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GREENSPRINGS I

SPECIALTY CARE ASSISTED

LIVING

ID# P0104

PLAN OF CORRECTION

A response to the Alabama Department of Public Health
Bureau of Health Provider Standards

Assisted Living Facilities Unit

Survey Exit Date: 12/11/2025

Submitted by:

Earnestine Rhodes, Administrator

Earnestine Rhodes, ALA
Signature

01/26/2026
Date:

Facility Name: Greensprings I
Facility ID: P0104
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A301*420-5-20-.03 (1)(a)(b)(c)(d): Administrations** – The Governing Authority failed to ensure the facility operated in compliance with the SBOH rules for the Specialty Care Assisted Living Facilities.

2. **Corrective Action:** The survey referenced deficiency numbers 301, 302, 303, 405, 406, 604, 611, 619, 702, 703, 901, 1101, 1203, and 1206. Please see the plan of correction for the referenced deficiencies for specific corrective actions taken to each resident or example identified.
   A representative of the Governing Authority will train the administrator on the SBOH rules and facility policies identified in the survey beginning 01/14/2026 and ending no later than 01/30/2026.

3. **Steps taken to identify other residents or concerns:** Please see the plan of correction for the referenced deficiencies for specific steps the community took to identify other residents or concerns not identified by the survey team who may have problems similar to those of the residents or concerns listed.
   A representative of the Governing Authority will train the administrator on the SBOH rules and facility policies identified in the survey beginning 01/14/2026 and ending no later than 01/30/2026.

4. **Measures put into place or systemic changes made to ensure the deficiency will not recur:** The representative of the governing authority will provide routine visits each month to ensure the facility operated in compliance with the SBOH rules.
   A representative of the Governing Authority will train the administrator on the SBOH rules and facility policies identified in the survey beginning 01/14/2026 and ending no later than 01/30/2026.

5. **Monitoring of corrective actions:** The governing authority and the administrator will provide oversight and properly operate the community. Routine monthly visits will be made by a representative of the governing authority to ensure the facility is in compliance with the SBOH rules beginning 01/15/2026 to 07/15/2026. Documentation of the visits will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings I
Facility ID: P0104
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A302 420-5-20-.03(e) Administration:** The facility failed to follow its own policies and procedures for operation of the facility.

2. **Corrective action:** The survey referenced deficiencies 301, 302, 303, 405, 406, 604, 611, 619, 702, 703, 901, 1101, 1203, and 1206. Please see plan of correction for the referenced deficiencies for specific corrective actions taken for each deficiency.
   A representative of the Governing Authority will train the administrator on the SBOH rules and facility policies identified in the survey beginning 01/14/2026 and ending no later than 01/30/2026.

3. **Steps taken to identify other residents or concerns:**
   Please see the plan of correction for the above referenced deficiencies for specific steps the facility took to identify other residents or concerns not identified by the survey team who may have similar problems.
   A representative of the Governing Authority will train the administrator on the SBOH rules and facility policies identified in the survey beginning 01/14/2026 and ending no later than 01/30/2026.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   All staff training on the specific policies mentioned in the survey will be complete by management department heads by 01/30/2026.
   A representative of the Governing Authority will train the administrator on the SBOH rules and facility policies identified in the survey beginning 01/14/2026 and ending no later than 01/30/2026.

5. **Monitoring of corrective actions:** The governing authority and the administrator / designee will provide oversight and properly operate the community. Routine monthly visits will be made by a representative of the governing authority to ensure the facility is in compliance with the SBOH rules beginning 01/15/2026 to 07/15/2026. Documentation of the visits will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings I
Facility ID: P0104
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A303* 420-5-20-.03 (2) (a) Administration:** The administrator failed to perform her duties to ensure the care needs of all residents were met. The administrator failed to ensure the facility was in compliance with the rules of the Alabama State Board of Health.

