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11/25/2024 Acccepted

November 20, 2024

Alabama Department of Public Health
Division of Health Care Facilities
Assisted Living Unit (ALF)
201 Monroe Street, Suite 710
P.O. Box 30317
Montgomery, Alabama 36130

Dear Mrs. Harrison,

Enclosed is the updated Plan of Correction in response to the Wesley Place on Honeysuckle survey conducted on Monday, September 30, 2024 through Wednesday, October 2, 2024.

If you have any questions, please feel free to contact me at 334-792-0921. Alternate points of contact are Mr. Hubert Paul, Jr., Executive Director, or Ms. Nancy Thompson, Registered Nurse.

Sincerely,

Vivian Readus 11-20-2024

Vivian Readus, Administrator

PLAN OF CORRECTION

Wesley Place on Honeysuckle Assisted Living Community

Vivian Readus, Administrator

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

2. RI#1, RI#2, RI#3, RI#4, and RI#5 were cited as company policy failures during survey conducted between September 30, 2024 and October 2, 2024, resulting in A611, A613, A614, A621, and A1101 deficiencies. All RI policy failures were identified by EI#1 and/or EI#2 and addressed accordingly by November 8, 2024.

3. All residents have the potential to be affected by this deficient practice; therefore, are included in this plan of correction. EI#1 and EI#2 reviewed all resident files on or before November 8, 2024 and were found to be in compliance.

4. All residents files will be reviewed monthly for three months by EI#1 and EI#2 for any policy deficiencies. Corrections will be made immediately if found by EI#1 or EI#2. Any deficient policy practice from employees and or residents will require an additional three month review if observed. All employees will be inserviced on or before November 19, 2024 of deficient company policies. All monthly reviewed information and employee inservices will be kept in a binder in the Administrator's office.

5. The Administrator and or RN will provide daily oversight of employee and or resident for policy compliance.

1. A 303 420-5-4-.03(2)(a) Administration.

2. See A301, A303, A403, A504, A602, A611, A613, A614, A621, A702, A804 and A1101 for corrective actions by EI#1 in response to residents identified in the Statement of Deficiencies from survey conducted September 30, 2024, through October 2, 2024.

3. Corrective actions prepared by EI#1 was read by Mission Support Services Vice President of Quality and Mission Integration, RN, NHA for further measures to ensure deficiency will not recur. All residents have the potential to be affected by this deficient practice, therefore are included in this plan of correction.

4. Vice President of Quality and Mission Integration RN, NHA will visit monthly for six months to discuss and ensure plan of correction is being followed based on the Statement of Deficiencies. Any corrective actions done by EI#1 or Vice President will be done during Vice President visit and documentation provided.

5. The Administrator will keep all visits and any corrective actions in a binder in the Administrator's office for future visits.

1. A 403 420-5-20-.04 (4) Personnel.

2. All employees hired prior to September 30, 2024, did not have a documented resident contact date in their employee file during the survey. All newly hired employees effective September 30, 2024, and beyond will complete New Employee Orientation in a non-residential location prior to any resident contact. New employees resident contact date will be listed in company UKG application by the Administrator or designee during employee first day of resident contact.

3. All residents and employees have the potential to be affected by this deficient practice; therefore, are included in this plan of correction. All employees hired prior to September 30, 2024, will have "not available" as resident contact date in the UKG application on or before November 8, 2024, provided by EI#1 and/or designee.

4. Methodist Homes of Alabama and Northwest Florida added on October 8, 2024 to the Company UKG application an area to post employees date of resident contact. The Administrator or designee will post during employee first day of resident contact in the UKG application. Mission Support Services will provide upon request a list of employees with resident contact dates for any employee hired after October 2024 to the appropriate agency.

5. The Administrator or designee will request and keep in a binder in the Administrator's office a list of employees that are hired during that month with the employee resident contact date listed. If no employee is hired during any given month, documentation will be provided stating, "No monthly hire."

1. A 504 420-5-20-.05 (3)(d) Records and Reports.

2. Postings

On September 30, 2024, the following listed agencies were in a notebook on a table in the living room; The Department of Bureaus of Health Provider Standards, Department of Human Resources, Department of Human Resources Elder Abuse Hotline and Resident Rights. All agencies were removed from the notebook, framed and posted in open, visible areas in the living room and den before the end of the day on September 30, 2024.

3. All residents have the potential to be affected by this deficient practice; therefore, are included in this plan of correction. The Administrator and RN reviewed all postings to ensure that postings were in a conspicuous locations on September 30, 2024.

