Theresa Hawkins chg

PLAN OF CORRECTION 10/09/2024

Facility Name: The Brennity at Daphne Assisted Living **Facility ID#:** DO217

Survey Exit Date: 05/16/2024 **Administrator:** Shameka Gregory

A302 420-5-4-.03 (1) (e) Administration.

The facility failed to follow its own policies.

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.**

    - The administrator and RSD identified RI#6 not appropriate for retention, and the resident was discharged from the hospital to SCALF on 04/18/24. This resident's closed chart was reviewed.

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

    - EI#2 will assess 100% of all current residents who live in the assisted living and proceed with notifying administrator and regional nurse if resident is no longer appropriate. These assessments will be utilized to determine eligibility to continued stay and review of current care plan to ensure reflects current condition of resident. This assessment included a cognitive assessment, medication awareness testing, and elopement risk assessment of all residents. The administrator will promptly issue 30-day discharge notices to all residents identified as inappropriate for retention. For those residents who may have medical reasons contributing to the concern for eligibility and the situation is believed to be temporary due to a change in condition, efforts will be made by the facility to resolve the concern. If the issue cannot be resolved, a 30-day discharge notice will be issued at that time.
    - For those residents who may have medical reasons contributing to the concern for eligibility and the situation is believed to be temporary due to a change in condition, efforts will be made by the facility to resolve the concern. If the issue cannot be resolved, a 30-day discharge notice will be issued at that time.
    - Completed on 8/15/2024. Those care plans who do not reflect the current condition of each resident will be promptly updated by EI#2. This will be completed by 9/13/24.
    - Review of all monthly assessments of all current residents of the facility for past twelve months. Those residents who were identified with omitted monthly assessments, late entry monthly assessments will be documented and completed by EI#2. This will be done by 8/16/2024.

- EI#1 and EI#2 immediately began reviewing the EMAR dashboard daily to identify any concerns or issues with omitted medication documentation. Any issues were immediately addressed with staff on duty and the pharmacy was contacted as needed. This started on 07/16/24. Education provided to all nurses to assist in checking EMAR dashboard for all shifts, with RSD and administrator following up with these checks. This education was provided on 08/16/24.
- All care staff employees have been interviewed to identify any other attempts of elopements by any current resident of the facility. None identified at this time. This started on 08/13/24 and was completed on 08/14/24.
- All current employee records were reviewed to identify any past due or needed CPR certifications. Those employees identified as not currently CPR certified were immediately scheduled for a CPR certification class. This was completed on 5/17/24 by the Business Director with a class scheduled on 05/29/24 for 11am, 1pm, and 3:30pm for all employees.
- The last 12 months of fire drills were reviewed by EI#1 and Maintenance Director, done 8/9/24. March and April 2024 fire drills were documented and available at the facility for review. However, the reports did not include the time of day the drill was performed. These were corrected by recording a late entry time of day the fire drills were performed. This was corrected by EI#1 on 08/14/24.
- Random observation of all staff conducting rounding of residents began on 8/13/24.

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.**

- Inservice was done with all current nurses employed by facility on 7/24/2024 by EI#1 reviewing Policy: Rounding of Residents Protocol that was implemented as a result of this survey.
- All current staff in service done by EI#1 and EI#2 on 6/27/24 reviewing Elopement Policy and Rounding of Residents Protocol.
- In service with care staff on 5/20/24 done by EI#1 and EI#2 with review of Elopement Policy.
- In service with nurses on Policy: Rounding of Residents Protocol, done by EI#1 and EI#2 on 06/13/24 and again on 07/24/24.
- In service with nursing staff on Policy: Incident Reports, Fall Prevention on 6/13/24. Done by EI#1 and EI#2.

- In service with care staff on Policy: Incident Reports, Investigations, ADPH Reports, and Fall Prevention 06/27/24. Done by EI#1 and EI#2.
- Inservice training with elopement drill performed on 5/22/24, done by EI#1.
- All staff training conducted by EI#1 on admission and retention of residents policy, including immediate notification to administrator shall concerns for eligibility are identified and medication policy to include daily med pass protocol, review of actions to take if medications are not available or if resident unable to protect self from potential medication error, review of elopement policy with specific attention to definition of elopement and actions to take if a resident is identified as missing, staff training on CPR requirement within 90 days of hire, fire drill policy and procedure, protocol for rounding on residents with specific attention that each employee shall visually see the resident during these rounds ensuring safety needs are met, Training is also provided review of Policy: Records and Reports-Resident Plan of Care (Service Plan) and Policy: Records and Reports-Resident Incident Reports, Investigations and ADPH Reports.. This was initiated on 08/14/24 and will be completed on 8/28/24, done by EI#1 and EI#2. This will be mandatory training for all staff, and should an employee not attend the in-service by 08/28/24, the employee will be removed from the schedule until the training has been completed. Refresher training and training on additional subject matter will be provided on an ongoing and as needed basis as determined by the administrator.
- Previously, facility LPN(s) were responsible for completing monthly assessments. This has been changed to the responsibility of RSD. RSD will complete all monthly assessments, effective 08/10/24. Shall any event that a facility LPN may need to assist the RSD with monthly assessments, the RSD will review those monthly assessments that were done by a facility LPN, ensuring accuracy of information documented. Training was provided to all LPN staff, including RSD, regarding properly conducting monthly assessments. Done by EI#1 on 8/13/24.
- Business Director with specific training provided by EI#1 that all new hires must be CPR certified within 90 days of hire and shall include a certification from an approved provider, done on 8/13/24.
- Maintenance director training provided by EI#1 on fire drill policy and procedure and responsibility of maintaining fire drills quarterly on each shift, responsibility of ensuring properly documented and if staff need improvement in fire drill process, education shall be provided at that time. Done by EI#1 on 8/13/24.
- Maintenance director training provided by EI#1 on elopement drill policy and procedure and responsibility of maintaining elopement drills quarterly on each

shift, responsibility of ensuring properly documented and if staff need improvement in elopement drill process, education shall be provided at that time. Done by EI#1 on 6/27/24.

- Specific training with RSD, done by administrator of RSD responsibility to immediately notify administrator of resident concerns for eligibility for admission and retention, done 8/13/24.
- Training provided by Sage Management consultant to RSD of properly assessing residents for admission and retention, completed on 08/14/24.
- All pre-admission assessments conducted by facility staff will include a cognitive assessment, elopement risk assessment, fall risk assessment, and medication awareness testing. These assessments will be reviewed by the administrator for approval prior to a prospective resident being admitted to the facility, effective immediately on 08/14/24.

