Approved 9/29/25

Summer Village Magnolia Place
Facility ID: P4102
Plan of Correction: Statement of Deficiencies dated April 15, 2025
Administrator: Amber Griggs

1. **A 301 Administration – Governing Authority**
   420-5-20-.03 (1) (a) (b) (c) (d): The governing authority failed to ensure the facility to adequately oversee the administrator to ensure the facility operated in compliance with the SOH rules for SVAF's.

2. **Corrective Action:**
   Please refer to 302, 303, 306, 401, 402, 406, 501, 504, 508, 601, 604, 608, 611, 616, 620, 621, 702, 804, 901, 1001, 1002, 1101, 1201, 1203, and 1206, for further corrective action. A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected. Please refer to 302, 303, 306, 401, 402, 406, 501, 504, 508, 601, 604, 608, 611, 616, 620, 621, 702, 804, 901, 1001, 1002, 1101, 1201, 1203, and 1206 to see how other residents were identified.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   A consulting company, as approved by ADPH, was contracted effective 07/31/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight. A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.
   Various members of the regional team will conduct facility visits no less than monthly for the next six months and then no less than quarterly for the next two quarters. The ADPH approved consulting company will continue to monitor for regulatory compliance throughout the probationary period with routine monthly visits. The Regional Director of Operations/Designee will provide at least bi-weekly meetings with the Administrator/Designee throughout the probationary period to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's

5. **Monitoring of corrective actions:**
   Various members of the regional team will conduct facility visits no less than monthly for the next six months and then no less than quarterly for the next two quarters. The ADPH approved consulting company will continue to monitor for regulatory compliance throughout the probationary period with routine monthly visits. The Regional Director of Operations/Designee will provide at least bi-weekly meetings with the Administrator/Designee throughout the probationary period to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. Documentation will be kept in the POC binder located in the Administrator's office.

Summer Village Magnolia Place
Facility ID: P4102
Plan of Correction: Statement of Deficiencies dated April 15, 2025
Administrator: Amber Griggs

1. **A 302 Administration**
   402-5-20-.03 (e) - The facility failed to implement its written policies and procedures.

2. **Corrective Action:**
   Please refer to deficiencies 504,608,621, and 1206 for further corrective action.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected.
   Refer to deficiencies 504, 608, 620, 621, and 1206 for additional information on how other residents could be affected.

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   All staff was trained on 08/13/2025 regarding the policies for Change on Condition, Weights, Admission Criteria for Memory Care, Resident Discharge and Transfer, and Door Alarm and Monitoring. A new Executive Director was hired 08/18/2025.
   All staff trained to be trained on Resident Meal Service by 10/10/2025.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.
   A consulting company, as approved by ADPH, was contracted effective 07/31/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   Various members of the regional team will conduct facility visits no less than monthly for the next six months and then no less than quarterly for the next two quarters. The ADPH approved consulting company will continue to monitor for regulatory compliance throughout the probationary period with routine monthly visits. The Regional Director of Operations/Designee will provide at least bi-weekly meetings with the Administrator/Designee throughout the probationary period to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. Documentation will be kept in the POC binder located in the Administrator's office.

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Summer Village Magnolia Place
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1. **A 303 Administration – Personnel and Training**
   420-5-20-.03 (2) (a) Administration – The administrator failed to adequately perform her duties to ensure the proper and safe management of the day-to-day operations of the facility in accordance to the rules of the SBOH for SCALF's and failed to ensure previous deficiencies were corrected and compliance was maintained.

2. **Corrective Action:**
   RI#3 was discharged on 11/30/2024.
   Please refer to deficiencies 401, 402, 406, 501, 504, 508, 601, 604, 608, 611, 616, 620, 621, 702, 804, 901, 1001, 1101, 1201, 1203, and 1206 for further corrective action.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.

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

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   Please refer to deficiencies 401, 402, 406, 501, 504, 508, 601, 604, 608, 611, 616, 620, 621, 702, 804, 901, 1001, 1101, 1201, 1203, and 1206 for further action taken to correct these deficiencies.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight

5. **Monitoring of corrective actions:**
   Various members of the regional team will conduct facility visits no less than monthly for the next six months and then no less than quarterly for the next two quarters. The ADPH approved consulting company will continue to monitor for regulatory compliance throughout the probationary period with routine monthly visits. The Vice President of Operations/Designee will provide bi-weekly meetings with the Administrator/Designee throughout the probationary period to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. Documentation will be kept in the POC binder located in the Administrator's office.

