POC accepted 12/16/2024

Plan of Correction

Facility Name:	Heritage Assisted Living
Facility ID Number:	D4209
Name of Administrator:	Lori Moore
Survey Exit Date:	11/20/2024

1. **Cited Deficiency Number: 420-5-4-.05 (3)(d) Records and Reports – Maintenance Door - A504**

2. **Corrective action taken for each Resident/example identified in the SOD/frequency of action:**
   The maintenance doorknob was replaced on 12/11/24 with a new automatic door locking knob that is coded for entry. The door is also being fitted with a self-closing mechanism so that the door closes automatically. The mechanism was ordered from HD Supply, and we are waiting for it to come in at the time of this POC writing.

3. **Additional corrective action(s) that the facility will take to identify other residents or concerns:**
   Staff will make sure that all doors that residents aren't allowed to enter are closed and locked behind them when they leave the room. The Maintenance Director will check the lock and closing mechanism monthly to ensure it is working correctly. This will be recorded on a log sheet hung in the Maintenance Shop.

4. **Measures and changes put in place to ensure deficiency will not recur.**
   All staff will be in serviced at the next employee meeting on 01/23/25 on the importance of making sure the Maintenance Shop door stays closed and always locked.

5. **Monitoring of corrective actions and staff accountability/frequency and location of logs:**
   The Executive Director will check the log maintained by the Maintenance Director bi-monthly to make sure it is being checked. The Executive Director will check the log maintained by the Maintenance Director bi- monthly to make sure it is being checked. After 12 months, the Executive Director will re-evaluate the log sheet recording and the compliance of the door remaining locked and shut. If the corrective action put in place is effective per the Executive Directors findings, Maintenance Director will no longer record the log sheet.

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1. **Cited Deficiency Number: 420-5-4-.05 (3)(d) Records and Reports – Person Centered Care- A504**

2. **Corrective action taken for each Resident/example identified in the SOD/frequency of action:**
   Three times daily and four times daily medications have been scheduled for specific times effective 11/21/24. Three times daily= 8:00am, 2:00pm, 8:00pm and four times daily= 8:00am, 12:00pm, 4:00pm and 8:00pm. This was put in place on 11/21/24 by the Director of Resident Services and Guardian Pharmacy Representative, Samone Miller. The medication times were fixed in the EMAR to reflect the changes above.

3. **Additional corrective action(s) that the facility will take to identify other residents or concerns:**
   All nurses and medication technicians were retrained on the new medication times on 11/21/24 by Samone Miller of Guardian Pharmacy.

4. **Measures and changes put in place to ensure deficiency will not recur.**
   All pharmacy orders will have the new scheduled medication times in place when the facility receives medications from Guardian Pharmacy. This went into effect on 11/21/24.

5. **Monitoring of corrective actions and staff accountability/frequency and location of logs:**
   The Director of Resident Services (DORS) or her representative will review all new orders to verify correct times. The third shift nurse will check all incoming meds for correctness nightly against what the EMAR says. The EMAR will be checked weekly by the DORS or her representative to make sure all medications are given correctly. If there is an error that has occurred, the staff member making the error will be taken off the schedule until they can be reeducated by proper procedure. A random audit of 5 residents will be performed by the DORS monthly for 9 months to ensure TID and QID medications are at scheduled times. After the 9-month period the DORS and the ED will evaluate that the corrective actions put in place are effective, and if determined effective will no longer record random audits. The nightly audits and weekly EMARS will continue but no longer be recorded after the nine (9) month period.

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1. **Cited Deficiency Number: 420-5-4-.06 (5)(a)(b)(c)(d)(e)- Care of Residents – No Physicians Orders – A613**

2. **Corrective action taken for each Resident/example identified in the SOD/frequency of action:**
   A Physician's order was obtained on 11/21/24 for the resident in question by the exit interview.

3. **Additional corrective action(s) that the facility will take to identify other residents or concerns:**
   All O2 orders will be in hand before admitting a new or returning resident.

4. **Measures and changes put in place to ensure deficiency will not recur.**
   O2 orders for new residents or returning residents will be verified by the Director of Resident Services or her representative before the resident may enter the community.

   Monitoring of corrective actions and staff accountability/frequency and location of logs:
   The Director of Resident Services (DORS) or her representative will check all new orders to make sure that O2 orders are seen and documented. The DORS will verify residents on oxygen and document monthly to ensure residents that are on oxygen have a current order and the oxygen is care planned; signage posted on door. The Administrator will review the documents monthly for 12 months then quarterly after that.

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1. **Cited Deficiency Number: 420-5-4-.06 (5)(a)(b)(c)(d)(e)- Care of Residents – Prescription Medication – A613**

2. **Corrective action taken for each Resident/example identified in the SOD/frequency of action:**
   As of 11/28/24, all apartments were checked for medications and orders that matched. If there were no orders for the medications, the medications were taken and given to the family or destroyed.