4. **Explain how you will monitor your proposed corrective actions to ensure 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 choose 2 residents monthly and review their assessments and appropriateness for continued stay. This started immediately and ongoing until December 2024.
- RSD will provide documentation to administrator monthly to ensure 100% of all current resident's monthly assessments are completed, effective August 2024.
- EMAR dashboard will be reviewed daily during business hours for monitoring of omissions of medications, unavailability of medications, or any other concerns relating to medication assistance. This will be done by RSD or nurse of facility. All issues will be promptly communicated to the administrator, initiated 07/16/24.
- The maintenance director will provide administrator with monthly fire drill reports for review, effective August 2024, ongoing until December 2024.
- The Business Director will review on monthly basis employees who need CPR certification and schedule CPR certification classes communicating to involved employees when this is needed completion. Those employees who do not complete their CPR certification within 90 days of hire will be removed from the staff schedule until CPR certification is completed, effective August 2024.
- With each new hire, the administrator will review the completed employee file and ensure that CPR certification is maintained, signing off a review of the file and ensuring Business Director has scheduled a CPR class for the individual as needed. Effective 08/14/24.

- Fire drill reports will be reviewed monthly by the administrator, effective August 2024.
- Random staff observation of rounds will be conducted by RSD or administrator weekly x 4 weeks, monthly x 3 months, then quarterly x 3 months. If issues are identified with staff properly rounding on residents this frequency will increase as needed. Effective September 2024 until December 2024.

- Sage management consultant will review all new resident admission records and meet with new residents of the facility during visits to ensure meets criteria for admission/retention, review of random monthly assessments, review EMAR dashboard for medication concerns, review of CPR status for all newly hired employees ensuring these are scheduled promptly, review of monthly fire drill reports, and randomly observe staff conducting rounds properly, review with ED and RSD any specific events relating to possible elopements to ensure proper documentation of incident reports and investigations were completed, and randomly conduct medication awareness testing. Visits will begin September 2024 for 3 monthly visits x3, then monthly basis x 3, then quarterly. Visits will increase as needed if the consultant and administrator feel it necessary to ensure the plan of correction is maintained.

- DAILY STAND-UP MEETINGS will be held by the administrator and attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). The group will discuss events occurring since the last meeting and review communication records, follow-up on previously noted issues, resident status changes and assessments, resident incidents (including related investigations, ADPH reports & follow-up notes), staffing needs or problems, employee training needs, medication delivery, dietary, plant maintenance and any other noteworthy concerns identified since the last meeting. Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and began on 8/1/24.
- WEEKLY MEETINGS will be conducted by the administrator. Weekly meetings will be attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). This meeting will include review of incident reports, investigations, weekly meeting minutes, new resident admission records, new employee records, monthly assessments, new or revised care plans, monthly in-service records and plans, medication delivery, etc. that have been completed or occurred since the last weekly meeting and any relevant staff observations or training needs identified (as well as a schedule to provide any identified training need). Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and will

begin on 8/23/24. Education provided to EI#1 and EI#2 on proper way of conducting the weekly meeting, done by Sage consultant on 08/14/24.

- Sage consultant will provide all visit reports to a representative of the governing authority for review and follow-up will be done by the governing authority representative with the facility administrator to ensure all items are promptly addressed and/or corrected. Starting September 2024, ongoing.

A303 420-5-4-.03 (2) (a) Administration

EI#9 former administrator, failed to perform administrative duties to ensure the care and safety needs of all residents were met. In addition, EI#9 failed to investigate and report an elopement and failed to ensure care plans were current and addressed resident problems with appropriate interventions. EI#9 and EI#1, current administrator also failed to ensure a resident who required a higher level of care was transferred or discharged to an appropriate setting.

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.**

    - EI#9 is no longer employed by the facility, effective 2/17/24.
    - EI#10 is no longer employed by the facility, effective 1/4/24.
    - RI#6 was discharged to SCALF the same day on 4/18/24 after the elopement that had occurred during the time EI#1 was administrator. This closed chart was reviewed.
    - An incident report and investigation were completed by EI#2 to the best ability of EI#2 (this employee was hired on 01/03/24 but did not start working within the facility until 01/08/24) for the elopement of RI#6 on 12/26/2023. This incident was submitted to ADPH online incident reporting system on 8/21/2024. EI#1 was not employed by the facility at the time of the incident.

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

- EI#2 will assess 100% of all current residents who live in the assisted living and proceed with notifying administrator and regional nurse if resident is no longer appropriate. These assessments will be utilized to determine eligibility to continued stay and review of current care plan to ensure reflects current condition of resident. This assessment included a cognitive assessment, medication awareness testing, and elopement risk assessment of all residents. The administrator will promptly issue 30-day discharge notices to all residents identified as inappropriate for retention. Completed on 8/15/24. Those care plans who do not reflect the current condition of each resident will be promptly updated by EI#2. This will be completed by 9/13/24.
- All incident reports were reviewed by Sage consultant on a quarterly basis with review dating to October 2023-March 2024, prior to survey. Any identified concerns noted by Sage consultant have been reviewed by EI#1 and EI#2 and all issues have been addressed and corrected currently, done 08/23/24. During the next Sage visit scheduled for September 2024, consultant will review all incident reports/investigations that have occurred since March 2024. All identified concerns will be promptly addressed by RSD and administrator.
- All care staff employees have been interviewed to identify any other attempts of elopements by any current resident of the facility. None identified at this time. This started on 08/13/24 and was completed on 08/14/24.

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.**

- Inservice was done with all current nurses employed by facility on 7/24/24 by EI#1 reviewing Policy: Rounding of Residents Protocol that was implemented as a result of this survey.
- All current staff in service done by EI#1 and EI#2 on 6/27/24 reviewing Elopement Policy and Rounding of Residents Protocol.
- In service with care staff on 5/20/24 done by EI#1 and EI#2 with review of Elopement Policy.
- In service with nurses on Policy: Rounding of Residents Protocol, done by EI#1 and EI#2 on 06/13/24 and again on 07/24/24.
- In service with nursing staff on Policy: Incident Reports, Fall Prevention on 6/13/24. Done by EI#1 and EI#2.

- In service with care staff on Policy: Incident Reports, Investigations, ADPH Reports, and Fall Prevention 06/27/24. Done by EI#1 and EI#2.
- Inservice training with elopement drill performed on 5/22/24, done by EI#1.
- Training provided by EI#1 & EI#2 on Policy: *Records and Reports-Resident Monthly Assessments* with all current nursing staff of facility. Properly assessing residents and identifying ineligible residents was reviewed during this training. Training is also provided on how and when to update a care plan with review of Policy: *Records and Reports-Resident Plan of Care (Service Plan).* Will be completed by 08/28/2024.
- All staff training conducted by EI#1 on admission and retention of residents policy, including immediate notification to administrator shall concerns for eligibility are identified and medication policy to include daily med pass protocol, review of actions to take if medications are not available or if resident unable to protect self from potential medication error, review of elopement policy with specific attention to definition of elopement and actions to take if a resident is identified as missing, staff training on CPR requirement within 90 days of hire, fire drill policy and procedure, protocol for rounding on residents with specific attention that each employee shall visually see the resident during these rounds ensuring safety needs are met, Training is also provided review of Policy: Records and Reports-Resident Plan of Care (Service Plan) and Policy: Records and Reports-Resident Incident Reports, Investigations and ADPH Reports.. This was initiated on 08/14/24 and will be completed on 8/28/24, done by EI#1 and EI#2. This will be mandatory training for all staff, and should an employee not attend the in-service by 08/28/24, the employee will be removed from the schedule until the training has been completed.
- Inservice was done with all current nurses employed by facility on 7/24/24 by EI#1 reviewing Policy: Rounding of Residents Protocol that was implemented as a result of this survey.
- All current staff in service done by EI#1 and EI#2 on 6/27/24 reviewing Elopement Policy and Rounding of Residents Protocol.
- In service with care staff on 5/20/24 done by EI#1 and EI#2 with review of Elopement Policy.
- In service with nurses on Policy: Rounding of Residents Protocol, done by EI#1 and EI#2 on 06/13/24 and again on 07/24/24.
- In service with nursing staff on Policy: Incident Reports, Fall Prevention on 6/13/24. Done by EI#1 and EI#2.

