Plan of Correction Accepted 7.23.25

Connie Cherry

BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER

FACILITY PROVIDER # P3701

PLAN OF CORRECTION

A response to the
Alabama Department of Public Health
Bureau of Health Provide Standards
Specialty Care Assisted Living Facility Unit's Survey Report

Survey Exit
March 20, 2025

Submitted by:
Callie Simmons, Administrator

Callie Simmons
Signature

7/15/25
Date

Briar Glen Alzheimer's Special Care Center
Facility ID: P3701
Plan of Correction: Statement of Deficiencies dated 03/20/2025
Administrator: Callie Simmons

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

2. **Corrective Action:**
   The previous administrator was replaced by a permanent administrator on 06/02/2025. ADPH was notified of the change in administration on 6/4/2025. Please refer to 303, 406, 501, 504, 508, 602, 604, 605, 608, 611, 613, 617, 621, 702, 703, 804, 901, 1001, 1002, 1101, and 1206 for further corrective action.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected. Refer to 303, 406, 501, 504, 508, 602, 604, 605, 608, 611, 613, 617, 621, 702, 703, 804, 901, 1001, 1002, 1101, and 1206 to see how other residents were identified.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   The previous administrator was replaced by a permanent administrator on 06/02/2025. ADPH was notified of the change in administration on 6/4/2025. A consulting company, as approved by ADPH, was contracted effective 07/01/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight. A new RN was hired and will start on 7/21/25 to ensure clinical duties will be completed timely and accurately.

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 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.

Briar Glen Alzheimer's Special Care Center
Facility ID: P3701
Plan of Correction: Statement of Deficiencies dated 03/20/2025
Administrator: Callie Simmons

1. **A 303 Administration – Administrator**
   420-5-20-.03 (2) (a): The administrator failed to adequately perform her duties to ensure the proper and safe management of the day-to-day operations of the facility.

2. **Corrective Action –**
   The Administrator separated from the community on 5/6/2025 and a temporary Operations Specialist was assigned to this community while recruiting for a new Administrator. The previous administrator was replaced by a permanent administrator on 06/02/2025. ADPH was notified of the change in administration on 6/4/2025. Please refer to 406, 501, 504, 508, 602, 604, 605, 608, 611, 613, 617, 621, 702, 703, 804, 901, 1001, 1002, 1101, and 1206 for further corrective action.

3. **Steps taken to identify other residents or concerns -**
   All residents have the potential to be affected. Refer to 301, 303, 406, 501, 504, 508, 602, 604, 605, 608, 611, 613, 617, 621, 702, 703, 804, 901, 1001, 1002, 1101, 1206 to see how other residents were identified.

4. **Measures put into place or systemic changes made to assure deficiency will not recur.**
   The previous Administrator was educated by the Regional Director of Operations on 5/5/2025 regarding the specific job duties and oversight of the community. This education included Alabama SCALF regulations, general safety and oversight of the community, resident care, cleanliness, expectations, and standards. The previous administrator was replaced by a permanent administrator on 06/02/2025. The current Administrator and new RN will be trained on the specific job duties and oversight of the community by the IGH consultant no later than 8/20/25. A consulting company, as approved by ADPH, was contracted effective 07/01/2025 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 weekly meeting with this Administrator/designee for throughout the probationary period to monitor this Plan of Correction. Documentation of these visits and calls will be kept in the POC binder located in the Administrator's office.

Briar Glen Alzheimer's Special Care Center
Facility ID: P3701
Plan of Correction: Statement of Deficiencies dated 03/20/2025
Administrator: Callie Simmons

1. **A 406 Administration – Personnel and Training**
   420-5-20-.04 (9) Personnel – Employees were not properly trained, and training was not documented.

2. **Corrective Action:**
   EI #11 and #8 completed the training required on 3/28/2025. EI #9 was terminated on 3/28/25. All nurses were retrained by the Health Services Specialist and the Health Services Director on 3/28/2025 in diabetic care, hospice care, and oxygen therapy. The Administrator and Business Office Manager were re-educated on 5/5/2025 by the Regional Director of Operations regarding initial and ongoing training requirements for employees.
   A new RN was hired and will start on 7/21/25 to ensure clinical duties will be completed timely and accurately.
   EI#11 will be trained on SCALF regs, advanced directives and DETA Care series by the Administrator by 07/31/25.
   EI #8 will be trained on SCALF regs, advanced directives, DETA Brain and DETA Assessment series, and pharmacological management of psychotropic drugs by Administrator by 07/31/25.
   All nurses will be trained on the Glucocard Vital blood glucose monitoring system by Administrator by 07/31/2025
   No current residents are using the Libre glucose monitoring system.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected. All employee files were audited by the Business Office Manager / Designee in April 2025. They will be re-audited by 8/1/25 by the Administrator/designee. Any identified missing elements of training will be completed by 8/31/2025.
   An audit was completed on 07/01/2025 of all residents who have diabetes by RN to see if they have a glucose monitoring system that the staff needs to be trained on. Any identified missing elements of training will be completed by 7/31/2025.

