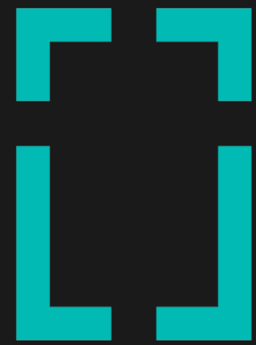


EVERTRUE™

Life according to **you**™

ALF TOP TEN DEFICIENCIES

SURVEY PROCESS AND PLAN OF CORRECTION

JUNE 9, 2026

AGENDA

- Introductions
- List of Most Frequently Cited Deficiencies
- Understanding the regulations behind the deficiencies
- Staying Survey Ready
- Writing a successful plan of correction
- Wrap up and questions

Assisted Living Facilities

Most Frequently Cited Deficiencies – Health

January 1, 2026 – March 31, 2026

MOST FREQUENTLY CITED DEFICIENCIES - HEALTH

JANUARY 1 – MARCH 31, 2026

86.047 (46)	Safe and effective medication system
86.032 (13)	Electrical wiring, maintained, inspected
86.022 (9)(C)	Fire alarm system – test/maintain
86.022 (5)(D)	Fire drill requirements, evacuation
86.047 (19)	TB screen residents and staff
86.047 (28)(G)	Individual service plan - develop
86.047 (28)(H)	Individual service plan – review requirements
86.032 (2)	Substantially constructed and maintained
86.047 (47) (A)	Physician's orders followed
87.030 (65)	Non food contact surfaces, cleaned as needed

Assisted Living Facilities – Additional Requirements

More than Minimal Assistance

January 1, 2026 – March 31, 2026

ADDITIONAL REQUIREMENTS – MORE THAN MIN ASSIST

JANUARY 1 – MARCH 31, 2026

86.045 (3)(A)5 Individual evacuation plan – in resident ISP

86.045 (3)(A)6. A Individual evacuation plan – staff requirements

86.045 (3)(A)6. C Individual evacuation plan - evaluate

86.045 (3)(A) 9 Resident evacuation plan – readily available

86.045 (3)(A) 10 Comply with all requirements of section (3) of this rule

86.045 (4)(D) Staffing – resident, more than minimal assistance

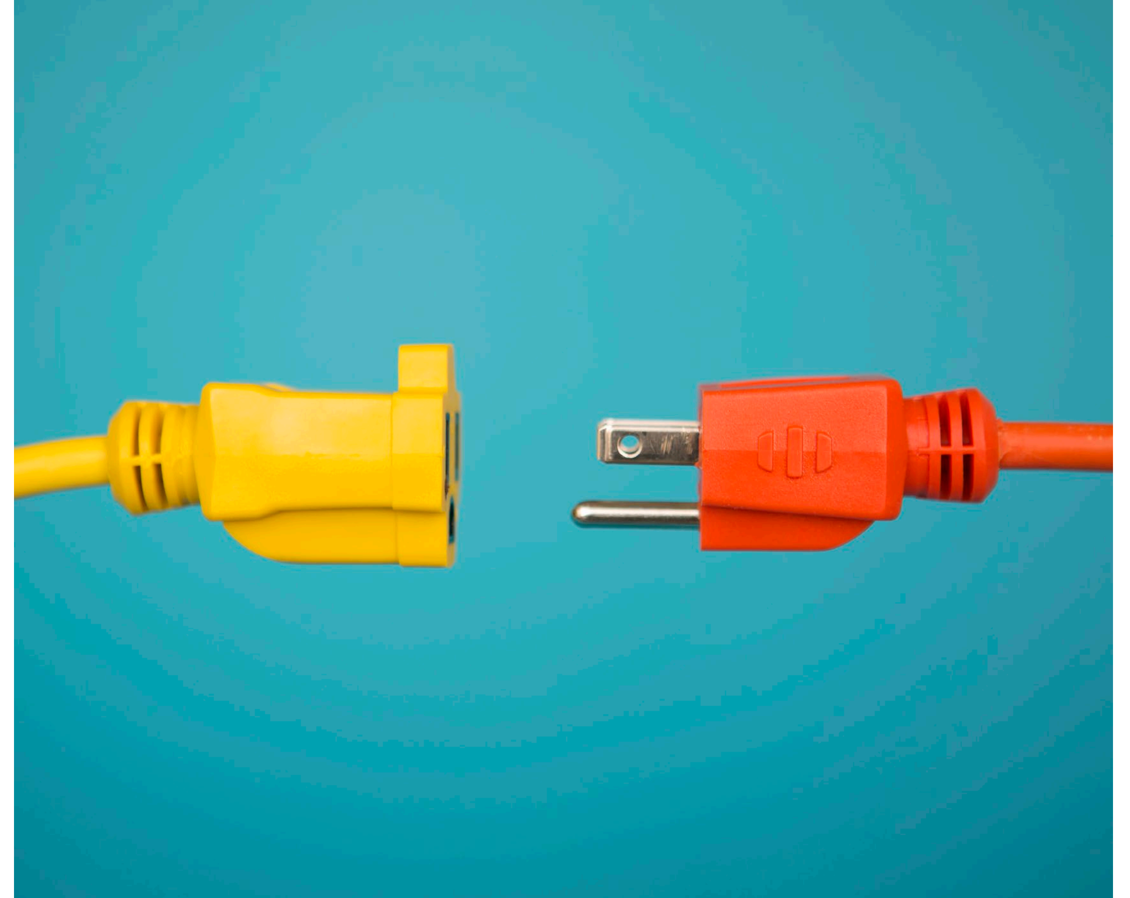
Breaking down the definition of the deficiency