- In service with care staff on Policy: Incident Reports, Investigations, ADPH Reports, and Fall Prevention 06/27/24. Done by EI#1 and EI#2.
- Inservice training with elopement drill performed on 5/22/24, done by EI#1.
- Refresher training and training on additional subject matter will be provided on an ongoing and as needed basis as determined by the administrator.
- All pre-admission assessments conducted by facility staff will include a cognitive assessment, elopement risk assessment, fall risk assessment, and medication awareness testing. These assessments will be reviewed by the administrator for approval prior to a prospective resident being admitted to the facility, effective immediately on 08/14/24.

4. **Explain how you will monitor your proposed corrective actions to ensure 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.**

- Assessments for incoming residents will be reviewed by the administrator and emailed to the regional corporate team for approval before acceptance into the community. This will start immediately and ongoing until 12/1/24.
- Sage management consultant will review all new resident admission records and meet with new residents of the facility during visits to ensure meets criteria for admission/retention, review of random monthly assessments, review EMAR dashboard for medication concerns, review of CPR status for all newly hired employees ensuring these are scheduled promptly, review of monthly fire drill reports, and randomly observe staff conducting rounds properly, review with ED and RSD any specific events relating to possible elopements to ensure proper documentation of incident reports and investigations were completed, and randomly conduct medication awareness testing. Visits will begin September 2024 for 3 monthly visits x3, then monthly basis x 3, then quarterly. Visits will increase as needed if the consultant and administrator feel it necessary to ensure the plan of correction is maintained.
- DAILY STAND-UP MEETINGS will be held by the administrator and attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). The group will discuss events occurring since the last meeting and review communication records, follow-up on previously noted issues, resident status changes and assessments, resident incidents (including related investigations, ADPH reports & follow-up notes), staffing needs or problems, employee training needs, medication delivery, dietary, plant maintenance and any other noteworthy concerns identified since the last meeting. Minutes will be maintained in the administrator's office in the

plan of correction binder. These meetings will be ongoing and began on 8/1/24.

- WEEKLY MEETINGS will be conducted by the administrator. Weekly meetings will be attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). This meeting will include review of incident reports, investigations, weekly meeting minutes, new resident admission records, new employee records, monthly assessments, new or revised care plans, monthly in-service records and plans, medication delivery, etc. that have been completed or occurred since the last weekly meeting and any relevant staff observations or training needs identified (as well as a schedule to provide any identified training need). Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and will begin on 8/23/24. Education provided to EI#1 and EI#2 on proper way of conducting the weekly meeting, done by Sage consultant on 08/14/24.

PLAN OF CORRECTION

Facility Name: The Brennity at Daphne Assisted Living Facility ID#: DO217

Survey Exit Date: 05/16/2024 Administrator: Shameka Gregory

A405 420-5-4-.04 (6) Personnel.

The facility failed to ensure staff Cardiopulmonary Resuscitation (CPR) certifications had not expired for 3 staff members.

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.**

    - EI#1 had a CPR certification class scheduled prior to survey. This class was scheduled for 5/29/24.
    - EI#3, EI#4, and EI#7 had CPR certification renewals completed on 5/29/24.

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

    - All current employee records were reviewed to identify any past due or needed CPR certifications. Those employees identified as not currently CPR certified were immediately scheduled for a CPR certification class. This was completed on 5/17/24 by the Business Director with a class scheduled on 05/29/24 for 11am, 1pm, and 3:30pm for all employees.

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.**

    - Business Director with specific training provided by EI#1 that all new hires must be CPR certified within 90 days of hire and shall include a certification from an approved provider, done on 8/13/24.
    - The Business Director will review on monthly basis employees who need CPR certification and schedule CPR certification classes communicating to involved employees when this is needed completion. Those employees who do not complete their CPR certification within 90 days of hire will be removed from the staff schedule until CPR certification is completed, effective August 2024.

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.

- With each new hire, the administrator will review the completed employee file and ensure that CPR certification is maintained, signing off a review of the file and ensuring business office manager has scheduled a CPR class for the individual as needed.
- Sage management consultant will review all new resident admission records and meet with new residents of the facility during visits to ensure meets criteria for admission/retention, review of random monthly assessments, review EMAR dashboard for medication concerns, review of CPR status for all newly hired employees ensuring these are scheduled promptly, review of monthly fire drill reports, and randomly observe staff conducting rounds properly, review with ED and RSD any specific events relating to possible elopements to ensure proper documentation of incident reports and investigations were completed, and randomly conduct medication awareness testing. Visits will begin September 2024 for 3 monthly visits x3, then monthly basis x 3, then quarterly. Visits will increase as needed if the consultant and administrator feel it necessary to ensure the plan of correction is maintained.
- DAILY STAND-UP MEETINGS will be held by the administrator and attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). The group will discuss events occurring since the last meeting and review communication records, follow-up on previously noted issues, resident status changes and assessments, resident incidents (including related investigations, ADPH reports & follow-up notes), staffing needs or problems, employee training needs, medication delivery, dietary, plant maintenance and any other noteworthy concerns identified since the last meeting. Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and began on 8/1/24.
- WEEKLY MEETINGS will be conducted by the administrator. Weekly meetings will be attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). This meeting will include review of incident reports, investigations, weekly meeting minutes, new resident admission records, new employee records, monthly assessments, new or revised care plans, monthly in-service records and plans, medication delivery, etc. that have been completed or occurred since the last weekly meeting and any relevant staff observations or training needs identified (as well as a

schedule to provide any identified training need). Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and will begin on 8/23/24. Education provided to EI#1 and EI#2 on proper way of conducting the weekly meeting, done by Sage consultant on 08/14/24.

PLAN OF CORRECTION

Facility Name: The Brennity at Daphne Assisted Living Facility ID#: DO217

Survey Exit Date: 05/16/2024 Administrator: Shameka Gregory

A501 420-5-4-.05 (1) Records and Reports.

The former licensed administrator, EI#9, failed to complete the required documentation of an elopement of a resident.

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.**

    - An incident report and investigation were completed by EI#2 to the best ability of EI#2 (this employee was hired on 01/03/24 but did not start working within the facility until 01/08/24) for the elopement of RI#6 on 12/26/2023. This incident was submitted to ADPH online incident reporting system on 8.21.2024. EI#1 was not employed by the facility at the time of the incident.

