Cummings Health Care Facility Plan of Correction for Site Visit on 06/09/2025

F 550

The corrective action taken for this deficient practice was to speak with the staff members involved immediately to explain about the dignity and respect that residents deserve. Completed on 06/10/2025.

The facility will identify other residents having the same potential to be affected and the systemic change we have made to ensure this deficient practice does not occur is to create a specific Dignity Inservice for all staff (see attachment #1) to complete ensuring the dignity and respect of our residents is not compromised moving forward. This in-service will be completed by all direct care staff by July 25th, 2025.

The facility will monitor this corrective action by submitting to Quality Assurance, at the next meeting, dignity audits completed for each shift weekly to ensure completion and compliance (see attachment #2). The next QA meeting is 08/14/2025.

F 578

The corrective action taken for this deficient practice was to discuss with the resident's guardian about the resident's advance directive wishes. The guardian brought into the facility the current advance directive wishes of the resident signed and date for 06/13/2025.

The facility will identify other residents having the same potential to be affected and the systemic change we have made to ensure this deficient practice does not occur is to complete an advanced directive audit of every resident to determine what is needed for the facility records and what families would like assistance with completing the advanced directives. Also, our admission packet will be audited to confirm that the correct information is available upon admission and the correct system is in place to follow through with families during the admission process. This audit will be completed by 07/25/2025.

The facility will monitor this corrective action by submitting to Quality Assurance, at the next meeting, the results of the Advanced Directive audit and the admission packet audit for review and discussion. The next QA meeting is 08/14/2025.

F 580

The corrective action taken for this deficient practice was to notify the MD and obtain the correct order on the day of the deficient practice finding.

The facility will identify other residents having the same potential to be affected and the systemic change we have made to ensure this deficient practice does not occur is to have a meeting to include the DON and FSS after the dietician's consultation to discuss all recommendations that the dietician requested. Any orders needed will be written at that time to communicate with the provider. This meeting took place on 6/16/2025 (see attachment #3).

The facility will monitor this corrective action by submitting to Quality Assurance, at the next meeting, the results of the dietician recommendation meetings for review and discussion. The next QA meeting is 08/14/2025.

F 684

The corrective action taken for this deficient practice was to notify the MD of the order not being followed, a new order was received and implemented the day of the deficient practice finding.

The facility will identify other residents having the same potential to be affected and the systemic change we have made to ensure this deficient practice does not occur is to have all nurses complete the in-service on following and noting orders (see attachment #4). This in-service will be completed by 07/25/2025 for all full time nurses and the next shift worked for all per diem nurses. Also, an audit will be completed weekly to ensure all orders were noted and signed off by nursing staff from the provider (see attachment #5).

The facility will monitor this corrective action by submitting to Quality Assurance, at the next meeting, the results of the provider new order audit for review and discussion. The next QA meeting is 08/14/2025.

F 711

The corrective action taken for this deficient practice was to notify provider of the medication orders not being signed. These were signed by the provider the day the deficient practice finding.

The facility will identify other residents having the same potential to be affected and the systemic change we have made to ensure this deficient practice does not occur is to have the providers company share their schedule with the facility to be compared with the facilities provider schedule for approval and to eliminate the potential for errors with provider timeliness. Also, after each provider visit, an audit of the provider orders will be completed to ensure that all orders are completed, and medication lists are signed correctly and timely (see attachment #5). This will be completed by 07/25/2025.

The facility will monitor this corrective action by submitting to Quality Assurance, at the next meeting, the results of the scheduling of providers and the providers orders audit for review and discussion. The next QA meeting is 08/14/2025.

F 801

The corrective action taken for this deficient practice was to enroll the Food Service Supervisor in a Managerial Servsafe course. The FSS was enrolled in and completed this course on 06/20/2025 with a scheduled proctored test date of 07/19/2025.

The facility will identify other residents having the same potential to be affected and the systemic change we have made to ensure this deficient practice does not occur is make sure the Food Service Supervisor completes the Managerial Servsafe course. This will be completed by 07/19/2025.

The facility will monitor this corrective action by submitting to Quality Assurance, at the next meeting, the results of the FSS course completion and test for review and discussion. The next QA meeting is 08/14/2025.

F 849

The corrective action taken for this deficient practice was to correct the care plan for the affected resident to include the collaboration efforts of both the facility and the hospice company. This was corrected on 06/11/2025.

The facility will identify other residents having the same potential to be affected and the systemic change we have made to ensure this deficient practice does not occur was to review all care plans for residents with hospice services to ensure that each care plan

explains the collaboration between the facility and the hospice company. This was completed successfully by 06/13/2025. Also, a weekly audit will be completed of each care plan that is updated to include any collaboration between the facility and hospice companies (see attachment #6).

The facility will monitor this corrective action by submitting to Quality Assurance, at the next meeting, the results of the care plan audit for review and discussion. The next QA meeting is 08/14/2025.

F 851

The corrective action taken for this deficient practice was to confirm that the PBJ submission was submitted for quarter 2. The administrator confirmed with the surveyor that the PBJ submission was indeed submitted into the PBJ system but had the wrong quarter designation and was 1 day late. This was confirmed on the day the deficient practice was identified.

The facility will identify other residents having the same potential to be affected and the systemic change we have made to ensure this deficient practice does not occur is to change the PBJ submission timeline to be submitted every month instead of quarterly to ensure each quarter get submitted before the deadline. Also, a PBJ submission audit will be completed monthly to confirm that the submission was completed and submitted. This will be completed by 07/25/2025.

The facility will monitor this corrective action by submitting to Quality Assurance, at the next meeting, the results of the PBJ submission audit and copy of the submission report for review and discussion. The next QA meeting is 08/14/2025.