4. All postings will remain in framed locations for easy, accessibility for residents and guest. Postings will be reviewed weekly for four weeks, then monthly by the Administrator and or designee. A check off list of postings will be kept in a binder in the Administrator's office.

5. The Administrator and designee will discuss weekly or as needed for replacement of any postings. If any postings require replacement it will be done on day of discovery or within 24 hours.

1. A 602 420-5-4-.06(2)(a)(b)(c) Care of Residents.

2. RI#1 weight was not documented on medical exam on date of admission. The RN contacted the physician's office to request updated medical exam form with RI#1 weight recorded from July 1, 2024 exam date. Updated medical exam form received on October 23, 2024.

3. The RN and designee reviewed the files of all residents currently in the building on October 3, 2024, for any omissions that would require updated med exam to be done. No other residents were identified.

4. The Admission's Office and RN will review all med exam forms prior to move in to ensure all documentation is present. Any missing documentation will be required from physician office prior to move in of a new resident.

5. The Administrator or designee will review medical exam forms monthly and as needed to ensure all required information is present and correct.

1. A 611 420-5-4-.06(4)(a)(b) Care of Residents.

2. Weight Loss
RI#2 monthly summary was completed on September 29, 2024, when his weight loss was recorded as an eleven pound weight loss from previous month. Physician, R.D. and family made aware on September 30, 2024, of weight loss. RD in facility on October 1, 2024, to speak to resident and provide recommendations. CRNP in facility on October 2, 2024, to address RI#2 weight loss, low back pain, labs and UTI. CRNP wrote new orders, faxed to pharmacy. RI#2 and sponsor made aware of CRNP and RD recommendations by EI#2.

Hearing Loss
RI#2 has difficulty hearing and a care plan addressing his hearing loss was not developed prior to survey. Care plan was developed on October 3, 2024, with interventions to speak slowly, clearly and to always look directly at resident when communicating. RI#2 care plans also indicate, when possible, to communicate in a quiet and undisturbed environment. RI#2 is a patient of local ENT physicians' group and is seen at resident request or follow-up from appointments. RI#2 has been provided a communication board that can be used should RI#2 cannot understand what is being communicated.

3. All residents have the potential to be affected by this deficient practice; therefore, are included in this plan of correction. RI#2 has care plans for weight loss and hearing developed by RN. All resident weights will be reviewed monthly and as needed by the RN or designee.

4. All employees were inserviced on or before October 4, 2024, of RI#2 care plans by the RN or designee. Any updated care plans for residents will be done by the RN or designee and employees will be communicated with through daily shift reports regarding care plan updates.

5. The Administrator and designee will meet weekly when updates are made to RI#2 weight loss and hearing loss and other resident updated care plans. The Administrator and designee will review RI#2 care plans weekly until weight is stable.

1. A 613 420-5-4-.06(5)(a)(b)(c)(d)(e) Care of Residents.

2. On September 26, 2024, EI#5 performed a Medication Awareness Assessment on RI#5 and resident failed the test. EI#5 checked that RI#5 could not recognize his/her name on a unit dose card/container. RI#5 could not recognize a label with another name when tested. RI#5 voiced that he/she could not even see using a magnifying glass. EI#5 documented that resident failed Medication Awareness Assessment test but failed to notify EI#1 or EI#2 of their results.

On October 2, 2024, RI#5 was given another Medical Awareness Assessment and resident failed. EI#2 implemented changes to include notifying physician and receiving orders for all medications for RI#5 to be administered by a licensed nurse. Guardian was notified of Medication Awareness Assessment failure and that all medications for RI#5 would be administered by a licensed nurse. Guardian made aware that although plans had already been made for RI#5 to leave the week of October 14, 2024, a 30-day discharge notification was being issued as well. RI#5 was discharged on October 15, 2024.

3. All remaining residents had Medication Awareness Assessment test done by licensed nurses on or before September 30,2024 and were found capable of recognizing his/her name on medication labels, understanding the unit dose system, and protecting themselves from medication errors. All residents have the potential to be affected by this deficient practice; therefore, are included in this plan of correction.

4. EI#5 was inserviced by EI#2 on Medication Awareness Assessment testing and changes in condition policies on October 3, 2024. All remaining staff will be inserviced on or before November 8, 2024, on Medication Awareness Assessment testing and change of condition policies by the Administrator or RN. All inservicing will be kept in a binder in the Administrator's office regarding Medication Awareness Assessment testing and change of condition policies.

5. The Administrator and RN will meet after staff inservices to identify any staff member needing additional inservicing. If any staff is identified or request additional inservicing, it will be provided immediately by the Administrator and or RN.