Summer Village Magnolia Place
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1. **A 306 Personnel**
   420-5-20-.03 (2) (d): the facility failed to ensure the license was current for an employee acting as the administrator.

2. **Corrective Action:**
   All buildings currently have a licensed administrator.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.

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

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   The Administrator/ Designee will maintain a current license as required. Each year as the license is renewed, a copy of the new license will be sent to the Vice President of Operations/Designee.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Vice President of Operations/Designee will inspect the Administrator's employee file annually to ensure there is a current license. A copy of the license will be added to the POC binder for review from 08/01/2025 – 07/31/2026.

Summer Village Magnolia Place
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1. **A401 Personnel**
   420-5-20-.04 (1) (2) Personnel: The facility was not staffed with at least the minimum required staff at all times.

2. **Corrective Action:**
   The building is currently staffed appropriately.
   The facility has contracted with a staffing agency for contingency staffing as needed.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.

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

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   The RN/Designee is responsible for the staffing schedule and will ensure the facility is properly staffed according to the SBOH rules and regulations.
   All leadership roles will be trained by the Vice President of Operations/Designee on the appropriate staffing requirements by 08/09/2025.
   The facility has contracted with a staffing agency for contingency staffing as needed.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Administrator/Designee Will review the staffing schedules each week or as they are created to ensure the facility is staffed appropriately from 08/01/2025 through 07/31/2026. Documentation will be kept in the POC binder located in the Administrator's office.

Summer Village Magnolia Place
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1. **A402 Personnel**
   420-5-20-.04 (3) Personnel / Employee Screening: A newly employed staff member was not properly screened prior to hire resident contact.

2. **Corrective Action:**
   EI#7 had an abuse registry check completed on 08/01/2025.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected. All employee records were audited on 08/01/2025 by the Business Office Director to ensure all employees have been screened through the Alabama Abuse Registry.

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   The Business Office Director/Designee will be responsible for ensuring each new employee is screened through the Abuse Registry before resident contact.
   The Business Office Director /Designee will print the orientation training papers and place it in the employee file for the Administrator/Designee to review prior to start date.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will review the new employee files monthly from 08/01/2025 through 07/31/2026 to ensure the employee has had an abuse registry check completed. Documentation will be kept in the POC binder located in the Administrator's office.

Summer Village Magnolia Place
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1. **A406 Personnel**
   420-5-20-.04 (9) Personnel: The facility failed to ensure staff completed all required training.

2. **Corrective Action:**
   EI#1, EI#17, and EI#18 had the State law and rules for a SCALF added to their Relias training curriculum during the survey. Their training was completed on 08/13/2025.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected. Employee files will be audited by the Business Office Director on or by 08/15/2025 to ensure each employee has the correct training required.

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   The Business Office Director/Designee will be responsible for ensuring the required training is completed before resident contact. The Business Office Director /Designee will print the orientation training report and place it in the employee file for the administrator to review prior to resident contact.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025. A new RN was hired on 09/03/2025 to ensure clinical duties are completed timely and accurately.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will review the new employee files monthly from 08/01/2025 through 07/31/2026 to ensure the employee has been trained on the State Law and Rules for a SCALF. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A 501 Records and Reports**
   420-5-20-.05 (1) Records and Reports: The facility failed to maintain records and make them available for the surveyors.

2. **Corrective Action:**
   The resident was discharged during the survey.
   Please refer to deficiency A508 and A1101 for further corrective action.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected.
   Resident charts who are on hospice will be audited by RN/Designee on or by 08/3/2025 to ensure the Hospice Care Plan is in the resident chart.