2. **Corrective action:** The survey referenced deficiencies 302, 303, 405, 406, 604, 611, 619, 702, 703, 901, 1101, 1203, and 1206. Please see the plan of correction for the referenced deficiencies for specific corrective actions taken for each deficiency.
   A representative of the Governing Authority will train the administrator on the SBOH rules, the role and responsibilities of an administrator, and facility policies identified in the survey beginning 01/14/2026 and ending no later than 01/30/2026.

3. **Steps taken to identify other residents or concerns:**
   Please see the plan of correction for the above referenced deficiencies for specific steps the facility took to identify other residents or concerns not identified by the survey team who may have similar problems.
   A representative of the Governing Authority will train the administrator on the SBOH rules, the role of an administrator, and facility policies identified in the survey beginning 01/14/2026 and ending no later than 01/30/2026.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   All staff training on the specific policies mentioned in the survey will be completed by Management department heads by 01/30/2026.
   A representative of the Governing Authority will train the administrator on the SBOH rules, the role and responsibilities of an administrator, and facility policies identified in the survey beginning 01/14/2026 and ending no later than 01/30/2026.

5. **Monitoring of corrective actions:** The governing authority and the administrator / designee will provide oversight and properly operate the community. Routine monthly visits will be made by a representative of the governing authority to ensure the facility is in compliance with the SBOH rules beginning 01/15/2026 to 07/15/2026. Documentation of the visits will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings I
Facility ID: P0104
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A405* 420-5-20-.04 (6) (7) (8) Personnel:** The facility failed to employ a registered nurse to provide oversight and coordination of resident care.

2. **Corrective action:** A consultant nurse was hired on 12/16/2025.

3. **Steps taken to identify other residents or concerns:**
   All residents had the ability to be affected. A nurse consultant was hired on 12/16/2025 by the administrator.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   The administrator posted an ad for a full time RN in October. A temporary consultant nurse was hired by the administrator on 12/16/2025 to assist the administrator / designee in providing oversight and coordination of resident care. The consultant RN provides feedback to the administrator during weekly visits. The RN consultant screens new potential residents as well as returning current residents for admission. The Governing Authority is currently assisting with phone interviews in an effort to find a full time RN.

5. **Monitoring of corrective actions:** The governing authority and the administrator/designee will provide oversight and properly operate the community. Routine monthly visits will be made by a representative of the governing authority to ensure the facility is in compliance with the SBOH rules beginning 01/15/2026 to 07/15/2026. Documentation of the visits will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings I
Facility ID: P0104
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A406* 420-5-20-.04 (9) Personnel:** The facility failed to ensure staff received required training.

2. **Corrective action:**
   RI#5 was changed to finger sticks on 12/06/2025. The Libre system was removed per family.

3. **Steps taken to identify other residents or concerns:**
   All residents had the ability to be affected. Currently, there are no residents on a glucose monitoring system.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   All staff training on the specific policies, deficits, and deficiencies mentioned in the survey including the blood glucose monitoring system and diabetes will be complete by management department heads by 01/30/2026.

   Topics for hospice, blood glucose monitoring, and diabetes have been added to the new employee training form to ensure new employees get the training when hired. Training information on the above titles was added to the new hire orientation binder by the Administrator on 01/06/2026.

   The administrator / designee will review all new employee files monthly to ensure the required training has been completed.

5. **Monitoring of corrective actions:** The administrator / designee will monitor 5 employee files a month to ensure staff has received the required training beginning 01/15/2026 to 07/15/2026. Documentation of the audits will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings I
Facility ID: P0104
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A604* 420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents:** The facility failed to provide adequate health supervision of a resident with significant weight loss and failed to perform monthly assessments.

2. **Corrective action:**
   An RN consultant was hired on12/16/2025 to assist with health supervision of residents. RI# remains in the facility. RI#3 remains in the facility. RI#4 discharged from the facility on 12/16/2025. Monthly assessments have been completed for December for both residents. RN consultant / designee will complete weight loss care plans and monthly assessments by 01/30/2026.