3. **Additional corrective action(s) that the facility will take to identify other residents or concerns:**
   A Resident Medication Policy Form will be included in the Move In Packet for all new residents. This form explains what medications may/may not be kept in the apartment and how it is to be stored. The form also explains what medications may need an order from their physician. All current residents/POA's will be given the medication form to fill out and complete. This will be completed by 01/31/25.

4. **Measures and changes put in place to ensure deficiency will not recur.**
   Residents' apartments will be checked monthly for 6 months, then quarterly to make sure all medications in the residents' apartment have orders if required. This action will be done by the nurses or the mediation technicians as they do monthly medication testing.

5. **Monitoring of corrective actions and staff accountability/frequency and location of logs:**
   The Director of Resident Services (DORS) or her representative will spot check biweekly medication orders as they come in for 6 months to make sure that bedside medications are/are not approved. After the 9-month period, the ED and DORS will see if the corrective action put in place is effective, if effective, the log sheets will no longer be recorded but still checked bimonthly.

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1. **Cited Deficiency Number: 420-5-4-.06 (9)- Care of Residents – Oxygen Therapy – A618**

2. **Corrective action taken for each Resident/example identified in the SOD/frequency of action:**
   The O2 sign was in place by the end of the exit interview on 11/21/24.

3. **Additional corrective action(s) that the facility will take to identify other residents or concerns:**
   All O2 orders will be in hand before admitting a new or returning resident.

4. **Measures and changes put in place to ensure deficiency will not recur.**
   O2 orders for new residents or returning residents will be verified by the Director of Resident Services or her representative before the resident may enter the community. There will be a sign by the resident's door before the resident moves into the community.

5. **Monitoring of corrective actions and staff accountability/frequency and location of logs:**
   The Executive Director or her representative will do monthly checks to make sure all O2 signs are properly placed.

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1. **Cited Deficiency Number: 420-5-4-.07 (1)- Food Service – A701**

2. **Corrective action taken for each Resident/example identified in the SOD/frequency of action:**
   The Dietary Manager has been registered for a Serve Safe class on January 14, 2025, in Athens, AL with TSC Associates LLC.

3. **Additional corrective action(s) that the facility will take to identify other residents or concerns:**
   The Dietary Manager will do semiannual checks on kitchen employee certifications.

4. **Measures and changes put in place to ensure deficiency will not recur.**
   The kitchen employees will be registered for a renewal class at least 30 days before the certification expires to make sure the employee is current.

5. **Monitoring of corrective actions and staff accountability/frequency and location of logs:**
   The Executive Director will check the postings in the dining room semiannually to ensure compliance. The Executive Director will have a calendar reminder set for 2 months prior to Serve Safe expirations to ensure compliance.

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1. **Cited Deficiency Number: 420-5-4-.07(2) - Food Service – A702**

2. **Corrective action taken for each Resident/example identified in the SOD/frequency of action:**
   Thermometer in refrigerator was replaced and Maintenance Director (MD) did a thorough check to make sure the refrigerator was in working order. This was done on 11/22/24.

3. **Additional corrective action(s) that the facility will take to identify other residents or concerns:**
   The MD will move all the thermometers to the back of the refrigerators to ensure consistent temperatures. All refrigerators will be cleaned and checked for proper working order by 01/31/25.

4. **Measures and changes put in place to ensure deficiency will not recur.**
   On a monthly basis, 8 refrigerators will be randomly checked for temperature correctness starting 02/01/25. If the refrigerator is not within the temperature guidelines, it will be removed, serviced and returned to the resident with 72 hours.

5. **Monitoring of corrective actions and staff accountability/frequency and location of logs:**
   The MD will check the 8 random fridges monthly. The Executive Director will check his log book monthly to verify the temperatures are within compliance. If the refrigerator temps continue to remain in compliance, the ED will check the temps quarterly.

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1. **Cited Deficiency Number: 420-5-4-.07(2) – Food Service – A703**

2. **Corrective action taken for each Resident/example identified in the SOD/frequency of action:**
   Additional potable water was purchased on 11/20/24 by the President of SRI Midsouth, Rick Sweeney. This rectified the shortage of water on site.

3. **Additional corrective action(s) that the facility will take to identify other residents or concerns:**
   Water will be placed in the kitchen food storage area and will be locked up to prevent the water from being used for other purposes.

4. **Measures and changes put in place to ensure deficiency will not recur.**
   As new residents move in, the Dietary Manager (DM) will order new water to ensure compliance.

5. **Monitoring of corrective actions and staff accountability/frequency and location of logs:**
   The Executive Director will make monthly checks for 6 months and then quarterly checks on emergency water to ensure compliance.

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