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   Please refer to deficiency A508 and A1101 for further action taken to correct this deficiency.
   The previous administrator trained staff regarding resident menu selection and customer service expectations on 08/13/2025. New staff will be trained during orientation.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025. A new Executive Director was hired 08/18/2025. A new RN was hired on 09/03/2025 to ensure clinical duties are completed timely and accurately.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight.
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   The nursing staff was trained by Wellness Director and Clinical Operations Specialist regarding the Medication Order Approval process on 8/21/2025. Facility will have the pharmacy print and send all e-scribed orders with the medications when they are delivered and then placed in the resident's chart.

   The nursing staff will be educated by Wellness Director and Clinical Operations Specialist regarding the requirement to keep the Hospice Care Plan in the resident's chart on or by 9/12/2025.

5. **Monitoring corrective actions:**

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The Administrator/Designee will randomly monitor different meal-times monthly to ensure residents are being given menu selections. The Administrator/Designee will review charts of those residents admitted to and/or receiving hospice services once monthly to ensure signed hospice care plans are present. All audits will be completed from 08/01/2025 – 07/31/2026.

The RN/Designee will monitor the received orders and ensure they have been approved weekly from 08/01/2025 though 07/31/2026.

Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A504 Records and Reports**
   420-5-20-.05 (3) (d) Records and Reports: The facility failed to ensure residents were treated with dignity and were free from chemical restraint.

2. **Corrective Action:**
   The Culinary Service Director/Designee will re-train current staff regarding the policy on resident menu selection and customer service expectations to include having water and other fluid choices as requested on the tables when residents come to a meal by 10/10/2025. New staff will be trained during orientation.

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

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   Culinary Service Director will train current staff regarding the policy on resident menu selection and customer service expectations to include having water and other fluid choices as requested on the tables when residents come to a meal on 10/10/2025. New staff will be trained during orientation.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025. A new RN was hired on 09/03/2025 to ensure clinical duties are completed timely and accurately.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will randomly monitor different meal-times monthly beginning 08/01/2025 – 07/31/2026 to ensure residents are being given menu selections. Documentation will be kept in the POC binder located in the Administrator's office.

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Summer Village Magnolia Place
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1. **A508 Records and Reports**
   420-5-20-.05 (3) (h) Records and Reports: The facility failed to ensure incident investigations were completed and requested information was provided to the ALF unit.

2. **Corrective Action:**
   Incident reports will be discussed during the daily stand-up meetings and the Administrator/Designee will ensure there is an investigation report completed.

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

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   Training on all leadership positions on incident reporting process and state requirements was completed by the ED/Designee on 08/09/2025. All staff was trained by the previous administrator on incident, reporting process, and state requirements on 08/15/2025. The ED/Designee Will be responsible for turning in the incident report to the ADPH Online Reporting System. Incident reports will be kept in the administrator's office.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025. A new RN was hired on 09/03/2025 to ensure clinical duties are completed timely and accurately.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will audit all incident reports monthly beginning 08/01/25 – 7/31/26 to ensure incident reports are completed and turned in timely. Documentation will be kept in the POC binder located in the Administrator's office.

Summer Village Magnolia Place
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1. **A601 Care of Residents**
   420-5-20-.06 (1) Care of Residents: The facility failed to follow physician's orders.

2. **Corrective Action:**
   RI#4 is no longer in the facility.

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

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   All nursing staff was trained on the order entry and approval process by RN/Designee on 08/21/2025 to ensure the facility is following the most current physician's orders.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025. A new RN was hired on 09/03/2025 to ensure clinical duties are completed timely and accurately.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The RN/Designee will audit the new orders weekly times 12 weeks then monthly beginning 08/01/25 – 7/31/26 to ensure incident reports are completed and turned in timely. Documentation will be kept in the POC binder located in the Administrator's office.

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~~4.~~1. **A604 Care of Residents**

420-5-20-.06 (3) (a) (b) (c) (d) Care of Residents: The facility failed to ensure the Registered Nurse (RN) or Care Coordinator completed an aphasia screening of perspective residents prior to admission, completed monthly assessment as required, insured weights were obtained and recorded monthly, and performed comprehensive assessment to address decline and health status, behaviors, lethargy, and over sedation. In addition, the RN failed to communicate significant changes with the resident, physician and sponsor and family.