3. **Steps taken to identify other residents or concerns:**
   All residents had the ability to be affected. An audit of all residents' weights was completed on 01/06/2026 by a corporate nurse to ensure other residents do not have a weight loss. Any new weight losses will be reported to the resident's physician for follow up and a weight loss care plan will be created by the RN consultant / designee.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   All staff training on the specific policies mentioned in the survey including weight loss and monthly assessments will be complete by management department heads by 01/30/2026.

   The RN consultant / designee will review weights each month to identify any residents with weight loss and report them to the Administrator / designee and the resident's physician for follow up. Any resident identified will have a weight loss care plan created.

   The RN consultant / designee will complete monthly assessments of each resident every month.

5. **Monitoring of corrective actions:** The administrator / designee will monitor 5 resident charts a month to ensure monthly assessments are being completed timely and weight losses are being identified beginning 01/15/2026 and ending 07/15/2026.
   Documentation of the audits will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings I
Facility ID: P0104
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A611* 420-5-20-.06 (4) (a) (b) Care of Residents:** The facility RN failed to develop and evaluate written plans of care that adequately address residents' care needs with appropriate interventions.

2. **Corrective action:** An RN consultant was hired on12/16/2025 to assist with health supervision of residents.
   RI#1 care plan was updated by RN consultant on 01/09/2026. RI#4 discharged from the facility on 12/16/2025.

3. **Steps taken to identify other residents or concerns:** All residents had the ability to be affected. A review of all current resident care plans will be completed by 01/30/2026 by the Consultant RN / Designee.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:** The RN consultant / designee will visit the facility each week to review and update care plans to ensure they are updated and have appropriate interventions. The consultant RN /designee provides feedback to the administrator during each visit. The Administrator / designee is responsible for ensuring all monthly assessments and care plans are completed accurately and timely.

5. **Monitoring of corrective actions:** The administrator / designee will review 5 resident charts each month to ensure care plans are up to date and have appropriate interventions beginning 01/15/2026 and ending 07/15/2026. Documentation of the audits will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings I
Facility ID: P0104
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A619* 420-5-20-.06 (8) Care of Residents:** The facility failed to annually inspect and maintain usability of the first aid supplies.

2. **Corrective action:** All expired items in the first aid kit were replaced 12/16/2025.

3. **Steps taken to identify other residents or concerns:** All residents had the ability to be affected.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:** The administrator / designee will be responsible for ensuring the first aid kits do not have any expired supplies. A first aid kit will be kept in the medication cart as well as the nurse's office. All supplies will be checked quarterly by the administrator / designee. Dates of checks will be documented on each box.
   All staff training on the specific policies mentioned in the survey including checking the first aid kit to ensure there are no expired items will be complete by management department heads by 01/30/2026. Any expired items will be reported to the administrator / designee so they can be replaced.

5. **Monitoring of corrective actions:** The administrator / designee will monitor the first aid supplies monthly beginning 01/15/2026 and ending 07/15/2026. Documentation of the audits will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings I
Facility ID: P0104
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A702* 420-5-20-.07 (2) Food Service:** The facility failed to monitor and document dish water temperatures and chlorine concentrations to ensure dishes have been properly sanitized. The facility failed to have a working thermometer in all refrigerators and freezers. The kitchen staff also failed to store the ice scoop properly so that it was protected from contamination. In addition, the garbage can was without a tightly fitting lid.

2. **Corrective action:** New thermometers were purchased by the maintenance director on 01/08/2026 and placed in the freezers and refrigerators. New hands-free trash cans with lids were purchased 01/08/2026 and placed in the kitchen by the maintenance director. During the survey the ice machine was inoperable and unplugged. The ice scoop on top of the ice machine was not being utilized. The scoop was removed immediately after the survey, washed and stored. The ice machine was removed from the kitchen by the maintenance director on 01/08/2026. Water temps, chemical concentrations, and freezer and refrigerator temperature forms have been posted by the administrator in the kitchen for daily documentation by kitchen staff.