1. A 614 420-5-4-.06 (5)(f)(g)(6)(7)(a)-(i) Care of Residents.

2. EI#4 opened RI#3 medication package on October 2, 2024, without allowing the resident the opportunity to identify the medication. EI#4 informed RI#3 that EI#4 had his/her patch. EI#4 was inserviced on October 2, 2024, by EI#2 on medication assistance vs medication administration policies.

3. All residents have the potential to be affected by this deficient practice; therefore, are included in this plan of correction. EI#4 voiced that RI#3 should have been shown the medication to confirm their name, the medication and time to use medication to the RN during the inservice.

4. EI#4 will be monitored for medication assistance to residents three times a week for one month, then once a week for one month by the RN or pharmacy designee. All staff will be inserviced on medication assistance policies on or before November 14, 2024 with results kept in a binder in the Administrator's office. All staff who provide medication assistance will have a medication observation done bi-annually by the RN and or pharmacy designee.

5. The RN or pharmacy designee will report all staff compliance to Administrator after each medication assistance observation.

1. A 621 420-5-4-.06(11)(b) Care of Residents.

2. On September 26, 2024, EI#5 gave RI#5 a Medication Awareness Assessment test and RI#5 failed. On October 2, 2024 , EI#3 tested RI#5 again and RI#5 failed. RI#5 was not able to recognize his/her name on a unit dose/container, or recognize a label with another name.

RI#5 was starting to have changes in condition with going to dining room at inappropriate times and thinking of needing to be somewhere for some reason. EI#1 spoke with family member that was in town to visit on September 9, 2024 about resident changes and that EI#1 had attempted to contact RI#5 legal guardian to inform them of changes and the need for a higher level of care but guardian had not returned telephone call. Spoke with guardian on September 12, 2024, and discussed RI#5 condition and needing a different level of care. Guardian agreed to need for more care. Arrangements were made with Guardian to move RI#5 within two weeks to another level of care.

RI#5 family member sent email to EI#1 on September 23, 2024, stating that arrangements had been made to move RI#5 to another facility the week of October 14, 2024 because it would save some money. EI#1 spoke with guardian again on September 26, 2024 of the email from RI#5 family member. Guardian was already aware of the arrangements.

EI#1 called guardian on October 2, 2024, to inform of 30-day discharge notification letter that had been mailed on October 2, 2024 regarding RI#5 discharge.

3. On October 2, 2024, the Administrator and RN reviewed all resident files for current Medication Awareness Assessments to identify anyone needing to move to another level of care. No other residents were identified. During monthly Medication Awareness Assessment test or at any time a resident is assessed to require a need for discharge as a result of not meeting Assisted Living criteria he/she will be issued an immediate or a 30 day notification of discharge letter addressed to resident and or family member. The Administrator will meet with ineligible resident and family member to discuss ineligibility and to offer assistance with locating to a different level of care.

4. The RN received and implemented orders on October 2, 2024, from RI#5 physician regarding medications. RI#5 orders included licensed nurses to administer all medications to RI#5 until discharge. The RN spoke to each licensed nurse on October 2, 2024, of new medication administration order for RI#5 and its duration. EI#2 and or designee will retest any resident that has failed a Medication Awareness Assessment test and report findings to EI#1. RI#5 was discharged on October 15, 2024.

5. The Administrator and or RN scheduled licensed nurses during RI#5 medication times until RI#5 was discharged. Staffing sheets from October 2, 2024, thru October 15, 2024, will be kept in a binder of survey results.

Addendum 11-20-2024

1. A 702 420-5-4-.07(2) Food Service

2. Items in the walk-in refrigerator did not have a use by date when surveyor toured on October 2, 2024. Use by dates were put on items immediately after tour by dining services staff and verified by CDM on October 2, 2024. The CDM inserviced all staff on importance of applying use by date label upon making or opening food items on October 2, 2024.

3. All residents have the potential to be affected by this deficient practice; therefore, are included in this plan of correction. The CDM and/or designee will monitor daily for compliance items that should have labels with use by date.

4. The CDM and or designee will monitor items for use by date labels daily for one week, then once a week for one month for compliance. CDM will keep logs in the dining service office of these observations of compliance or non-compliance in a binder. If non-compliance is discovered, inservicing will be done by the CDM and or designee immediately and monitoring will resume daily for one week, then once a week for one month.

5. The Administrator, CDM or designee will meet weekly for a month to discuss compliance or non-compliance of use by date labels.