~~5.~~2. **Corrective Action:**

RI#1 was issued a 30-day discharge notice. RI#1 discharged from the community on 08/27/2025. RI#2 was discharged from the facility on 04/17/2025. RI#3 was already discharged before the survey. RI#4 was discharged from the facility on 04/09/2025.

~~6.~~3. **Steps taken to identify other residents or concerns:**

All residents have the potential to be affected.
All residents had an aphasia screening completed on 08/22/2025 by the RN/Designee.
All resident monthly assessments will be audited by the new administrator on or before 08/31/2025.

~~7.~~4. **Measures put into place or systemic changes made to assure deficiency will not recur:**

Vice president of Operations/Designee will train the Executive Director/Designee and Clinical Leadership regarding monthly weights, completing required assessments prior to admission, as needed for changes in conditions and monthly, as well as admission, retention, and discharge criteria by 08/09/2025.
The RN/Designee will be responsible for ensuring assessments are completed timely and accurately.
A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025. A new RN was hired on 09/03/2025 to ensure clinical duties are completed timely and accurately.
A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight.
All screenings will be kept in the resident's chart.

~~8.~~5. **Monitoring of corrective actions:**

The Administrator/Designee will audit all new admissions monthly beginning 08/01/25 – 07/31/26 to ensure required screenings, weights, and assessments are completed appropriately and communicated to the family/sponsor, and MD. Five Monthly assessments will be audited each month beginning 08/01/25 – 07/31/26. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A608 Care of Residents**
   420-5-20-.06 (3) (j) Care of Residents: the facility treated a resident who exhibited emergency behavioral symptoms with anti-anxiety and antipsychotic medications.

2. **Corrective Action:**
   No residents in the facility currently have an order for Haldol. RI#4 was discharged from the facility on 04/09/2025.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected.
   An audit of all residents' orders was completed on 08/21/2025 by Vice President of Wellness to ensure no other residents were on Haldol. There are currently no residents on Haldol.

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   All nursing staff was trained on the order entry and approval process by Wellness Director and Clinical Operations Specialist on or before 09/12/2025 to ensure the facility is following the most current physician's orders.
   All nursing staff will be trained by Wellness Director and Clinical Operations Specialist on or before 9.12.2025 regarding the use of chemical restraints.
   Wellness Director educated the hospice company regarding not ordering Haldol.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025. A new RN was hired on 09/03/2025 to ensure clinical duties are completed timely and accurately.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The RN/Designee will audit the new orders weekly times 12 weeks then monthly beginning 08/01/25 – 7/31/26 to ensure chemical restraints are not used on residents. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A611 Care of Residents**
   420-5-20-.06 (4) (a) (b) Care of Residents: the facility failed to develop a current plan of care which contained interventions to meet the care and safety needs of the residents.

2. **Corrective Action:**
   RI#4 was discharged from the facility on 04/09/2025.
   All resident service plans will be updated with correct information by 09/12/2025 by Clinical Operations Specialist. The RN/Designee will be responsible for ensuring care plans are current and have appropriate interventions.

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

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   The RN was trained by the Clinical Specialist/VP of Wellness regarding developing care plans with appropriate interventions, and keeping them current on 08/22/2025
   All staff was trained by the previous administrator regarding reporting changes in condition to the RN/Designee so the care plan can be updated accordingly 08/13/2025.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025. A new RN was hired on 09/03/2025 to ensure clinical duties are completed timely and accurately.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Care plans will be kept in the resident's chart for staff access.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will audit random care plans weekly times 12 weeks then monthly beginning 08/01/25 – 7/31/26 to ensure care plans are current and include appropriate interventions to meet the care and safety needs of the residents.
   Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A616 Care of Residents**
   420-5-20-.06 (5) (i) (j) (k) (l) (m) Care of Residents: the facility failed to ensure the medication cart was locked when unattended.

2. **Corrective Action:**
   EI#7 was educated by Wellness Director on keeping the cart locked when not in use.

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

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   Training for all nursing staff was completed by the RN/Designee on 08/13/2025 regarding keeping the medication cart locked when not in use.
   Weekly safety rounds to be completed by RN/Designee to ensure the medication carts are locked.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025. A new RN was hired on 09/03/2025 to ensure clinical duties are completed timely and accurately.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will audit the safety rounds form monthly beginning 08/01/25 – 7/31/26 to ensure that nursing staff keep the medication cart locked when not in use. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A620 Care of Residents**
   420-5-20-.06 (9) (a) Care of Residents: the facility admitted a resident in need of hospice services, whose PSMS score exceeded the allowable score in physical ambulation, and who was resistive to care.