3. **Steps taken to identify other residents or concerns:** All residents had the ability to be affected.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:** The administrator / designee will train the dietary manager / designee on the regulations and policies for the freezer and refrigerator temps, how to sanitize the dishes properly, documenting water temps and chemical concentrations, keeping lids on trash cans and the proper use and storage of ice scoops by 01/20/2026. The dietary manager / designee will train all dietary staff on the same topics no later than 01/30/2026. The dietary manager / designee will be responsible for ensuring the above items are being done accurately and timely. Currently the ice will be transported from the ALF in protective 2-gallon bags purchased through Gordon foods until a new ice machine can be purchased.

5. **Monitoring of corrective actions:** The administrator / designee will make rounds in the kitchen monthly and audit dish water temperatures, freezer and refrigerator temps and ensure thermometers are being used, trash cans have lids in use, and ice scoops are being used correctly beginning 01/15/2026 and ending 07/15/2026. Documentation of the audits will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings I
Facility ID: P0104
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A703* 420-5-20-.07 (3) Food Service:** The facility failed to ensure a sufficient quantity of non-perishable food and potable water was maintained for all the residents for three days.

2. **Corrective action:** All food items relating to the disaster menu were replaced on 12/31/2025. Enough potable water was purchased on 12/30/2025. All food items are stored in locked cabinets. All water is stored in the kitchen pantry. A sign stating "Emergency Supply Do Not Use" will be placed on the cabinets and near the emergency water in the pantry.

3. **Steps taken to identify other residents or concerns:** All residents had the ability to be affected.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:** All staff will be trained on the emergency food and water supply by the dietary manager / designee no later than 01/30/2026. The dietary manager / designee will be responsible for ensuring that all emergency supplies are kept current and in an appropriate amount.

5. **Monitoring of corrective actions:** The administrator / designee will monitor the emergency supplies monthly to ensure they are being kept current and in the appropriate amount beginning 01/15/2026 and ending 07/15/2026. Documentation of the audits will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings I
Facility ID: P0104
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A901* 420-5-20-.09 (1) (2) Laundry:** The facility failed to maintain clean lint traps in all dryers.

2. **Corrective action:** Lint was removed by the maintenance director on 12/12/2025.

3. **Steps taken to identify other residents or concerns:** All residents had the ability to be affected.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:** All staff will be trained by the maintenance director / designee on keeping the lint traps clean no later than 01/30/2026. A sign will be posted in the laundry room to remind staff to clean the lint traps after each use. The maintenance director / designee will conduct weekly rounds in the laundry room to ensure the lint traps are being cleaned.

5. **Monitoring of corrective actions:** The administrator / designee will monitor the lint traps monthly to ensure lint traps are being cleaned beginning 01/15/2026 and ending 07/15/2026. Documentation of the audits will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings I
Facility ID: P0104
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A1101* 420-5-20-.11 (1) Fire Safety:** The facility failed to conduct fire drills monthly and quarterly on each shift. The facility failed to ensure the sprinkler system was inspected semi-annually.

2. **Corrective action:** The sprinkler system was inspected by Brendle on 12/15/2025. A fire drill was conducted on 12/31/2025.

3. **Steps taken to identify other residents or concerns:** All residents had the ability to be affected.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:** A member of the regional maintenance team / designee will train the maintenance director on fire drills, when they are due and how to document them by 1/20/2026.
   Each shift will have a fire drill monthly once per quarter. The fire drills will be documented and contain all required information. The maintenance director /designee is responsible for keeping this information in a binder.
   All staff will be trained on fire drills by the maintenance director / designee no later than 01/30/2026.
   A maintenance form was created with due dates and shifts for each fire drill due for the 2026 year to ensure they are completed appropriately and timely.
   The maintenance director / designee will be responsible for ensuring the semi-annual sprinkler checks and fire drills are completed timely.