86.047 SAFE AND EFFECTIVE MEDICATION SYSTEM

- The administrator shall develop and implement a safe and effective system of medication control and use, which assures that all residents' medications are administered
  - By personnel at least eighteen years of age
  - In accordance with physicians' instructions using acceptable nursing techniques
  - The facility shall employe a licensed nurse eight hours per week for every 30 residents to monitor each resident's condition and medication

86.032 (13) ELECTRICAL WIRING, MAINTAINED, INSPECTED

- In facilities that are constructed or have plans approved after July 1, 2005, electrical wiring shall be installed and maintained in accordance with the requirements of the National Electrical Code, 1999 edition, National Fire Protection Association, Inc……and by local codes.



86.022 (9)(C) FIRE ALARM SYSTEM – TEST/MAINTAIN 86.022 (5)(D) FIRE DRILL REQUIREMENTS, EVACUATION

Fire alarm system

- All facilities shall test and maintain the complete fire alarm system in accordance with NFPA 72, 1992 edition

Fire Drill

- A minimum of twelve fire drills shall be conducted annually with at least one every three months on each shift
  - At least four of the required fire drills must be unannounced to residents and staff, excluding staff who are assigned to evaluate staff and resident response to the drill
  - The fire drills shall include a resident evacuation at least once a year

86.047 (19) TB SCREEN RESIDENTS AND STAFF
86.047 (28)(G) INDIVIDUAL SERVICE PLAN – DEVELOP
86.047 (28)(H) INDIVIDUAL SERVICE PLAN – REVIEW REQUIREMENTS

TB SCREEN

- The facility shall screen residents and staff for tuberculosis as required for long term care facilities by 19 CSR 20-20.100

ISP - DEVELOP

- Develop an individualized service plan (ISP), which means the planning document prepared by an assisted living facility which outlines a resident's needs and preferences, services to be provided, and goals expected by the resident or the resident's legal representative in partnership with the facility.

ISP - REVIEW

- Reviews the ISP with the resident, or legal representative of the resident, at least annually or when there is a significant change in the resident's condition which may require a change in service.

86.032 (2) SUBSTANTIALLY CONSTRUCTED AND MAINTAINED

- The building shall be substantially constructed and shall be maintained in good repair and in accordance with the construction and fire safety rules in effect at the time of initial licensing.

86.047 (47) (A) PHYSICIAN'S ORDERS FOLLOWED

- No medication, treatment or diet shall be administered without an order from an individual lawfully authorized to prescribe such and the order shall be followed.

87.030 (65) NONFOOD CONTACT SURFACES, CLEANED AS NEEDED

- Nonfood – contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles and other debris.