2. **Corrective Action:**
   RI#3 was already discharged before the survey.

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

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   VP of Wellness trained the RN/Designee and RN/Designee and the administrator /Designee regarding Admission,
   Retention and Discharge criteria for a SCALF on 08/06/2025.
   All assessments will be kept in the resident's chart for staff access.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025. A new RN was hired on 09/03/2025 to ensure clinical duties are completed timely and accurately.
   New admissions will be screened within 7 days prior to admission to ensure the assessments are current and the resident meets criteria. The Administrator/Designee will review the assessments prior to admission to ensure the resident meets admission criteria.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will audit new admission assessments weekly for 12 weeks then monthly from 08/01/25 – 7/31/26 to ensure that residents are appropriate for admission. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A621 Care of Residents**
   420-5-20-.06 (9) (b) Care of Residents: the facility failed to discharge or transfer a resident who demonstrated behaviors or symptoms which interfered with the rights or safety of other residents as well as the safety and well-being of the individual resident.

2. **Corrective Action:**
   RI#4 was discharged from the facility on 04/09/2025.

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

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   VP of Wellness/Designee will train the RN/DESIGNEE and Administrator/Designee regarding Admission, Retention and Discharge criteria for a SCALF and issuing a 30-day discharge notice on or by 08/09/2025.

   The RN/Designee will notify the Administrator immediately if a resident's PSMS score does not meet criteria. The Administrator/Designee will issue a 30-day discharge notice to residents who no longer meet continued to stay criteria for a SCALF.
   All assessments will be kept in the resident's chart for staff access.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025. A new RN was hired on 09/03/2025 to ensure clinical duties are completed timely and accurately.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will audit five PSMS assessments monthly from 08/01/25 – 07/31/26 to ensure that residents meet the continued stay requirements for a SCAL 621F. Documentation will be kept in the POC binder located in the Administrator's office.

Summer Village Magnolia Place
Facility ID: P4102
Plan of Correction: Statement of Deficiencies dated April 15, 2025
Administrator: Amber Griggs

1. **A702 Food Service**
   420-5-20-.07 (2) (b) Food Service: the facility failed to properly label food products, and to ensure adequate equipment and measures were used to prevent food contamination.

2. **Corrective Action:**
   The bulb cover in the freezer will be replaced. A deep clean of the kitchen was completed on 04/29/2025. Another deep cleaning will be completed by 08/30/2025.

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

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   A new Culinary Services Director was hired 06/04/2025.
   The Culinary Service Director/Designee will complete training for dietary staff on labeling foods, ensuring the kitchen and equipment is cleaned, and on sanitation by 08/30/2025.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Culinary Services Director\Designee will do weekly audits for 12 weeks then monthly from 08/01/25 – 7/31/26 to ensure the kitchen and food equipment is clean, and food products are labeled appropriately. Documentation will be kept in the POC binder located in the Administrator's office.

Summer Village Magnolia Place
Facility ID: P4102
Plan of Correction: Statement of Deficiencies dated April 15, 2025
Administrator: Amber Griggs

1. **A804 Physical Facilities**
   420-5-20-.08 (4) Physical Facilities: the facility failed to maintain cleanliness of the kitchen floors and equipment.

2. **Corrective Action:**
   The bulb cover in the freezer was replaced 08/30/25. The trash can covers ordered and in place.
   A deep clean of the kitchen was completed on 04/29/2025. Another deep cleaning will be completed by 08/30/2025.
   The dislodged ceiling tiles were repaired by Maintenance Tech on 08/21/2025.
   The areas of the wall that had peeling paint or blistered wall surface will be repaired by Vendor by 10/31/2025.
   The hand wash station in the kitchen area above the sink wall was repaired by Maintenance Tech on 09/16/2025.