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

    - All incident reports were reviewed by Sage consultant on a quarterly basis with review dating to October 2023-March 2024, prior to survey. Any identified concerns noted by Sage consultant have been reviewed by EI#1 and EI#2 and all issues have been addressed and corrected currently, done 08/23/24. During the next Sage visit scheduled for September 2024, consultant will review all incident reports/investigations that have occurred since March 2024. All identified concerns will be promptly addressed by RSD and administrator.
    - All care staff employees have been interviewed to identify any other attempts of elopements by any current resident of the facility. None identified at this time. This started on 08/13/24 and was completed on 08/14/24.
    - EI#2 completed an elopement risk assessment on 100% of all current residents of the facility. No further residents were identified at risk for elopement, done by EI#2 on 08/12 /24. The remaining assessment documents implemented will be completed by 08/14/24 by EI#2 to ensure no other concerns are identified with retention of residents.

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 staff training conducted by EI#1 on admission and retention of residents policy, including immediate notification to administrator shall concerns for eligibility are identified and medication policy to include daily med pass protocol, review of actions to take if medications are not available or if resident unable to protect self from potential medication error, review of elopement policy with specific attention to definition of elopement and actions to take if a resident is identified as missing, staff training on CPR requirement within 90 days of hire, fire drill policy and procedure, protocol for rounding on residents with specific attention that each employee shall visually see the resident during these rounds ensuring safety needs are met, Training is also provided review of Policy: Records and Reports-Resident Plan of Care (Service Plan) and Policy: Records and Reports-Resident Incident Reports, Investigations and ADPH Reports... Refresher training and training on additional subject matter will be provided on an ongoing and as needed basis as determined by administrator. This was initiated on 08/14/24 and will be completed on 8/2/24, done by EI#1 and EI#2. This will be mandatory training for all staff, and should an employee not attend the in-service by 08/28/24, the employee will be removed from the schedule until the training has been completed.

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.

- Sage management consultant will review all new resident admission records and meet with new residents of the facility during visits to ensure meets criteria for admission/retention, review of random monthly assessments, review EMAR dashboard for medication concerns, review of CPR status for all newly hired employees ensuring these are scheduled promptly, review of monthly fire drill reports, and randomly observe staff conducting rounds properly, review with ED and RSD any specific events relating to possible elopements to ensure proper documentation of incident reports and investigations were completed, and randomly conduct medication awareness testing. Visits will begin September 2024 for 3 monthly visits x3, then monthly basis x 3, then quarterly. Visits will increase as needed if the consultant and administrator feel it necessary to ensure the plan of correction is maintained.
- DAILY STAND-UP MEETINGS will be held by the administrator and attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). The group will discuss events occurring since the last meeting and review communication records, follow-up on previously noted issues, resident status changes and assessments, resident incidents (including related investigations, ADPH reports & follow-up notes), staffing needs or problems, employee training

needs, medication delivery, dietary, plant maintenance and any other noteworthy concerns identified since the last meeting. Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and began on 8/1/24.

- WEEKLY MEETINGS will be conducted by the administrator. Weekly meetings will be attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). This meeting will include review of incident reports, investigations, weekly meeting minutes, new resident admission records, new employee records, monthly assessments, new or revised care plans, monthly in-service records and plans, medication delivery, etc. that have been completed or occurred since the last weekly meeting and any relevant staff observations or training needs identified (as well as a schedule to provide any identified training need). Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and will begin on 8/23/24. Education provided to EI#1 and EI#2 on proper way of conducting the weekly meeting, done by Sage consultant on 08/14/24.

PLAN OF CORRECTION

Facility Name: The Brennity at Daphne Assisted Living **Facility ID#:** DO217

Survey Exit Date: 05/16/2024 **Administrator:** Shameka Gregory

A508 420.5.4.05 (3) (h) Records and Reports.

EI#9 failed to investigate an elopement and report the elopement to the Alabama Department of Public Health's Online Incident Reporting System.

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.**

    - An incident report and investigation were completed by EI#2 to the best ability of EI#2 (this employee was hired on 01/03/24 but did not start working within the facility until 01/08/24) for the elopement of RI#6 on 12/26/2023. This incident was submitted to ADPH online incident reporting system on 8.21.2024. EI#1 was not employed by the facility at the time of the incident.

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

    - All incident reports were reviewed by Sage consultant on a quarterly basis with review dating to October 2023-March 2024, prior to survey. Any identified concerns noted by Sage consultant have been reviewed by EI#1 and EI#2 and all issues have been addressed and corrected currently, done 08/23/24. During the next Sage visit scheduled for September 2024, consultant will review all incident reports/investigations that have occurred since March 2024. All identified concerns will be promptly addressed by RSD and administrator.
    - All care staff employees have been interviewed to identify any other attempts of elopements by any current resident of the facility. None identified at this time. This started on 08/13/24 and was completed on 08/14/24.
    - EI#2 completed an elopement risk assessment on 100% of all current residents of the facility. No further residents were identified at risk for elopement, done by EI#2 on 08/12 /24. The remaining assessment documents implemented will be completed by 08/14/24 by EI#2 to ensure no other concerns are identified with retention of residents.

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 staff training conducted by EI#1 on admission and retention of residents policy, including immediate notification to administrator shall concerns for eligibility are identified and medication policy to include daily med pass protocol, review of actions to take if medications are not available or if resident unable to protect self from potential medication error, review of elopement policy with specific attention to definition of elopement and actions to take if a resident is identified as missing, staff training on CPR requirement within 90 days of hire, fire drill policy and procedure, protocol for rounding on residents with specific attention that each employee shall visually see the resident during these rounds ensuring safety needs are met, Training is also provided review of Policy: Records and Reports-Resident Plan of Care (Service Plan) and Policy: Records and Reports-Resident Incident Reports, Investigations and ADPH Reports... Refresher training and training on additional subject matter will be provided on an ongoing and as needed basis as determined by administrator. This was initiated on 08/14/24 and will be completed on 8/28/24, done by EI#1 and EI#2. This will be mandatory training for all staff, and should an employee not attend the in-service by 08/28/24, the employee will be removed from the schedule until the training has been completed.

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.

