The following is the Plan of Correction for Monarch Place regarding the statement of Deficiencies dated April 03, 2025.

Accepted 1220 PM May 19, 2025 chg

Gregory C. Settlin, RN, MSHAI

PLAN OF CORRECTION

Facility Name: Monarch Place- ALF Facility ID#: D2209

Survey Exit Date: April 03, 2025 Administrator: Amanda Christopher

Deficiency Number:420-5-4.12 (5) Physical Environment

1. A 1203

2. Specify the corrective action that you will take in response to each resident or example identified in the Deficiency.

- On the morning of April 5, 2025 the Director of Engineering along with Administrator, Health and Wellness Director and Director of Dining Services, relocated Resident's that occupied apartment 16 and 21 to temporary available apartments that were comparable in size while damaged flooring was replaced in their current apartments.
- New flooring arrived on April 11, 2025, removal and replacement of the flooring in apartment 16 began on April 14, 2025 and was completed on April 16, 2025. Resident for apartment 16 was then assisted in moving furniture and belongings back to his original apartment on April 18, 2025.
- New flooring arrived on April 11, 2025, removal and replacement of flooring in apartment 21 began on April 21, 2025. Replacement of flooring for apartment 21, to be completed by May 7, 2025. Resident will be assisted in moving back to original apartment the following day on May 8, 2025. On May 8, 2025 upon completion of flooring it was discovered that the flooring that was put down was already peeling up and not safe for resident. Executive Director had homegenie return and pull flooring, contacted another contractor to replace a safer flooring option. This flooring is set to be completed on May 15, 2025, Resident will remain in the apartment that we transferred to until original apartment is completed and safe for her to live in.

3. Specify the corrective action that you will take to identify other concerns not identified by the survey team that are related to those cited in the deficiency. Be sure to include specific timetables and identify responsible facility staff.

- Other areas identified during rounds will be placed in TELS work ticket for completion going forward.

4. Describe the measures/changes you have put into place or made to ensure the same deficiency will not recur in your facility. Be sure to include specific timetables and identify responsible facility staff; staff training; policy changes; use of consultants; resident input; physical environment modification; changes or expansion of staffing positions; increase in staff numbers; and improvement of staff qualifications.

- All identified areas will be entered into TELS system for completion
- Administrator will train staff on recording issues for repair on TELS system

5. Explain how you will monitor your corrective action to ensure that they are fully implemented; adequately address the identified problems; and are effective. Must also identify positions of staff that will accomplish the monitoring; when and how often the monitoring will take place; and where the documentation of the monitoring will be kept.

- The Administrator will monitor progress of future flooring replacement to ensure the correct flooring is being applied.
- Any issues with delays in materials will be monitored and added to the TELS work system to be ordered.

Note: All Plan of Correction documentation will be in a binder, organized and filed by the Administrator. This binder will be stored in the Administrator's office.

Should any corrective action be determined as ineffective, the Administrator and Governing Authority shall make immediate revisions and submit an amended Plan of Correction to the Alabama State Board of Health.

Administrator Signature Amanda Christopher Date: 05/15/25

Prepared by:

Amanda Christopher, Administrator of Monarch Place

256-352-3141

The following is the Plan of Correction for Monarch Place regarding the statement of Deficiencies dated April 03, 2025.

PLAN OF CORRECTION

Facility Name: Monarch Place- ALF Facility ID#: D2209

Survey Exit Date: April 03, 2025 Administrator: Amanda Christopher

Deficiency Number: 420-5-4-.06 (10) Care of Residents.

1. A 619

2. Specify the corrective action you will take in response to each resident or example listed in the deficiency. Include specific timetables and title of staff who will accomplish the corrective action.

- 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 04/03/2025 The Director of Dining disposed of the expired first aid kit, The Health and Wellness Director ordered a new kit.
- On 04/04/2025 The new first aide Kit arrived and was inspected by the Health and Wellness Director and inspection date and signature applied onto the outside of the kit box.

3. Specify the corrective action that you will take to identify other concerns not identified by the survey team that are related to those cited in the deficiency. Be sure to include specific timetables and identify responsible facility staff.

- Bi-annually, Med techs will inspect the first aid kits for expired items and ensure that sufficient stock levels are present. Needed items to keep stock levels current will be ordered immediately.

4. Describe the measures/changes you have put into place or made to ensure the same deficiency will not recur in your facility. Be sure to include specific timetables and identify responsible facility staff; staff training; policy changes; use of consultants; resident input; physical environment modification; changes or expansion of staffing positions; increase in staff numbers; and improvement of staff qualifications.