5. **Monitoring of corrective actions:** The administrator / designee will monitor the maintenance binder monthly to ensure fire drills and sprinkler inspections are being performed accurately beginning 01/15/2026 with no end date. Documentation of the audits will be documented in the POC binder located in the administrator's office.

FACILITY MONTHLY MAINTENANCE CHECKLIST

YEAR _____

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
Sprinkler Test (Semi-Annual)												
Fire Alarm System (Semi-Annual)												
Fire Extinguishers (Monthly) Annual Inspection (Keep Old Tags)												
Emergency Lights (30 sec. - Monthly)												
Exit Lights Working (Monthly)												
Fire Drills -Monthly (Fill out forms on alternating Shifts each quarter) Date / Time Keep forms in book	7-3	3-11	11-7	7-3	3-11	11-7	7-3	3-11	11-7	7-3	3-11	11-7
Resident Hot Water Temps Not to exceed 110 degrees Monthly												
Emergency Call System Monthly												
Kitchen Hood Every 6 months												

FACILITY MONTHLY MAINTENANCE CHECKLIST YEAR _____

Central Control Switch Test (SCALF) Monthly												
Generator Testing Monthly												
Lint Traps Monitoring Monthly												

Fire Company Name _____ Sprinkler Company _____

Facility Name: Greensprings I
Facility ID: P0104
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A1203* 420-5-20-.12 (5) Physical Environment:** The building structure was not free from leaks, not in good repair and not kept clean and orderly. The visual inspections of fire extinguishers were not performed and documented monthly as required.

2. **Corrective action:** Supplies needed for repairs have been ordered by Corporate Maintenance Director. These repairs will be completed by the corporate maintenance team the last week of January weather permitting but no later than February 15, 2026.

   All fire extinguishers have been visually checked for the month of December by the maintenance director.

3. **Steps taken to identify other residents or concerns:** All residents had the ability to be affected.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:** The maintenance director / designee and administrator / designee will conduct rounds of the building at least twice a month and document any areas in need of repair. The administrator / designee will document in writing the repairs needed to the regional director of operations for approval. Repair requests and documentation of completion will be kept in the maintenance binder.

   The maintenance director / designee will visually check each fire extinguisher monthly and document the date they were checked. The monthly maintenance form will be documented with the date they were checked.

5. **Monitoring of corrective actions:** The administrator / designee will conduct monthly inspections of fire extinguishers to ensure they are being checked and dated and rounds of the building to ensure repairs are being made beginning 01/15/2026 and ending 07/15/2026. Documentation of the audits will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings I
Facility ID: P0104
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A1206* 420-5-20-.12 (8) Physical Environment:** The facility failed to provide a functioning central control panel for remotely unlocking all exit doors.

2. **Corrective action:** Vector Security installed a central control switch on 12/15/2025.

3. **Steps taken to identify other residents or concerns:** All residents had the ability to be affected.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:** Vector Security installed a central control switch on 12/15/2025. The maintenance director / designee will test the switch monthly to ensure it is working properly. Documentation of these checks will be kept in the maintenance book.

5. **Monitoring of corrective actions:** The administrator / designee will audit the maintenance book monthly to ensure the control switch is being tested beginning 01/15/2026 with no end date. Documentation of the audits will be documented in the POC binder located in the administrator's office.

Monthly Safety Door Switch Testing Form

Facility Name: _____

Location/Area of Switch: _____

Maintenance Director: _____ Date: _____

Instructions: Test the safety door switch monthly to ensure it functions properly. Document results below.

Month	Date Tested	Pass / Fail	Issues Identified	Corrective Action Taken	Initials
January					
February					
March					
April					
May					
June					
July					
August					
September					
October					
November					
December					

Test Procedure Verification (check all that apply):

☐ Safety door switch activated properly

☐ Reset function operable

☐ Door signage and labels visible

☐ Documentation updated after test

☐ Door stopped movement as intended

☐ No visible damage to switch or wiring

☐ Area free of obstruction

Corrective Action Taken: _____

_____

_____

_____

_____