- Sage management consultant will review all new resident admission records and meet with new residents of the facility during visits to ensure meets criteria for admission/retention, review of random monthly assessments, review EMAR dashboard for medication concerns, review of CPR status for all newly hired employees ensuring these are scheduled promptly, review of monthly fire drill reports, and randomly observe staff conducting rounds properly, review with ED and RSD any specific events relating to possible elopements to ensure proper documentation of incident reports and investigations were completed, and randomly conduct medication awareness testing. Visits will begin September 2024 for 3 monthly visits x3, then monthly basis x 3, then quarterly. Visits will increase as needed if the consultant and administrator feel it necessary to ensure the plan of correction is maintained.
  - DAILY STAND-UP MEETINGS will be held by the administrator and attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). The group will discuss events occurring since the last meeting and review communication records, follow-up on previously noted issues, resident status changes. assessments, resident incidents (including

related investigations, ADPH reports & follow-up notes), staffing needs or problems, employee training needs, medica. n delivery, dietary, plant maintenance and any other noteworthy concerns identified since the last meeting. Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and began on 8/1/24

- WEEKLY MEETINGS will be conducted by the administrator. Weekly meetings will be attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). This meeting will include review of incident reports, investigations, weekly meeting minutes, new resident admission records, new employee records, monthly assessments, new or revised care plans, monthly in-service records and plans, medication delivery, etc. that have been completed or occurred since the last weekly meeting and any relevant staff observations or training needs identified (as well as a schedule to provide any identified training need). Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and will begin on 8/23/24. Education provided to EI#1 and EI#2 on proper way of conducting the weekly meeting, done by Sage consultant on 08/14/24.

PLAN OF CORRECTION

Facility Name: The Brennity at Daphne Assisted Living **Facility ID#:** DO217

Survey Exit Date: 05/16/2024 **Administrator:** Shameka Gregory

A601 420-5-4-.06 (1) Care of Residents

Based on interviews and record reviews, the facility failed to follow a physician's order for a medication prescribed for RI#6.

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.**

    - An incident report and investigation were completed by EI#2, with the assistance of Sage consultant, done on 01/08/24. This incident was submitted to ADPH online incident reporting system on 01/08/24.

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

    - With the assistance of Sage Management consultant, EI#2 immediately implemented a staff in-service with all med techs and nurses on 01/08/24. This included a review of the following: Implementation of Pharmacy Clipboard System, Medication Overflow including location and steps to take if medication not located, Cycle Delivery of Meds and Check in Process by nurses, Checking EMAR Dashboard and staff responsibility for review and reporting of Dashboard medication concerns. All staff were retrained on the above topics on 08/14/24 by EI#1 and EI#2.
    - As each medication tech arrived at facility for their shift, Sage consultant provided 1:1 training on the medication pass process and the new interventions that were initiated to prevent reoccurrence.
    - 3-way match back of all resident medication orders and medications were completed by EI#2 and Sage consultant. This was completed on 01/09/24. No other issues were identified, and all currently ordered medications were in place on the medication cart for the new cycle of medications that started on 01/10/24.

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 staff training conducted by EI#1 on medication policy to include daily med pass protocol, review of actions to take if medications are not available or if resident unable to protect self from potential medication error safety needs are met, Policy: Records and Reports-Resident Incident Reports, Investigations and ADPH Reports. Refresher training and training on additional subject matter will be provided on an ongoing and as needed basis as determined by administrator. This was initiated on 08/14/24 and will be completed on 8/28/24, done by EI#1 and EI#2. This will be mandatory training for all staff, and should an employee not attend the in-service by 08/28/24, the employee will be removed from the schedule until the training has been completed.

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.

- Sage management consultant will review all new resident admission records and meet with new residents of the facility during visits to ensure meets criteria for admission/retention, review of random monthly assessments, review EMAR dashboard for medication concerns, review of CPR status for all newly hired employees ensuring these are scheduled promptly, review of monthly fire drill reports, and randomly observe staff conducting rounds properly, review with ED and RSD any specific events relating to possible elopements to ensure proper documentation of incident reports and investigations were completed, and randomly conduct medication awareness testing. Visits will begin September 2024 for 3 monthly visits x3, then monthly basis x 3, then quarterly. Visits will increase as needed if the consultant and administrator feel it necessary to ensure the plan of correction is maintained.
- DAILY STAND-UP MEETINGS will be held by the administrator and attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). The group will discuss events occurring since the last meeting and review communication records, follow-up on previously noted issues, resident status changes and assessments, resident incidents (including related investigations, ADPH reports & follow-up notes), staffing needs or problems, employee training needs, medication delivery, dietary, plant maintenance and any other noteworthy concerns identified since the last meeting. Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and began on 8.1/24.
- WEEKLY MEETINGS will be conducted by the administrator. Weekly meetings will be attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). This meeting will include review of

incident reports, investigations, weekly meeting minutes, new resident admission records, new employee records, monthly assessments, new or revised care plans, monthly in-service records and plans, medication delivery, etc. that have been completed or occurred since the last weekly meeting and any relevant staff observations or training needs identified (as well as a schedule to provide any identified training need). Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and will begin on 8.23/24. Education provided to EI#1 and EI#2 on proper way of conducting the weekly meeting, done by Sage consultant on 08/14/24.

PLAN OF CORRECTION

Facility Name: The Brennity at Daphne Assisted Living **Facility ID#:** DO217

Survey Exit Date: 05/16/2024 **Administrator:** Shameka Gregory

A604 420-5-4-.06 (3) (a) (b) Care of Residents

The facility failed to ensure a monthly assessment was completed for RI#6.

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.**

    - RI#6 was discharged by the facility on 04/18/24. The resident's closed record was reviewed.

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

    - Review of all monthly assessments of all current residents of the facility for the past twelve months were reviewed by EI#2. Those residents who were identified with omitted monthly assessments, late entry monthly assessments were documented and completed by EI#2 8/16/24.

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.**

    - Previously, facility LPN(s) were responsible for completing monthly assessments. This has been changed to the responsibility of RSD. RSD will complete all monthly assessments, effective 08/10/24. Shall any event that a facility LPN may need to assist the RSD with monthly assessments, the RSD will review those monthly assessments that were done by a facility LPN, ensuring accuracy of information documented. Training was provided to all LPN staff, including RSD, regarding properly conducting monthly assessments. Done by EI#1 on 8/13/24.

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.**

    - RSD will provide documentation to administrator monthly to ensure 100% of all current resident's monthly assessments are completed, effective August 2024.

- Sage management consultant will review all new resident admission records and meet with new residents of the facility during visits to ensure meets criteria for admission/retention, review of random monthly assessments, review EMAR dashboard for medication concerns, review of CPR status for all newly hired employees ensuring these are scheduled promptly, review of monthly fire drill reports, and randomly observe staff conducting rounds properly, review with ED and RSD any specific events relating to possible elopements to ensure proper documentation of incident reports and investigations were completed, and randomly conduct medication awareness testing. Visits will begin September 2024 for 3 monthly visits x3, then monthly basis x 3, then quarterly. Visits will increase as needed if the consultant and administrator feel it necessary to ensure the plan of correction is maintained.
- DAILY STAND-UP MEETINGS will be held by the administrator and attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). The group will discuss events occurring since the last meeting and review communication records, follow-up on previously noted issues, resident status changes and assessments, resident incidents (including related investigations, ADPH reports & follow-up notes), staffing needs or problems, employee training needs, medication delivery, dietary, plant maintenance and any other noteworthy concerns identified since the last meeting. Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and began on 8/1/24.
- WEEKLY MEETINGS will be conducted by the administrator. Weekly meetings will be attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). This meeting will include review of incident reports, investigations, weekly meeting minutes, new resident admission records, new employee records, monthly assessments, new or revised care plans, monthly in-service records and plans, medication delivery, etc. that have been completed or occurred since the last weekly meeting and any relevant staff observations or training needs identified (as well as a schedule to provide any identified training need). Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and will begin on 8/23/24. Education provided to EI#1 and EI#2 on proper way of conducting the weekly meeting, done by Sage consultant on 08/14/24.

