admitting or readmitting residents and that all medical exam forms or new orders for oxygen have appropriate orders and are listed correctly on the MAR.
   - In-services will be performed 3/25/24 and 3/26/24 by pharmacy with nursing staff on proper steps to acknowledge all orders in the EMAR by matching the order from the physician prior to approving the order in the EMAR system.

5. **Monitoring of proposed corrective actions to ensure implementation.**

   - Copies of all oxygen orders and the sign off from the clinical designee will be placed in the Plan of Correction binder after the administrator has verified that the oxygen order was transcribed properly for compliance review for a period of six (6) months.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team and the Governing Authority.

1. **Deficiency Number: 420-5-20-.06(1) Care of Residents A 602**

   - RI#8's initial Medical Exam was not documented prior to the resident's admission to the facility.
   - RI#8 was admitted to the facility 3/31/21. Review of RI#8's facility record on 3/7/24 revealed RI#8's Admission Medical Examination was dated for 4/1/21, after RI#8's admission to the facility.

2. **Corrective Action**

   - RI#8 is an existing resident in the facility with a current Medical Exam.

3. **Steps taken to identify other concerns**

   - An audit of all current resident's Admission Medical Exams was performed on 3/22/24 by Administrator to ensure that all Admission Medical Exams were properly dated, furthermore, that all residents have current Medical Exams.

4. **Measures, systems, or changes put in place to ensure this deficiency will not reoccur:**

   - In-service was performed by Regional Director of Operations on 3/7/24 with Administrator, Resident Services Director, and RN regarding residents not physically moving in the community until after the medical exam form is complete and received by facility.
   - The community enhanced the resident face sheet to reflect two areas, one specifying a billing start date and one specifying the date of physical move-in. SEE ATTACHMENT B

5. **Monitoring of proposed corrective actions to ensure implementation**

   - The administrator or designee will sign off on all Admission Medical Exams and Face sheets that will be placed in the survey binder to ensure that dates are correct based on physical admission on each newly admitted residents for six (6) months.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team and the Governing Authority.

1. **Deficiency Number: 420-5-20-.06 (3) (f) Care of Residents. A 605**

   - The facility failed to arrange prompt medical attention for a resident when a change in the resident's health condition occurred in 2021.

2. **Corrective Action**

   - RI#11 is no longer a resident of the community.

3. **Steps taken to identify other concerns**

   - The nurse contacted by care staff in response to this incident is no longer employed with the facility as of 8/26/2022.
   - Administrator performed an audit of incident reports for the last six (six) months in order to verify that no other delays in care are identified on 3/22/24, no further concerns were identified.

4. **Measures, systems, or changes put in place to ensure this deficiency will not reoccur:**

   - In-service was performed by Administrator on 3/12/24 with all staff on resident safety, fall protocols in reporting of injuries, EMS activation, as well as the chain of command for notification of incidents.
   - Business Office Manager to provide training on resident safety, fall protocols in reporting of injuries, EMS activation, as well as the chain of command for notification of incidents, with new staff members upon hire. These training topics will be emphasized on the New Hire Checklist. SEE ATTACHMENT C.
   - Shift reports, to include any incidents, to be reviewed by Administrator during stand-up to ensure injuries are properly reported and treatment is sought as appropriate.

5. **Monitoring of proposed corrective actions to ensure implementation**

   - Incident Log to be maintained by Administrator in the survey binder as incidents occur and reviewed weekly times four (4) weeks then monthly times five (5) months to ensure that all incidents were addressed timely and all residents received care as appropriate.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team and the Governing Authority.

1. **Deficiency Number: 420-5-20-.06 (7) Care of Residents. A 618**

   - The facility failed to document Oxygen usage on residents' MARs.
   - Oxygen tanks were not stored safely.

2. **Corrective Action**

   - In response to the deficiency cited, RI#4, physician was contacted for clarification on Oxygen order. On 3/7/2024, a clarification order was received for oxygen saturations to be checked daily and was transcribed correctly on the MAR.
   - RI#8 physician was contacted for clarification on Oxygen order. On 3/7/2024, a clarification order was received for oxygen saturations to be checked daily and was transcribed correctly on the MAR.
   - Portable Oxygen cylinders were removed from the facility by Lincare on 3/6/24.