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

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   A new Culinary Services Director was hired 06/04/2025.
   The Culinary Service Director/Designee will complete training for dietary staff on labeling foods, ensuring the kitchen and equipment is cleaned, and on sanitation by 08/30/2025.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Culinary Services Director\Designee will do weekly audits for 12 weeks then monthly from 08/01/25 – 7/31/26 to ensure the kitchen and food equipment is clean, and

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food products are labeled appropriately. Documentation will be kept in the POC binder located in the Administrator's office.

Summer Village Magnolia Place
Facility ID: P4102
Plan of Correction: Statement of Deficiencies dated April 15, 2025
Administrator: Amber Griggs

1. **A 901 Laundry**
   420-5-20-.09 (1)(2) Laundry: the facility's failed to provide adequate effective lint traps in all dryers.

2. **Corrective Action:**
   The lint was removed from dryers, underneath dryers, flooring, and vents by the Maintenance Director/Designee on 08/08/2025.

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

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   Staff was re-trained on 08/13/2025 regarding cleaning the lint traps. The Administrator/Designee will post a sign in laundry room reminding staff to check the lint traps. Weekly safety rounds will be completed by the Maintenance Director/Designee to ensure traps are clean.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.
   A consulting company, as approved by ADPH, was contracted effective 07/31/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Maintenance Director/Designee will check lint traps, vents, and flooring in the laundry room at least weekly beginning 8/01/25 and ending 7/31/26 to ensure the facility's laundry room is properly maintained. Documentation will be kept in the POC binder located in the Administrator's office.

Summer Village Magnolia Place
Facility ID: P4102
Plan of Correction: Statement of Deficiencies dated April 15, 2025
Administrator: Amber Griggs

1. **A1001 Sanitation and Housekeeping**
   420-5-20-.10 (1) Sanitation and Housekeeping: the facility failed to maintain water temperature, accessible to residence, no greater than 110°F as required.

2. **Corrective Action:**
   On 04/09/2025 during the survey, the water temperature was adjusted on the boiler and rooms rechecked to ensure temperatures were with in appropriate range.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected. A full building sweep will be completed to check all room temperatures completed by 08/06/2025 by the Maintenance Tech/Designee.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   The Maintenance Director/Designee was trained on regarding the required temperatures. The Maintenance Director/Designee will check temperatures in 5 random rooms each month to ensure temperatures are correct.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will review the audits each month from 08/01/2025 and ending 07/31/2026 to ensure the temperatures are being checked. Documentation will be kept in the POC binder located in the Administrator’s office.

Summer Village Magnolia Place
Facility ID: P4102
Plan of Correction: Statement of Deficiencies dated April 15, 2025
Administrator: Amber Griggs

1. **A1002 Sanitation and Housekeeping**
   420-5-20-.10 (2) Sanitation and Housekeeping: – facility failed to maintain a safe, functional, decent, sanitary and comfortable environment for staff, residents staff and public.

2. **Corrective Action:**
   The dryer in the laundry room has been repaired and is currently working properly. The electric receptacle box for the damage dryer has been repaired and is mounted properly.

3. **Steps taken to identify other residents or concerns:**
   All dryers in the facility were checked to make sure they were in proper working order. All residents have the potential to be affected.

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   Maintenance staff was trained on lock out tag out procedures for inoperable equipment or electric devices not working by Previous Administrator on 08/09/2025.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.
   The ED/Designee will complete monthly safety inspections throughout the facility.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight

5. **Monitoring of corrective actions:**
   The Administrator/Designee will review the inspection reports each month from 08/01/2025 and ending 07/31/2026 to ensure equipment is in proper working order. Documentation will be kept in the POC binder located in the Administrator's office.

Summer Village Magnolia Place
Facility ID: P4102
Plan of Correction: Statement of Deficiencies dated April 15, 2025
Administrator: Amber Griggs

1. **A1101 Fire and Safety**
   420-5-20-.11 (1) – Fire and Safety: facility failed to perform fire drills.

2. **Corrective Action:**
   Corporate Head of Facilities VP trained the Maintenance Director/Designee and Administrators/Designees on when fire drills are due each month and quarterly on 08/06/2025.