A606 420-5-4-.06 (3) (d) Care of Residents

The facility failed to promptly discharge or transfer residents who required care beyond the capabilities of the assisted living facility, to an appropriate setting.

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.**

    - RI#1 was discharged by the facility on 6/14/2024. The resident's closed record was reviewed.
    - RI#6 was discharged by the facility on 4/18/24. The resident's closed record was reviewed.

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

    - EI#2 will assess 100% of all current residents who live in the assisted living and proceed with notifying administrator and regional nurse if resident is no longer appropriate. These assessments will be utilized to determine eligibility to continued stay and review of current care plan to ensure reflects current condition of resident. This assessment included a cognitive assessment, medication awareness testing, and elopement risk assessment of all residents. The administrator will promptly issue 30-day discharge notices to all residents identified as inappropriate for retention. Completed on 8/15/24. Those care plans who do not reflect the current condition of each resident will be promptly updated by EI#2. This will be completed by 8/28/24.
    - A review of 100% of all current residents who have sitters in place will be reviewed to determine the reason for the sitter's presence. If reasons for sitter services are related to cognition or risk for elopement, those sitters will be educated that the resident's egress must not be restricted and to always stay with the resident and report attempts of leaving facility to EI#1 and/or EI#2 shall an event occur. This review will include a review of the hours of sitter presence for each resident to determine whether appropriate hours of sitter presence are scheduled. These residents will be issued 30-day notice of discharge. Only one current resident in the facility has sitters and these sitters are present to assist with fall safety for this individual. Review completed by EI#1 and EI#2 on 08/13/24.

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 staff training conducted by EI#1 on admission and retention of residents policy, including immediate notification to administrator shall concerns for eligibility are identified and medication policy to include daily med pass protocol, review of actions to take if medications are not available or if resident unable to protect self from potential medication error, review of elopement policy with specific attention to definition of elopement and actions to take if a resident is identified as missing, staff training on CPR requirement within 90 days of hire, fire drill policy and procedure, protocol for rounding on residents with specific attention that each employee shall visually see the resident during these rounds ensuring safety needs are met, Training is also provided review of Policy: Records and Reports-Resident Plan of Care (Service Plan) and Policy: Records and Reports-Resident Incident Reports, Investigations and ADPH Reports.. This was completed on Refresher training and training on additional subject matter will be provided on an ongoing and as needed basis as determined by administrator. This was initiated on 08/14/24 and will be completed on 8/28/24, done by EI#1 and EI#2. This will be mandatory training for all staff, and should an employee not attend the in-service by 08/28/24, the employee will be removed from the schedule until the training has been completed.

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.

- Sage management consultant will review all new resident admission records and meet with new residents of the facility during visits to ensure meets criteria for admission/retention, review of random monthly assessments, review EMAR dashboard for medication concerns, review of CPR status for all newly hired employees ensuring these are scheduled promptly, review of monthly fire drill reports, and randomly observe staff conducting rounds properly, review with ED and RSD any specific events relating to possible elopements to ensure proper documentation of incident reports and investigations were completed, and randomly conduct medication awareness testing. Visits will begin September 2024 for 3 monthly visits x3, then monthly basis x 3, then

quarterly. Visits will increase as needed if the consultant and administrator feel it necessary to ensure the plan of correction is maintained.

- DAILY STAND-UP MEETINGS will be held by the administrator and attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). The group will discuss events occurring since the last meeting and review communication records, follow-up on previously noted issues, resident status changes and assessments, resident incidents (including related investigations, ADPH reports & follow-up notes), staffing needs or problems, employee training needs, medication delivery, dietary, plant maintenance and any other noteworthy concerns identified since the last meeting. Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and began on 8/1/24.
- WEEKLY MEETINGS will be conducted by the administrator. Weekly meetings will be attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). This meeting will include review of incident reports, investigations, weekly meeting minutes, new resident admission records, new employee records, monthly assessments, new or revised care plans, monthly in-service records and plans, medication delivery, etc. that have been completed or occurred since the last weekly meeting and any relevant staff observations or training needs identified (as well as a schedule to provide any identified training need). Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and will begin on 8/23/24. Education provided to EI#1 and EI#2 on proper way of conducting the weekly meeting, done by Sage consultant on 08/14/24.

PLAN OF CORRECTION

Facility Name: The Brennity at Daphne Assisted Living **Facility ID#:** DO217

Survey Exit Date: 05/16/2024 **Administrator:** Shameka Gregory

A613 420-5-4-.06 (5) (a) (b) (c) (d) (e) Care of Residents

The facility failed to ensure a resident was capable of utilizing the unit dose packaging system to protect themselves from a medication error by staff.

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.**

    - RI#1 was discharged by the facility on 6/14/24. The resident's closed record was reviewed.

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

    - EI#2 will assess 100% of all current residents who live in the assisted living and proceed with notifying administrator and regional nurse if resident is no longer appropriate. These assessments will be utilized to determine eligibility to continued stay and review of current care plan to ensure reflects current condition of resident. This assessment included a cognitive assessment, medication awareness testing, and elopement risk assessment of all residents. The administrator will promptly issue 30-day discharge notices to all residents identified as inappropriate for retention. Completed on 8/15/24. Those care plans who do not reflect the current condition of each resident will be promptly updated by EI#2. This will be completed by 8/28/24.

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 staff training conducted by EI#1 on admission and retention of residents policy, including immediate notification to administrator shall concerns for eligibility are identified and medication policy to include daily med pass protocol, review of actions to take if medications are not available or if resident unable to protect self from potential medication error, review of elopement policy with specific attention to definition of elopement and actions to take if a resident is identified as missing, staff training on CPR requirement within 90 days of hire, fire drill policy and procedure, protocol for rounding on residents

with specific attention that each employee shall visually see the resident during these rounds ensuring safety needs are met, Training is also provided review of Policy: Records and Reports-Resident Plan of Care (Service Plan) and Policy: Records and Reports-Resident Incident Reports, Investigations and ADPH Reports.. This was completed on Refresher training and training on additional subject matter will be provided on an ongoing and as needed basis as determined by administrator. This was initiated on 08/14/24 and will be completed on 828/24, done by EI#1 and EI#2. This will be mandatory training for all staff, and should an employee not attend the in-service by 08/28/24, the employee will be removed from the schedule until the training has been completed.

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.**

- Sage management consultant will review all new resident admission records and meet with new residents of the facility during visits to ensure meets criteria for admission/retention, review of random monthly assessments, review EMAR dashboard for medication concerns, review of CPR status for all newly hired employees ensuring these are scheduled promptly, review of monthly fire drill reports, and randomly observe staff conducting rounds properly, review with ED and RSD any specific events relating to possible elopements to ensure proper documentation of incident reports and investigations were completed, and randomly conduct medication awareness testing. Visits will begin September 2024 for 3 monthly visits x3, then monthly basis x 3, then quarterly. Visits will increase as needed if the consultant and administrator feel it necessary to ensure the plan of correction is maintained.