3. **Steps taken to identify other concerns**

   - An audit was conducted of all resident rooms on 3/7/24. It was verified that no further Oxygen tanks were found to be stored inappropriately in the community.

4. **Measures, systems, or changes put in place to ensure this deficiency will not reoccur:**

   - In-services to be conducted on 3/25/24 and 3/26/24 by pharmacy regarding safe storage of portable Oxygen cylinders and that all individual oxygen cylinders to be secured at the nurses' station in racks with security chains. All Staff education to include to direct all DME companies to the nurses' station for the delivery and proper storage of oxygen.
   - In services to be conducted on 3/25/24 and 3/26/24 by the community Administrator to re-educate all nurses on the community's policy that all oxygen orders will be verified daily and documented on the MAR to include date, time, rate, and proper function of the equipment.
   - Oxygen Storage Checks have been added to the preventative maintenance program to be inspected on a monthly basis by the Facility Plant Director.

5. **Monitoring of proposed corrective actions to ensure implementation**

   - An audit of resident apartments with Oxygen orders as well as observation of Oxygen storage in the nurses' station will be conducted by the Administrator or designee monthly times six (6) months to ensure that all Oxygen is stored safely and appropriately within the facility. The Oxygen checks will be logged and placed in the survey binder.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team and the Governing Authority.

1. **Deficiency Number: 420-5-20-.07 (2) Food Service A 702**

- The facility refrigerators did not maintain a maximum temperature of 41 degrees Fahrenheit. It was noted that facility refrigerators were not maintaining the maximum temperature of 41 degrees in the following rooms: 1, 3, 4, 7, 9, 11, 12, 13, 14, 15, 20, 23, and 24.
- In addition, the facility failed to provide hot food at the minimum temperature of 135 degrees. Hot food was not maintained at 135 degrees as required.

2. **Corrective Action**

- Upon identification of the deficiency on 3/5/2024, the Plant Director immediately adjusted resident refrigerators in rooms 1, 3, 4, 7, 9, 11, 12, 13, 14, 15, 20, 23, and 24 to maintain a temperature of no greater than 41 degrees.
- In-service conducted by Regional Director of Operations with Dietary Manager on 3/21/24 regarding water fill levels on steam table to ensure that steam table is heated up appropriately to maintain food temperatures at 135 degrees prior to serving meals.

3. **Steps taken to identify other concerns**

- All refrigerator temperatures were checked on 3/7/24 by the community Plant Director and temperature adjustments were made as necessary to maintain a temperature of no greater than 41 degrees, no further concerns were identified.
- Lunch service was observed by the Administrator on 3/22/2024 with temperatures taken during meal prep, plate prep, and serving. The hushpuppies were served at 123.3 degrees.

4. **Measures, systems, or changes put in place to ensure this deficiency will not reoccur:**

- In-service conducted with staff by the Administrator on 3/22/24 regarding daily task of refrigerator temperature monitoring and use of refrigerator temperature logs. Logs to be kept in a log book. The community Plant Director will review refrigerator temperature logs weekly to ensure no refrigerator temperature adjustments are needed. Adjustments to be made as necessary and logged in to the Maintenance Reporting System (TELS).
- In-service conducted by Regional Director of Operations with Dietary Manager on 3/21/24 on dietary food temperature regulations.
- The community has contracted with Gordons Food Service to recalibrate the communities steam table so that it will hold proper temperature prior to serving food. Awaiting completion of service call.
- The community's meal prep, plate prep, and meal service process was enhanced to include food temperatures to be taken every 15 minutes while serving to verify that all food temperatures are maintained at 135 degrees prior to serving meals and logged at each meal.

5. **Monitoring of proposed corrective actions to ensure implementation**

- Administrator or designee to review refrigerator temperature logs monthly times six (6) months to ensure refrigerator temperatures are being recorded daily and that they are maintained at a temperature of no greater than 41 degrees.

- Administrator or designee to review log of food temperatures weekly times four (4) weeks then monthly times five (5) months to ensure appropriate food temperatures are being met at each meal.
- Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team and the Governing Authority.