Staying survey ready

OH NOOOOOO – STATE IS IN THE BUILDING

RESIDENT CARE SURVEY

FACILITY NAME	☐ RCFI ☐ RCFII ☐ ALFI ☐ ALFII	FACILITY ID NUMBER	
ADDRESS (STREET, CITY)			
CAPACITY	CENSUS	ADULT DAY CARE PARTICIPANTS	DMH PLACED RESIDENTS

NO. OF RESIDENTS	CATEGORY
	1. Residents using canes _____ walkers _____ wheelchairs _____ **(List number of each)**
	2. Residents requiring staff assistance with transfer or ambulation - List names in comments or attach a list
	3. Residents who are blind _____ or deaf or require use of hearing aids _____ **(List number of each)**
	4. Residents with catheters
	5. Residents who are frequently to totally incontinent of bladder and/or bowel
	6. Residents with a mental illness diagnosis and/or a developmental disability
	7. Residents who receive a physician prescribed special diet (other than regular)
	8. Residents who have pressure sores/ulcers _____ or other skin issues _____ **(List number of each)**
	9. Residents who self-administer prescription or over-the-counter medication
	10. Residents who are diabetic and insulin dependent
	11. Residents who have experienced falls in the past 60 days
	12. Residents with a diagnosis of Alzheimer's disease or dementia
	13. Residents hospitalized during the last 45 days
	14. Residents experiencing a short period of incapacity (45 day timeframe) due to illness, injury or recuperation from surgery
	15. Residents who required infectious disease treatment within the last 30 days
	16. Residents receiving hospice
	17. New residents in the last 30 days
	18. Residents who reside above the first floor
	19. Residents who require the use of oxygen
	20. Residents who are an elopement risk
	21. Residents who require physical or chemical restraints
	22. Residents who have exhibited behaviors that present a reasonable likelihood of harm to themselves or others
	23. Residents who are mentally incapable and/or require physical assistance or the use of an assistive device in order to negotiate a pathway to safety. List names in comments or attach a list.
	24. **ALF IIs only:** Residents with a physical, cognitive, or other impairment who require more than minimal assistance in order to safely evacuate the facility. The following actions required of staff are considered to be more than minimal assistance: assistance to traverse down stairways, assistance to open a door, and assistance to propel a wheelchair. List names in comments or attach a list.

COMMENTS

DOCUMENTATION NEEDED: EMPLOYEE

FACILITY NAME		SURVEYOR NAME / ID NUMBER	
FACILITY NUMBER		DATE	ACTIVITY

TIME/SOURCE OF EVIDENCE	DOCUMENTATION
	o **Employee Name:** o Job Title
	o Address:
	o Social Security Number:
	o Date of Birth: o Date of Hire
	o Certification/Education
	o Criminal Background Check/o FCSR: Request___________ Received ___________
	o Findings:
	o Reason for Termination (if applicable)
	o EDL check:
	o TB status:
	o Physician Statement:
	Orientation Training:
	o Job responsibilities:
	o Emergency response:
	o Infection control/hand washing:
	o Hippa:
	o Preservation of Resident Dignity:
	o Abuse/Neglect
	o Resident Rights/Protection of Property:
	o EDL info
RCF II N/A	o Mental Illness:
RCF II N/A	o Alzheimer's Training:
	o *ALF Transfer Training:*
	o *ALF Person Centered Care/ Social Model of Care:*

EVERTRUE™

DOCUMENTATION NEEDED: RESIDENT

EVERTRUE™

FACILITY NUMBER	DATE	ACTIVITY

TIME/SOURCE OF EVIDENCE	DOCUMENTATION	
	o Resident Name:	
	o Admission Date:	
	o Confidential Number:	
	o Previous Address:	
	o Date of Birth:	
	o Sex	
	o Marital Status:	
	o Social Security Number:	
	o Medicare/Medicaid Number:	
	o Name/Phone Number of Physician:	
	o Alternate Physician:	
	o Pharmacist:	o Diet Order
	o Dentist:	o Funeral Director:
	o Admission Agreement:	o Resident Rights:
	o Personal Inventory:	o TB testing:
	o Name/Address of legal Authorized responsible party/designee to be notified in emergency:	
	o History and Physical:	
	o Diagnosis:	

DOCUMENTATION NEEDED: RESIDENT

FACILITY NAME	SURVEYOR NAME / ID NUMBER	
FACILITY NUMBER	DATE	ACTIVITY

TIME/SOURCE OF EVIDENCE	DOCUMENTATION
	o **Resident Name:**
	o Physician Reviews:
	o Pharmacy Reviews:
	o Medications: oDate of POS: o Labs:

EVERTRUE™

DOCUMENTATION NEEDED: RESIDENT, MONTHLY SUMMARY AND NOTES

FACILITY NUMBER	DATE	ACTIVITY

TIME/SOURCE OF EVIDENCE	DOCUMENTATION
	○ **Resident Name:**
	○ Monthly Summaries: Include weights
	○ Review of Nursing Notes:

EVERTRUE™

DOCUMENTATION NEEDED: RESIDENT, PRE-SCREEN, CBA, ISP/IEP

FACILITY NUMBER	DATE	ACTIVITY

TIME/SOURCE OF EVIDENCE	DOCUMENTATION
	o **Resident Name:**
	o *Assisted Living Facilities:*
	o Pre-Screen
	o CBA (Community Based Assessment)
	o ISP/IEP (Individual Service Plan) (Individual Evacuation Plan)

EVERTRUE™

TIPS AND TRICKS

ADMISSION PACKETS

Move in Checklist

Admission Audit

Resident Orientation Checklist

Pre-Screen and CBA

AUDITS AND TRACKING

Schedule of assessments

Clinical Chart Audits quarterly

Update resident care survey

HR files and education

ADMISSION PACKET: MOVE IN CHECKLIST

AL/ALMC Clinical Move in Check List

__Fax cover letter and Med Cert to Physician. Date sent________

__Received Med Cert and orders from physician, to include med list, H & P, etc. Date Received_________

__MO Pre-Screen (MO 580-2835 (9-06), section 1 completed prior to admission but must be completed before admission. Date completed___________Date sent to med records_________

__MO Community Based Assessment (CBA), (MO 580-2835 (9-06)) to be completed no more than 5 days post admission in MyUnity. If on paper, send to med records. Date sent to med records, if applicable__________

__Resident needs assessment completed upon admission

__Resident rights review/education to resident and/or family upon admission

__New Resident AL Acknowledgements signed by resident and/or family upon admission. Date sent to med records__________

__Inventory of Personal Belongings by staff upon admission. Place in hard chart until DC – then forward to med records.

__Billing notification of move in date completed and sent to Business office (BO). Date sent to BO___________

__Authorization of Use and Disclosure signed by resident and/or family. Date sent to med records________________

__My Story Packet upon admission

__TB test order(s) placed in MyUnity utilizing TB order set

__ISP to completed in MyUnity within 7 days of admission. Assess for IEP. Complete if applicable.

__Scheduler set up in MyUnity to include touchscreen documentation.

__Pendants, if needed, request sent to maintenance. Date sent___________________

__Key cards for family members, request sent to maintenance. Date sent___________

__Keys to Apartment for AL requested from maintenance. Date sent________________

__Name plate on door completed by Al receptionist prior to move in

__Upload picture into MyUnity completed by AL receptionist upon move in

__DNR signed (if applicable). Keep in chart – send copy to med records. Date sent______

- Follows guidelines for:
  - Pre-screen
  - CBA
  - ISP/IEP

Also includes surveyor information requested:

- Resident rights
- Admission agreement
- Personal Inventory
- TB order
- Code Status

ADMISSION PACKET: ADMISSION AUDIT

PAGE 1

Admission Process Audit—AL/ALMC

Name of Guest: ________________ Rm # _______ Admit Date: ___________

Admission Item	Met	Unmet—Action	Recommendation
RIBBON			
1. **Bed Assignment:** Verify Guest is in the correct room			
2. **Verify/Add Allergies:** Verify allergies are entered • No allergies=NKA			
3. **Verify/Add Physician:** Verify there is a physician assigned			
4. **Code Status** • Make sure there is an order in Orders and in Ribbon			
5. **Diagnosis** • Primary diagnosis is correct • Co-morbidities			
6. **Resident photo**: • Verify the photo is in the ribbon			
Alerts			
1. **Anticoagulant** • **PT/INR ordered** • **Add to ISP**			
Vitals			
1. **Vitals signs upon admission** 2. **Weight upon admission** 3. **Height upon admission**			
Assessments			
Admission Assessment completed, signed, locked			
Community Based Assessment (CBA) • **Pre-Screen**—prior to admission **Assessment**—within 5 days of admission			
Individual Needs Assessment (AL only)—Upon admission			
TB 2 step initiated • **1st step must be given within 24 hours of admission** • **2nd step given 10-14 days later**			
Medication Self Administration—as needed for residents that self-medicate			
Individualized Evacuation Plan—(MO only) Complete for affected residents (No more than 1			