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

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   Each shift will have a fire drill once per quarter. The fire drills will be documented and contain all required information. The Maintenance Tech/Designee is responsible for keeping this information in the Fire and Life Safety binder.
   All staff was trained on 08/13/2025 by Maintenance Director regarding fire drills.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight

5. **Monitoring of corrective actions:**
   The Administrator/Designee will review the fire drill reports each month from 08/01/2025 and ending 07/31/2026 to ensure fire drills are being completed timely. Documentation will be kept in the POC binder located in the Administrator's office

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Summer Village Magnolia Place
Facility ID: P4102
Plan of Correction: Statement of Deficiencies dated April 15, 2025
Administrator: Amber Griggs

1. **A1201 Physical Environment**
   420-5-20-.12 (1) – Physical Environment: facility failed to maintain facility equipment in safe operating condition.

2. **Corrective Action:**
   The dryer in the laundry room has been repaired and is currently working properly. The electric receptacle box for the damage dryer has been repaired and is mounted properly.

3. **Steps taken to identify other residents or concerns:**
   All dryers in the facility were checked to make sure they were in proper working order. All residents have the potential to be affected.

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   Maintenance staff was trained on lock out tag out procedures for inoperable equipment or electric devices not working by the previous administrator on 08/09/2025.
   The Maintenance Director will complete monthly safety inspections throughout the facility.
   A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight

5. **Monitoring of corrective actions:**
   The Administrator/Designee will review the safety inspection reports each month from 08/01/2025 and ending 07/31/2026 to ensure equipment is in proper working order. Documentation will be kept in the POC binder located in the Administrator's office.

Summer Village Magnolia Place
Facility ID: P4102
Plan of Correction: Statement of Deficiencies dated April 15, 2025
Administrator: Amber Griggs

1. **A1203 Physical Environment**
   420-5-20-.12 (5) – Physical Environment: the facility failed to have an operable call system.

2. **Corrective Action:**
   Rooms 104,110,112,114, and 215 were checked 08/05/2025 by Maintenance Tech.
   Palcare came out on 07/30/2025 and updated the call system and new pagers were purchased on 08/13/2025.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected.
   All resident rooms were checked on 08/31/2025 by Maintenance to ensure the call system was working properly.

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   The ED/Designee will train the staff on call light procedures on 08/13/2025.
   Med Techs / Designee will inspect random rooms monthly to ensure the call lights are working.
   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight

5. **Monitoring of corrective actions:**
   The Administrator/Designee will review the inspection reports each month from 08/01/2025 and ending 07/31/2026 to ensure the call lights are working properly.
   Documentation will be kept in the POC binder located in the Administrator's office.

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Summer Village Magnolia Place
Facility ID: P4102
Plan of Correction: Statement of Deficiencies dated April 15, 2025
Administrator: Amber Griggs

1. **A1206 Physical Environment**
   420-5-20-.12 (8) – Physical Environment: the facility failed to provide a gate that was easily unlockable from either side, along the discharge path of travel from the building egress doors to the public way.

2. **Corrective Action:**
   The chain was immediately replaced with a stainless chain and a new padlock. All directors have a key to the lock. A key was placed at the nurse's station and courtyard lockbox so authorized personnel can unlock gate from either side, inside, or outside area. All staff were trained on the lock box code to access the key to padlock on 08/13/25. Additionally, all staff were trained on the location of extra key in the nurses station on 08/13/25.

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

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   Staff were trained by the previous administrator on 08/31/2025. Key lock is accessible from both sides of gate. Staff can access lock and storage of keys from both sides of gate. Additional key is available in the key lock box at front desk.

   The Maintenance Director/Designee will inspect the chains and locks monthly to ensure they are functional, as well as ensure there is a key in lock box at gate and front desk. A new Executive Director was hired 08/18/2025. A new administrator was hired on 08/18/2025.

   A new consulting company, as approved by ADPH, was contracted effective 07/31/2025. to provide routine monthly visits and assist with regulatory compliance and POC oversight

5. **Monitoring of corrective actions:**
   The Administrator/Designee will review the inspection reports each month from 08/01/2025 and ending 07/31/2026 to ensure the locks are in proper working order and

there are keys for staff use. Documentation will be kept in the POC binder located in the Administrator's office.