- DAILY STAND-UP MEETINGS will be held by the administrator and attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). The group will discuss events occurring since the last meeting and review communication records, follow-up on previously noted issues, resident status changes and assessments, resident incidents (including related investigations, ADPH reports & follow-up notes), staffing needs or problems, employee training needs, medication delivery, dietary, plant maintenance and any other noteworthy concerns identified since the last meeting. Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and began on 81/24.
- WEEKLY MEETINGS will be conducted by the administrator. Weekly meetings will be attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance

Staff, Dietary Manager, etc.). This meeting will include review of incident reports, investigations, weekly meeting minutes, new resident admission records, new employee records, monthly assessments, new or revised care plans, monthly in-service records and plans, medication delivery, etc. that have been completed or occurred since the last weekly meeting and any relevant staff observations or training needs identified (as well as a schedule to provide any identified training need). Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and will begin on 8/23/24. Education provided to EI#1 and EI#2 on proper way of conducting the weekly meeting, done by Sage consultant on 08/14/24.

A621 420-5-4-.06 (11) (b) Care of Residents

PLAN OF CORRECTION

Facility Name: The Brennity at Daphne Assisted Living **Facility ID#:** DO217

Survey Exit Date: 05/16/2024 **Administrator:** Shameka Gregory

The facility retained a resident who could not safely reside in the facility unless the resident's egress was restricted.

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.**

    - RI#6 was discharged by the facility on 04/18/24. The resident's closed record was reviewed.

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

    - EI#2 will assess 100% of all current residents who live in the assisted living and proceed with notifying administrator and regional nurse if resident is no longer appropriate. These assessments will be utilized to determine eligibility to continued stay and review of current care plan to ensure reflects current condition of resident. This assessment included a cognitive assessment, medication awareness testing, and elopement risk assessment of all residents. The administrator will promptly issue 30-day discharge notices to all residents identified as inappropriate for retention. Completed on 8/15/24. Those care plans who do not reflect the current condition of each resident will be promptly updated by EI#2. This will be completed by 8/28/24.
    - A review of 100% of all current residents who have sitters in place will be reviewed to determine the reason for the sitter's presence. If reasons for sitter services are related to cognition or risk for elopement, those sitters will be educated that the resident's egress must not be restricted and to always stay with the resident and report attempts of leaving facility to EI#1 and/or EI#2 shall an event occur. This review will include a review of the hours of sitter presence for each resident to determine whether appropriate hours of sitter presence are scheduled. These residents will be issued 30-day notice of discharge. Only one current resident in the facility has sitters and these sitters are present to assist with fall safety for this individual. Review completed by EI#1 and EI#2 on 08/13/24.

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 staff training conducted by EI#1 on admission and retention of residents policy, including immediate notification to administrator shall concerns for eligibility are identified and medication policy to include daily med pass protocol, review of actions to take if medications are not available or if resident unable to protect self from potential medication error, review of elopement policy with specific attention to definition of elopement and actions to take if a resident is identified as missing, staff training on CPR requirement within 90 days of hire, fire drill policy and procedure, protocol for rounding on residents with specific attention that each employee shall visually see the resident during these rounds ensuring safety needs are met, Training is also provided review of Policy: Records and Reports-Resident Plan of Care (Service Plan) and Policy: Records and Reports-Resident Incident Reports, Investigations and ADPH Reports... Refresher training and training on additional subject matter will be provided on an ongoing and as needed basis as determined by administrator. This was initiated on 08/14/24 and will be completed on 8/28/24, done by EI#1 and EI#2. This will be mandatory training for all staff, and should an employee not attend the in-service by 08/28/24, the employee will be removed from the schedule until the training has been completed.
- All pre-admission assessments conducted by facility staff will include a cognitive assessment, elopement risk assessment, fall risk assessment, and medication awareness testing. These assessments will be reviewed by the administrator for approval prior to a prospective resident being admitted to the facility, effective immediately on 08/14/24.

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.

- Sage management consultant will review all new resident admission records and meet with new residents of the facility during visits to ensure meets criteria for admission/retention, review of random monthly assessments, review EMAR dashboard for medication concerns, review of CPR status for all newly hired employees ensuring these are scheduled promptly, review of monthly fire drill reports, and randomly observe staff conducting rounds properly, review with ED and RSD any specific events relating to possible elopements to ensure proper documentation of incident reports and investigations were completed, and randomly conduct medication awareness testing. Visits will begin September 2024 for 3 monthly visits x3, then monthly basis x 3, then

quarterly. Visits will increase as needed if the consultant and administrator feel it necessary to ensure the plan of correction is maintained.

- DAILY STAND-UP MEETINGS will be held by the administrator and attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). The group will discuss events occurring since the last meeting and review communication records, follow-up on previously noted issues, resident status changes and assessments, resident incidents (including related investigations, ADPH reports & follow-up notes), staffing needs or problems, employee training needs, medication delivery, dietary, plant maintenance and any other noteworthy concerns identified since the last meeting. Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and began on 8/1/24.
- WEEKLY MEETINGS will be conducted by the administrator. Weekly meetings will be attended by key personnel (such as RSD, LPN personnel, Activity staff, Maintenance Staff, Dietary Manager, etc.). This meeting will include review of incident reports, investigations, weekly meeting minutes, new resident admission records, new employee records, monthly assessments, new or revised care plans, monthly in-service records and plans, medication delivery, etc. that have been completed or occurred since the last weekly meeting and any relevant staff observations or training needs identified (as well as a schedule to provide any identified training need). Minutes will be maintained in the administrator's office in the plan of correction binder. These meetings will be ongoing and will begin on 8/23/24. Education provided to EI#1 and EI#2 on proper way of conducting the weekly meeting, done by Sage consultant on 08/14/24.

PLAN OF CORRECTION

Facility Name: The Brennity at Daphne Assisted Living **Facility ID#:** DO217

Survey Exit Date: 05/16/2024 **Administrator:** Shameka Gregory

A703 420-5-4-.07 (3) Food Service.

The facility failed to maintain a three-day emergency supply of non-perishable foods.

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.**

    - On 5/14/24, EI#1 immediately directed Culinary Director to order food items needed to complete a 3-day supply of emergency non-perishable foods. These food items were delivered and available in the facility on 6/13/24.

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

    - Education provided to Culinary Director by EI#1 on rotating non-perishable food supply and order items when food items are soon to expire., and responsibility to inventory emergency food and water supply monthly to ensure sufficient supply on hand for all current residents of facility. This was completed on 8/13/24.

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 Culinary Director will complete a review each month of the facility's current inventory of emergency food and water supply. Any concerns identified with supply will be reported immediately to the Administrator. This will be documented on file in the administrator's office monthly x 6 months.