1

PAGE 2

physical intervention and not more than 3 verbal interventions)			
52 Week Wound Assessment as needed ○ Complete weekly and PRN ○ Reason in the Reason column			
Individualized Service Plan • Upon admission then review/edit yearly and with significant change • Signed by staff and resident/representative ○ Fall ○ Wound ○ Weight Change ○ Behavior ○ Anticoagulant			
ORDERS TAB			
Medication Orders: • **Diagnosis/Reason**: Check for diagnosis or reason in the Notes field or Diagnosis code • **Physical Monitors:** Added to medications requiring monitoring			
Treatment Orders: • **Enteral Feeding:** Flushes, type of tube feeding • **Nebulizer and O2 orders**: Need order to change tubing/humidifier and mask monthly, clean humidifier filters monthly • **Wound treatments:** Medication/Dressing, site, how often • **Pacemaker Checks:** • **Therapy orders**: • **Equipment:** Use, cleaning, maintenance			
• **Diet order**			
• **Lab and xray orders**: Verify these were entered into myUnity and the lab site			
• **COVID monitoring orders in place**			
Clinical Notes			
• Admission Note • Date/Time of admission • Where admitted from, how arrived, who accompanied • General condition • Other			
Providers			
• **Physician:** ○ **MO**—within 10 days of admission ○ **IL**-- No more than 120 days prior to admission • **Notes scanned into myUnity or entered**			
Belongings Inventory completed			

Nurse Leader Signature: _______________________________________

2

Continues to follow requested information and ensures compliance with documentation standards.

ADMISSION PACKET: RESIDENT ORIENTATION CHECKLIST

Assisted Living Resident Orientation

I have reviewed the following facility policies and emergency procedures with an Assisted Living staff member:

- ☐ MEDICAL EMERGENCY POLICY.
- ☐ DISASTER AND EMERGENCY PREPAREDNESS POLICY.
- ☐ FIRE AND EVACUATION PLAN.
- ☐ HIGH WINDS AND TORNADO POLICY.
- ☐ I HAVE BEEN GIVEN MEAL TIMES AND MEAL SUBSTITUTIONS.
- ☐ I HAVE REVIEWED THE MEDICATION POLICY.
- ☐ I KNOW THE SIGN OUT POLICY FOR LEAVING THE FACILITY.
- ☐ I HAVE BEEN SHOWN THE EMERGENCY EXIT AND FIRE ALARM LOCATION.
- ☐ I HAVE BEEN INSTRUCTED IN THE USE OF THE EMERGENCY PULL CORDS OR ALERT BUTTONS IN MY APARTMENT.
- ☐ I HAVE RECEIVED A CURRENT RESIDENT HANDBOOK.
- ☐ I HAVE BEEN SHOWN THE HEATING/COOLING CONTROLS IN MY ROOM.
- ☐ PENDANT USE.

Employee Signature ____________________ Date ____________

AUDITS AND TRACKING

SCHEDULE

- On admit – schedule assessments and annual screens using tool of choice or your eMAR

ONGOING AUDITS

- Clinical Chart Audit
  + Quarterly
  + Sig change

UPDATE RESIDENT CARE SUMMARY

- Keep updated – especially during survey window

HR AND EDUCATION

- HR "state" files
- Education tracking

ADDITIONAL INFO TO HAVE AVAILABLE

- Staff schedules
- Medication policies
- Fire alarm documentation (training and live)
- Fall reports
- Special diets
- Copy of NEO information that includes Dementia training
- Staff contacts

Writing a Successful Plan of Correction

PLAN OF CORRECTION (POC)

- Your POC must contain the following:
  - What corrective action(s) will be accomplished for those residents found to have been affected the deficient practice
  - How you will identify other residents having the potential to be affected by the same deficient practice
  - What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur
  - How the facility plans to monitor its performance to make sure that solutions are sustained.
    - The facility must develop a plan for ensuring that corrections achieved are sustained.
    - This plan must be implemented, and the corrective action evaluated for its effectiveness.
  - Your plan of correction must include dates by which corrective action will be completed
  - Your plan of corrections MUST NOT INCLUDE THE NAMES OF RESIDENTS. In addition, your POC should not include other resident specific information such as medical records.