1. A 804 420-5-20-.08 (4) Physical Facilities.

2. The door that separates the kitchen from the dry storage area with the missing bottom portion and with rust on the door was checked by one vendor on October 31, 2024, for possible repair or replacement. EI#6 is working to get additional vendor quotes for a possible repair or replacement.

The double door that separates the kitchen from the food serving area was coming apart, rusty, and in need of painting during survey. The maintenance staff repaired, cleaned and painted the door on October 31, 2024.

The double door that separates the kitchen from the South Wing was in need of repair or replacement during survey. The doors and frames were painted and adjustments made for better on October 31, 2024.

The door from the food service area to the exterior of the facility had rust on bottom of door frame and handle during survey. The door frame and handle were cleaned and painted by the Maintenance Department on November 1, 2024.

The cracked and missing tiles in the various areas of the kitchen were cleaned, filled with concrete, and sealed by the Maintenance Department on October 31, 2024. Grout was filled in missing areas throughout the kitchen on October 31, 2024 by the Maintenance Department.

The Maintenance Department cleaned and filled in missing tiles with concrete and grout behind the oven on October 31, 2024.

The floor underneath the serving table that holds the coffee and tea makers was cleaned and the concrete used for missing tile was sealed by the Maintenance Department on October 31, 2024.

Carpetland placed tiles on the side of the wall between the dishwasher station and the main kitchen on October 4, 2024.

The ceiling air vents behind the oven area were cleaned and painted by the Maintenance Department on November 1, 2024.

The main food warmer was not working during the survey. TWC repaired the food warmer on October 11, 2024, and it was put back in use by dining services.

The outside ovens and fryer were wiped down on October 2, 2024, by the dining services staff ad inspected by the CDM. Ovens and fryers will be wiped down at the end of every shift by the dining services staff and inspected every day by the CDM and or designee for two weeks, then once a week for a month.

The commercial floor standing mixer was thoroughly cleaned by the dining services staff on October 31, 2024, and painted by the Maintenance Department. The dining services staff was inserviced by the CDM on November 1, 2024 on covering mixer from contamination when not in use.

3. All residents have the potential to be affected by this deficient practice; therefore, are included in this plan of correction. On or before November 15, 2024, the CDM and Maintenance Director will provide detailed cleaning schedule and repair list to the Administrator. All areas of dining services were inspected on October 31, 2024 by the Administrator, CDM, and Maintenance Director.

4. The CDM will inservice all dining staff on routine cleaning of equipment, assignments, and due dates on or before November 15, 2024. The assignment list will be kept in a binder in the CDM's office. The CDM will visually, observe assignments five days a week for one month, then weekly thereafter.

The CDM and Maintenance Director will meet weekly to discuss any equipment or facility repairs. Repairs will be inputted in the TELS System and upon completion, TELS repair ticket will be closed out by the Maintenance Director.

5. The Administrator and CDM will conduct visual inspections of the kitchen area weekly for four weeks and report results to Mission Support Services (Corporate Office). All results will be kept in a binder in the Adminsrator's Office.

1. A 1101 420-5-4-.11(1) Fire and Safety.

2. Fire Drills
Fire drills were not being done once per month with varying times, days and quarterly on each shift. The facility was not keeping written observations of the effectiveness of the fire drills performed. EI#6 has developed a form to set up monthly fire drills, shifts, and effectiveness of the drills.

Fire Safety Training
During the fire drill on October 1, 2024, EI#3 directed residents toward the fire instead of away from the fire. Employees and residents were confused about going just beyond the fire doors or to continue to the outside of the building. EI#6 informed employees and residents after the drill of the failure due to residents being directed toward the fire and not knowing whether to stop just beyond the fire door or exit the facility. EI#3, residents and employees were inserviced immediately by the Maintenance Director of the fire drill policy.

3. A fire drill was done on October 25, 2024, by the Maintenance Director and all residents and employees followed policy and drill was effective. Documentation of effectiveness done by Maintenance Director. All residents have the potential to be affected by this deficient practice; therefore, are included in this plan of correction.

4. EI#6 and/or designee will inservice all employees on Fire Drill policies on or before November 8, 2024. EI#6 and/or designee will inservice new employees hired after November 8, 2024, individually to ensure all staff is properly inserviced on the Fire Drill Policy. All new residents will be inserviced by the Administrator and or designee upon admission of fire drill policy.

5. The Maintenance Director will keep all reports in a binder in the Maintenance Office for minimum of three years. The Maintenance Director will meet with the Administrator after each drill to discuss compliance.