1. **Deficiency Number: 420-5-20-.10 (1) Sanitation and Housekeeping A 1001**

   - Resident Rooms 12,14,3,2, and 1 water temperatures were not maintained below 110 degrees.

2. **Corrective Action:**

   - The Plant Director immediately adjusted water temperatures in rooms 12, 14, 3, 2, and 1 when the deficiency was identified on 3/6/2024 by the ADOPH survey team. The temperatures were verified to be maintained at no greater than 110 degrees on 3/6/2024.

3. **Steps taken to identify other concerns:**

   - On 3/6/2024, the Plant Director assessed water temperatures throughout the remainder of the community and adjustments were made to any water temperature that exceeded 110 degrees.

4. **Measures, systems, or changes put in place to ensure this deficiency will not reoccur:**

   - In-service conducted with the Plant Director by the Governing Authority Director of Physical Plant Support on 3/6/24 on proper water temperature regulations.
   - Water temperature checks to be implemented weekly times four (4) weeks then resume monthly by Maintenance Director and recorded in the Maintenance Reporting System (TELS).

5. **Monitoring of proposed corrective actions to ensure implementation:**

   - Administrator or designee to verify the water temperature checks along with the Plant Director weekly times four (4) weeks and then monthly times five (5) months to ensure that no water temperature exceeds 110 degrees.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team and the Governing Authority.

1. **Deficiency Number: 420-5-20-.10 (2) Sanitation and Housekeeping A 1002**

   - The facility lavatory was not in proper working order in room 14 as the toilet rocked in multiple directions when pressure was applied to the toilet.

2. **Corrective Action**

   - On 3/6/2024, immediately when the deficiency was identified by the ADPH survey team, the Plant Director stabilized the toilet for immediate safety.
   - On 3/21/24, the Plant Director removed the toilet and re leveled the concrete flooring. The toilet was then replaced once the flooring surrounding the toilet was level.

3. **Steps taken to identify other concerns**

   - The Plant Director assessed all facility lavatories on 3/21/24 for toilet instability and verified that all other lavatories were in proper working order. No further concerns identified.

4. **Measures, systems, or changes put in place to ensure this deficiency will not reoccur:**

   - In-service will be conducted on 3/25/24 and 3/26/24 with all staff by the community Plant Director to educate staff on how to place a work order for repairs of items that staff identify as needed repaired or potentially unsafe for assessment and review.

5. **Monitoring of proposed corrective actions to ensure implementation**

   - Administrator or designee to verify that the community monthly safety audits have been performed for six (6) months to make sure checks are being performed as implemented. The monthly safety audit includes an audit of flooring and resident room safety checks in the TELS system.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team and the Governing Authority.

1. **Deficiency Number: 420-5-20-.12 (5) Physical Environment A 1203**

   - Fire extinguisher #6 located in hallway did not have an inspection tag to document monthly visual inspections.
   - The emergency lighting system between the administrator's office and storage room was not working.

2. **Corrective Action:**

   - On 3/6/24, immediately when the citation was identified by the ADPH survey team, East Alabama Fire and Safety was notified of the citation and arrived onsite to audit all fire extinguishers. The tag was replaced on Fire Extinguisher #6.
   - On 3/6/2024, immediately when the citation was identified by the ADPH survey team, the Plant Director replaced the emergency light.

3. **Steps taken to identify other concerns:**

   - The Plant Director assessed all fire extinguishers on 3/6/24 and verified that all fire extinguishers had tags as appropriate. No further concerns identified.
   - The Plant Director assessed all emergency lights on 3/6/24 and verified that all other emergency lights were in proper working order. No further concerns identified.

4. **Measures, systems, or changes put in place to ensure this deficiency will not reoccur:**

   - The Plant Director was in-serviced by Governing Authority Director of Physical Plant Support on 3/6/24 regarding monthly fire extinguisher checks to include ensuring tags are in place and not damaged. Any missing or damaged tags will be addressed and corrected immediately.
   - The Plant Director was in-serviced by Governing Authority Director of Physical Plant Support on 3/6/2024 regarding performing monthly emergency light checks.

5. **Monitoring of proposed corrective actions to ensure implementation:**

   - Administrator or designee to monitor TELS monthly times six (6) months to ensure fire extinguisher checks and emergency light checks are being completed.
   - Further Compliance of this deficiency will be overviewed monthly by our Quality Assurance Committee, including the Interdisciplinary Team and the Governing Authority.