POC

PLAN OF CORRECTION

Provider/Supplier Name:	
Street Address, City, Zip:	
Date of Survey:	

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	**PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**	**COMPLETION DATE**

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

DEVELOPMENT OF YOUR PLAN OF CORRECTION (POC)

- Make sure to read your Statement of Deficiencies in its entirety.
- Don’t rely on your notes from the exit interview to write a POC.
- Make sure to highlight the important things that must be addressed – for example, and hypothetically:
  - 1. Review of Resident #1’s physician order sheets (POS) dated January 2020, showed an order for Morphine (scheduled II narcotic used for pain) 20 milligrams (mg) liquid every four hours as needed.
    - Review of the facility’s Controlled Drugs-Count Record sign in/sign out sheet, dated January 2020, showed the sign in/sign out sheet did not contain documentation of the reconciliation the resident's Morphine on:
      - These dates

STATEMENT OF DEFICIENCY VERBIAGE

- The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility:
- (E)The premove-in screening shall be completed prior to admission with the participation of the prospective resident and be designed to determine if the individual is eligible for admission to the assisted living facility and shall be based on the admission restrictions listed at section (29) of this rule; II
- This regulation is not met as evidenced by: Class II
  - Based on interviews and record reviews, the facility staff failed to complete the required pre-move-in screening to determine if the individuals were eligible for assisted living facility admission for six of six residents sampled. (Resident #23, Resident #15, Resident #3, Resident #4, Resident #25, and Resident #6) The facility census was 34. The facility does not have a policy related to premove-in screening.

WRITING YOUR POC

- As you start writing your POC, remember again, you must develop a plan of correction for each item. In our example, there were 6 residents affected, so on that deficiency, you must have 6 plans that identify HOW, WHAT, WHEN, WHERE it was or will be corrected and the plan should also include provision instituted to prevent reoccurrence.

WRITING YOUR POC

- All residents have the potential to be directly affected by the deficient practice of not completing the pre-move-in screening to ensure the individual is eligible for admission to the assisted living facility and does not require hospitalization or skilled nursing placing. Resident's #23, 15, 3, 4, 25, and 6 were assessed prior to move in utilizing an internal assessment and not placed on the MO 580-2835 (9-06) page 1, to assess eligibility for required move in criteria for Assisted Living. Resident #23 was assessed, 10/22/18, prior to move in on 12/6/18, etc. with each resident.

WRITING YOUR POC

- Resident's #23, #15, #3, #4, #25, and #6 will have the MO 580-2835 (9-06) section 1 completed, or the information contained with the MO 580-2835 (9-06) section 1 documented to show they meet qualification for AL as of the current assessment date. All other residents currently residing in AL will be audited to see if they had section 1 of MO 580-2835 (9-06) completed prior to and before admission. All residents that are found not to have the above section completed will be completed as of the current assessment date.

WRITING YOUR POC

- All future residents will have a pre-move-in screening completed prior to move in utilizing the MO 580-2835 (9-06), page 1 form to determine eligibility. This will be uploaded into the resident's electronic medical record and shall be monitored by the Health Information Coordinator as part of their admission paperwork audit.
- In addition, all nursing leadership for AL will be completing and Admission Process Audit within 24 hours, or end of the next business day, of admission to their respective unit to ensure that the Pre-Screen has been sent to medical records.
- All new admissions moving forward will have a "new admission packet" that includes a Clinical Move In Checklist, Pre-Screen form, Community Based Assessment (CBA), Resident Orientation, and Admission Process Audit. These packets were developed on 4/20/20. Please see attachment B

WRITING YOUR POC

- All nursing leaders in Assisted Living, and other leadership that have been certified to complete the CBA were given education on 4/20/20 and 4/22/20. Please see attachment C.
- Monitoring will occur by the Health Information Coordinator and Administrator on all Pre-Screens completed on all new admission for 1 month X 2, then quarterly through unit documentation compliance audits by the Medical Records Department. Any variance will be addressed immediately and reported to the Care Center Administrator.
- Policy was given to survey staff during survey. Please see attached policy on documentation standards, attachment D.

WRITING YOUR POC

- To make sure corrections are achieved and permanent, Administrator will report monthly to QA. Identified problems or issues, and/or trends will be immediately corrected and will be brought to the attention of the QA team for further correction action.

WRITING YOUR POC

- Remember you have to include dates by which corrective action will be completed.
- On the plan of correction form there is a column marked completion date.
  - 4/28/20

QUESTIONS

THANK YOU

EverTrueLiving.org

EVERTRUE™