- On 04/10/2025 The administrator devised a checklist for the Bi-annual dates to be signed off at the time that inspection of the first aide kits occur, by the Med Tech and then the Health and Wellness Director.
- Dates will be 6 months from the initial date of the inspection, and then again 6 months from the date of the 2nd inspection going forward.
- Health and Wellness Director and Med Techs were educated on this process by Administrator.
- A binder with the check list will be kept in the room where the first aid kit is stored. Annually in April the Health and Wellness Director will begin a new inspection sheet in the binder for the next year's inspections.

5. Explain how you will monitor your corrective action to ensure that they are fully implemented; adequately address the identified problems; and are effective. Must also identify positions of staff that will accomplish the monitoring; when and how often the monitoring will take place; and where the documentation of the monitoring will be kept.

- Administrator will Monitor annually to ensure completion of the Inspection of kits.
- Inspection check lists will remain in the binder for the entire year then will be combined and kept in the Administrator's office for three years.

Note: All Plan of Correction documentation will be in a binder, organized and filed by the Administrator. This binder will be stored in the Administrator's office.

Should any corrective action be determined as ineffective, the Administrator and Governing Authority shall make immediate revisions and submit an amended Plan of Correction to the Alabama State Board of Health.

Administrator Signature Amanda Christopher Date: 05/15/25

Prepared by:

Amanda Christopher, Administrator of Monarch Place

256-352-3141

The following is the Plan of Correction for Monarch Place regarding the statement of Deficiencies dated April 03, 2025.

PLAN OF CORRECTION

Facility Name: Monarch Place- ALF Facility ID: D2209

Survey Exit Date: April 03, 2025, Administrator: Amanda Christopher

Deficiency Number:420-5-4-.09 (1)(2) Laundry.

1. A 901

2. Specify the corrective action that you will take in response to each resident or example identified in the Deficiency.

- On April 2,2025 The Director of Engineering pulled out washing machine and dryers and swept and mopped up behind machines, removing lint and debris from the floor and walls. Lint traps were inspected and cleaned.
- On April 3, 2025 At the beginning of the day, Director of Engineering met with all staff to educate on the findings of the debris and lint.

3. Specify the corrective action that you will take to identify other concerns not identified by the survey team that are related to those cited in the deficiency. Be sure to include specific timetables and identify responsible facility staff.

- · No other instances identified; this is the only laundry room in the community.

4. Describe the measures/changes you have put into place or made to ensure the same deficiency will not recur in your facility. Be sure to include specific timetables and identify responsible facility staff; staff training; policy changes; use of consultants; resident input; physical environment modification; changes or

expansion of staffing positions; increase in staff numbers; and improvement of staff qualifications.

- Care staff will clean lint traps at the end of each drying session prior to loading the next load of wet laundry.
- Director of Engineering will log onto TELS to monitor tasks that are due and complete them.
- Monthly Director of Engineering will inspect Machines to ensure that safe operation is maintained. Completion will be logged in TELS software service, and repairs or finding recorded.
- Staff training will occur upon hire and quarterly in staff in-services.
- On 04/05/2025 The Administrator devised signs and displayed them in laundry to serve as reminders to clean lint traps immediately upon removal of dry laundry.
- On 04/02/2025 The Administrator ordered a laptop for Director of Engineering and implemented access to TELS software for DOE to be able to track daily, monthly and Annual tasks and record them.

5. Explain how you will monitor your corrective action to ensure that they are fully implemented; adequately address the identified problems; and are effective. Must also identify positions of staff that will accomplish the monitoring; when and how often the monitoring will take place; and where the documentation of the monitoring will be kept.

- Five (5) times per week for the next 12 weeks, the Director of Engineering will inspect dryer lint traps to ensure proper cleaning is being implemented
- The Administrator will review tasks and logs to ensure completion is up to date. Any documentation not present will be scanned and uploaded to the corresponding task.

Note: All Plan of Correction documentation will be in a binder, organized and filed by the Administrator. This binder will be stored in the Administrator's office.

Should any corrective action be determined as ineffective, the Administrator and Governing Authority shall make immediate revisions and submit an amended Plan of Correction to the Alabama State Board of Health.

Administrator Signature Amanda Christopher Date: 05/15/25

Prepared by:

Amanda Christopher, Administrator of Monarch Place

256-352-3141