POC Accepted 4.10.2024

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Plan of Correction

Providence Home Assisted Living
Facility D2301
Amanda Gamble, Administrator
Survey Exit Date: 3/27/24

1. A 302 **420-5-4-03 Administration (e) Policies**

2. On March 27, 2024, EI#3 was questioned on the policy for hand hygiene since she failed to sanitize between two medication passes. EI#3 was able to recite the protocol as written in the facility policy. On April 2, 2024, EI#3 was counseled for her failure to follow the facility policy to sanitize between each resident medication pass according to the infection control policy. The counseling form is found in the employees' file. EI#3 verbally acknowledged her understanding of the requirement and importance of proper sanitation practices.

3. Between the dates of March 27, 2024 and April 2, 2024, EI#1 has spoken with the other Resident Attendance on the importance of the facility policy for infection control and reviewed the facility's policy.

4. To ensure this deficient practice does not recur, staff were retrained April 2, 2024 on facility policy regarding hand hygiene in the infection control policy. This form includes an acknowledgment that staff will comply with the facility policy and failure to follow policy will result in disciplinary action. In addition, a Med Pass Review will be conducted with staff for the next three months by the Wellness Nurse to ensure proper hand sanitation between residents. After a three month period of satisfactory Med Pass Observations, Resident Attendants may go back to the Quarterly Med Pass Observation as stated in facility policy.

5. Each staff member's signed acknowledgment on facility's hand hygiene located in the infection control policy, will be maintained in the employee files. The Med Pass Reviews conducted by the Wellness Nurse will be kept in a survey binder in the Administrator's office ensuring the oversight of the Administrator.

1. 616 **420-5-4-07 (5) Medications (f)**

2. On March 26, 2024, EI#1 and EI#2 had a discussion with RI#3 regarding her medication being left out of her lock box. RI#3 was also counseled on the importance of keep her medication lock box locked at all times so that she could continue managing her medication safely.

3. On April 2, 2024, El#1 and El#7 met with all of the residents within the facility to discuss the rules and regulations of medications inside of resident's possession/rooms. Residents were reminded of the importance of keeping all medications locked away for safety at all times.

4. During the meeting, El#1 verbally shared with the residents of the facility that during the normal monthly room checks, Team Leaders would also be checking to make sure all medications are kept safely and according to State guidelines to ensure this deficient practice does not recur. This will be performed for the next six months. During the next six months, residents will be given up to two warnings if medications are found within the room without being in the provided lock box or other means of safely locking their medications within the rooms. After two warnings, which will be filed in the resident's binder, a resident that does not keep medications properly stored for safety will need to allow the facility to manage the resident's medication or either given a thirty day notice by the facility.

5. The room check sheets containing findings of medication that are not properly stored will be documented on a form which will be kept in the resident's file in the Administrator's office ensuring the oversight of the Administrator.

1. A 702 **420-5-4-07 Food Handling Procedures (k)**

2. On March 26, 2024, the emergency food of can goods and boxed foods with the emergency water was stored off of the floor in plastic bins away from the laundry but was in the same room due to storage issues. El#1 agreed that there needed to be a different location since laundry and chemicals were in the same room.

3. El#1 and maintenance moved all of the food and water on March 27, 2024 to the office of El#7 where it will be kept safely away from any possible contamination.

4. To ensure this deficient practice does not recur, monthly building checks of the facility's laundry room performed by the Assistant Administrator will be documented.

5. The monthly building check sheet will be documented and kept in Administrator's office in a binder and overseen by the Administrator to ensure this does not happen again.

1. A1002 **420-5-4-10 Sanitation and Housekeeping ; (d) General Storage (5)**

2. On March 26, 2024, there were multiple closets which served as storage that also contained water heaters. El#1 agreed that there needed to be a different location for all items and that water heater closets needed to be free and clear of any items store in the closets. On March 26, 2024, there were two small propane tanks which were being stored in the laundry room inside of a plastic bin for emergency purposes. El#1 agreed that the propane tanks should be removed.

3. On March 27, 2024, El#1 and El#3 removed all items from each closet and stored those items away from the water heater closets. On March 27, 2024, maintenance removed the two small propane tanks from the facility, which were located in the laundry room. Propane tanks will not be stored within the facility.

4. To ensure this deficient practice does not recur, monthly building checks of the facility's water heater closets and the laundry room which are performed by the Assistant Administrator will be documented. Water heater closets will stay free and clear of any other items within the facility now and in the future. Propane tanks will not be stored within the facility.

5. The monthly building check sheet will be documented and kept in Administrator's office in a binder and overseen by the Administrator to ensure this does not happen again.

1. A1203 **420-5-4-12 (5) Physical Environment (s) 1 Emergency Lighting; Fire Extinguishers**

2. On March 26, 2024, there were two emergency lights on hall "B" in the facility that were dim and not working at full capacity. There were also two fire extinguishers that were not visually inspected within the facility for February 2024. One fire extinguisher was discovered on March 26, 2024 and the other fire extinguisher was discovered on March 27, 2024. EI#1 agreed that all emergency lights should work at full capacity and that all fire extinguishers should be visually checked monthly.

3. On March 27, 2024, Maintenance replaced the bulbs on the two emergency lights discovered on hall "B" within the facility. On March 27, 2024, Maintenance also checked the two fire extinguishers that were missed in the month of February bringing all fire extinguishers current for March 2024.

4. To ensure this deficient practice does not recur, there is a monthly building check sheet for all fire extinguishers and emergency lighting that has been put into place for the facility. After Maintenance performs their monthly check, EI#7 will also check all emergency lighting and all fire extinguishers within the facility.

5. The monthly building check sheet will be documented and kept in Administrator's office and overseen by the Administrator to ensure this does not happen again.

Respectfully,
Amanda Gamble, Administrator
April 3, 2024