Note: All Plan of Correction documentation will be in a binder, organized and filed by the Administrator. This binder will be stored in the Administrator's office.

Should any corrective action be determined as ineffective, the Administrator and Governing Authority shall make immediate revisions and submit an amended Plan of Correction to the Alabama State Board of Health.

Administrator Signature: Sharon Lee *Date:* 3-25-24

Prepared by Sharon Lee, Administrator

The Harbor at Opelika, 334-451-1245

ATTACHMENT A

The Harbor
at Opelika
A Premier Memory Care Center

Employee Name: _____

Title: _____

Date of hire: _____

Date of initial resident contact: _____

- Application Date:_____
- Abuse Registry Check Date: _____
- DHR Abuse Registry Check Date: _____
- TB Screening Date:_____
- MD Exam Date: _____
- Drug Test Date:_____
- Vaccine Acceptance/Declination Date:_____
- Background Check Date:_____
- Verification of licensure and/or certifications (if applicable) Expiration Date:_____
- CPR Certification Expiration Date:_____
- Initial Training Checklist completion Date: _____

_____

BOM/HR Date

_____

Administrator Date

THE HARBOR AT OPELIKA

ATTACHMENT B

The Harbor at Opelika
A Premier Memory Care Center

ADMISSION INFORMATION RECORD

Admission Date:_____ Billing Start Date:_____

Resident Name_____

Address_____Discharge Date:_____

Marital Status_____Sex_____Religion_____Nationality_____

Social Security Number_____Date of Birth _____Age _____

Legal Guardian or P.O.A._____ Relationship _____

Address _____ Zip Code _____Telephone ( ) _____

Sponsor _____ Relationship _____

Address _____Zip Code _____ Telephone ( ) _____

Nearest Relative _____ Relationship _____

Address _____Zip Code _____ Telephone ( ) _____

Medicare Number _____Other Insurance _____

Veteran Status and Number _____

Name of Private Physician _____ Telephone ( )_____

Name of Private Dentist_____ Telephone ( ) _____

Pharmacy _____

Living Will?_____ Advanced Directive_____Copy for our file_____ DNR__

Ambulance Preference _____

Religious Preference _____

Hospital Preference _____

Nursing Home Preference _____

Funeral Home Preference _____

Insurance Policies (Funeral Arrangements/Burial Provisions)_____

_____

OTHER PHYSICIANS OR AGENCIES PROVIDING ASSISTANCE TO RESIDENT:

Name _____ Phone No. ( ) _____

Name _____ Phone No. ( ) _____

Name _____ Phone No. ( ) _____

FACILITY SETTING OR INSTITUTION TO WHICH DISCHARGED _____

DATE OF DEATH _____ CAUSE OF DEATH (IF KNOWN) _____

DISCHARGE NOTE _____

_____

ATTACHMENT C

THE HARBOR AT OPELIKA

SCALF LICENSED TEAM MEMBER INITIAL TRAINING RECORD

Employee Name: _____ Date of Hire: _____

INITIALS	*INSERVICE*	*DATE*	*HOURS*
	Licensed: DETA Brain Series / Non-licensed: DETA Care Series		
	Nutrition, Hydration, Feeding Techniques		
	Safety Needs		
	CPR		
	Basic First Aid		
	Diversion and Redirection Techniques		
	Understanding of caring for Residents with Agnosia, Amnesia, Aphasia and Apraxia		
	State Law and Rules for SCALF		
	Identification and Reporting of Abuse, Neglect and Exploitation		
	Advance Directives		
	Protecting Resident Confidentiality (includes residents rights)		
	Safety & Nutritional Needs (includes incident reporting, fall prevention & infection control)		
	Oxygen Safety		
	Fire Safety		
	Special Needs of the Elderly, Mentally Ill & Mental Retardation		
	Identifying Signs & Symptoms of Dementia		
	Administrator, RN, Nurses and Unit Coordinator		
	DETA Assessment Series		
	Pharmacological Management of Psychotropic Drugs		

_____ _____ _____

Employee Signature Trainer Date

_____ _____

Administrator Signature Date