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 conduct an audit of the 3-day emergency food and water supply during weekly 1:1 meeting with Culinary Director. This was effective immediately and ongoing until December 2024.

- Sage Management will complete a random inventory audit of 3-day emergency food supply, Every Other Quarter, ongoing.

PLAN OF CORRECTION

Facility Name: The Brennity at Daphne Assisted Living **Facility ID#:** DO217

Survey Exit Date: 05/16/2024 **Administrator:** Shameka Gregory

A1101 420-5-4-.11 (1) Fire and Safety.

The facility failed to ensure fire extinguishers were visually inspected monthly and that fire drills were performed every month as required.

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.**

    - The Maintenance Director immediately inspected all other fire extinguishers to identify if any other monthly visual inspections were missing. Other fire extinguisher monthly inspections were identified as missing for January 2024 and February 2024. All fire extinguishers recertified on 8/9/24,

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

    - On 05/17/24 the Maintenance Director and EI#1 rounded the facility to assess all fire extinguishers. Other fire extinguisher monthly inspections were identified as missing for January 2024 and February 2024. All fire extinguishers recertified on 8/9/24.
    - The last 12 months of fire drills were reviewed by EI#1 and Maintenance Director, done 8/9/24. March and April 2024 fire drills were documented and available at the facility for review. However, the reports did not include the time of day the drill was performed. These were corrected by recording a late entry time of day the fire drills were performed. This was corrected by EI#1 on 08/14/24.

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.**

    - A map of all fire extinguishers inside the community has been shown and discussed with the Maintenance Director. A monthly form will be completed documenting that a visual inspection was conducted by the Maintenance Director and reviewed monthly by the administrator, effective 8/9/24.
    - All maintenance personnel will be trained on responsibility of monthly fire extinguisher inspections and documenting these inspections on the tags of the

extinguishers. Monthly fire extinguisher visual inspections will be the Maintenance Director's responsibility. However, if the Maintenance Director is not available in the facility to conduct these inspections before the last day of each month, it will be the responsibility of the other remaining maintenance personnel to complete the inspection. This will be completed by EI#1 with all maintenance personnel on 08/14/24.

- Maintenance Director training provided by EI#1 on fire drill policy and procedure and responsibility of maintaining fire drills quarterly on each shift, responsibility of ensuring properly documented and if staff need improvement in fire drill process, education shall be provided at that time. Done by EI#1 on 8/13/24.
- The maintenance director will provide administrator with monthly fire drill reports for review, ongoing.

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 randomly review 7 different fire extinguisher tags monthly, rotating which ones visualized until a complete audit of all extinguishers has been completed. Once a complete audit has been completed, the random audit of 7 different fire extinguishers will be repeated. This will start in September 2024 and will be ongoing until December 2024.
- The administrator will review monthly fire drill reports to ensure completed each month, accuracy of completion of documentation, and review of staff response to identify any further training needs, effective August 2024.
- Fire drill reports will be reviewed monthly by the administrator, effective August 2024.
- Sage Management will complete a random inspection of fire extinguishers throughout the facility quarterly, ongoing.

PLAN OF CORRECTION

Facility Name: The Brennity at Daphne Assisted Living **Facility ID#:** DO217

Survey Exit Date: 05/16/2024 **Administrator:** Shameka Gregory

A1203 420-5-4-.12 (5) Physical Environment.

The facility failed to ensure the building was free from leaks in the ceiling. The facility further failed to provide a functional call system for each resident.

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.**

    - The leak at the front of dining room entry way was repaired. The ceiling was repaired and there is no longer a water puddle in this area. This was repaired by Build Right Construction on 5/20/24.
    - The leak in the area across the hallway of dining room was repaired. The leak stain on the ceiling was repaired. This was repaired by Build Right Construction on 5/20/24.
    - The wet carpet was assessed in the pool table room. A leak was identified in the area and was repaired by Build Right Construction on 5/21/24.
    - Room 104 and 107 call lights were immediately assessed for proper function after surveyor reported issue to EI#2 and Sage Management consultant. Both call lights were identified as not working. This was immediately reported to the Maintenance assistant by EI#2.

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

    - The Maintenance Director rounded facility on 5/21/24 to identify any other leak concerns throughout the facility. None identified.
    - EI#2 and Sage Management consultant immediately began checking all call lights in 100% of all resident rooms, both bed and bath pull cord lights. Communication took place with personnel at nurses' station and/or staff pagers to assist in verifying that each call light did or did not sound and whether notification was received. List of those malfunctioning was provided to Maintenance assistant immediately after audit completed. The maintenance assistant verified that all pull cords that were identified as not functioning were related to low battery power. All batteries were replaced in the involved rooms that were not functioning properly. The call system report was printed and reviewed verifying all room call light checks, ensuring both bed and bathroom call lights appeared on the report. This was reconciled with the current resident

census, verifying 100% of all current residents had a functioning call light system. Case # 185628 was created with Sentrics Company as there were some call lights replaced with new batteries that continued to not function thereafter. Code was provided to the administrator to clear prior alerts. The system was checked by Sentrics personnel remotely with no concerns identified, per Sentrics personnel. 100% of all resident room call lights were functioning properly as of 05/16/24.

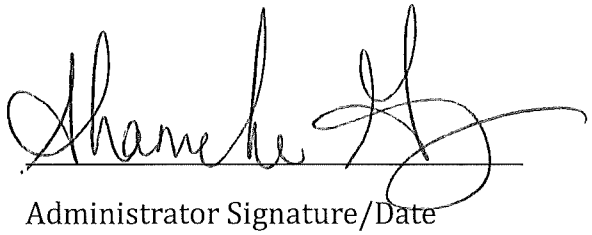
- Room 104 and 107 was given a bell for use to call for staff assist PRN- both bells placed within resident's reach and educated on it use. Both residents verbalized their understanding. These resident call lights were functioning properly as of 05/16/24.
- All other resident rooms affected, was verified that each resident had a pendant necklace available to them, which also was verified as working properly, and education was provided to those residents regarding always keeping with them and using for all PRN needs. These affected residents call lights were functioning properly as of 05/16/24.

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 Maintenance Director will conduct a round of all areas of the facility to identify any concerns regarding leaks and will document these rounds monthly x 6 months. Rounds will continue monthly thereafter and will increase as needed during periods when increased rain has occurred. Initiated September 2024.
- The Maintenance Director or designee will conduct a monthly test on 100% of all call lights in resident rooms. Once completed the Maintenance Director or designee will print a report to verify all call lights are functioning. The Maintenance Director or designee will follow-up to correct any identified malfunctioning call lights promptly and an immediate alternative method will be provided to any residents affected. This began immediately with overview of EI#1, although no documentation was recorded for these checks. Starting September 2024, this will be documented and kept on file at the facility.

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.

- Administrator will randomly test 5 call lights monthly to ensure they are functioning properly. This began immediately, although no documentation was recorded for these checks. Starting September 2024, this will be documented and kept on file at the facility until December 2024.



Administrator Signature/Date