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   All nursing staff will be trained on the Glucocard Vital blood glucose monitoring system the Administrator by 7/31/25. No current residents are using the Libre glucose monitoring system. The Business Office Manager/designee will ensure that the new employee training form is completed before resident contact. After the training has been provided the Business Office Manager/designee will initial the form indicating that the training has been provided and the form is complete, then provide it to the Administrator for review. The Administrator/Designee will initial the form indicating the employee training is

complete. A new administrator (ED) was put into place on 6/2/25. A new RN was hired and will start on 7/21/25 to ensure clinical duties will be completed timely and accurately. A new consulting company, as approved by ADPH, was contracted effective 07/01/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will audit new employee files monthly beginning 8/1/2025 through 5/31/26 by the Administrator/designee to ensure that employees are properly trained, and training is documented. Documentation will be kept in the POC binder located in the Administrator's office.

Briar Glen Alzheimer's Special Care Center
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Plan of Correction: Statement of Deficiencies dated 03/20/2025
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1. **A 501 Records and Reports**
   420-5-20-.05 (1) Records and Reports: The facility failed to make medical records available for review and copying by ADPH upon request.

2. **Corrective Action:**
   The previous administrator was replaced by a permanent administrator on 06/02/2025. A new RN was hired and will start on 7/21/25 to ensure clinical duties will be completed timely and accurately.

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 previous Administrator and previous Health Services Director were educated on 5/5/2025 and 5/6/2025 by the Regional Director of Operations and the Regional Director of Health Services regarding providing requested documentation by the survey team in a timely manner. This information is to be either printed or copied as soon as possible after the request. Surveyor access to the EHR is available. They were also educated that if there are issues with gathering documentation, they are to reach out to the regional team for assistance. A new Administrator was hired and put into place on 6/2/25. A new RN was hired and will start on 7/21/25 to ensure clinical duties will be completed timely and accurately. The facility will print the care plans and assessments each month and place them in the resident charts.

5. **Monitoring of corrective actions:**
   The HSD/AHSD/designee will audit resident charts monthly beginning 8/1/25 – 5/31/26 to ensure that care plans and assessments are completed and placed in resident's charts and to ensure that medical records are available for review by ADPH upon request. Documentation will be kept in the POC binder located in the Administrator's office.

Briar Glen Alzheimer's Special Care Center
Facility ID: P3701
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1. **A 504 Administration – Governing Authority**
   420-5-20-.05 (3) (d) Records and Reports: Facility failed to provide a safe and decent environment.

2. **Corrective Action:**
   1. All medication staff were trained on HIPAA and resident confidentiality with computer information by the Health Services Director Specialist on 3/20/2025.
   2. The training room was purged of all safety issues by the Health Services Director Specialist and Health Services Director on 3/24/2025.
   3. A room-to-room safety sweep was conducted by the Health Services Director Specialist on 3/25/2025. Families were educated by the Administrator on 3/20/25 about medications, personal care items and safety. Lock boxes for each individual resident were purchased and received on 4/9/2025. All safety items are secured in resident apartments. Locks were placed on all resident vanities on 7/3/25 to secure toiletries and safety items of residents in their apartments.
   4. All staff were educated on resident safety and hazardous materials by the Health Services Director Specialist/ED/HSD on 3/26/2025.
   5. Smoke detectors were replaced 4/2/2025 by the Maintenance Director. An additional audit of smoke detectors was completed by the current Maintenance Director on 6/30/25. Rooms with missing smoke detectors were replaced by the maintenance team on 6/30/25.
   6. No residents are physically restrained. The Health Services Director was educated on 5/6/2025 by the Regional Director of Health Services re: restraint free environment.
   7. Chemicals and flammable materials were secured during the survey by the Maintenance Director, Health Services Director, HSD Specialist, and Administrator. An additional room sweep was conducted on 6/30/25 by the maintenance team and lead caregiver to ensure that chemicals and flammable materials were secured.
   8. Residents (RI#1, RI#2, RI#17, RI#4, RI#13) were issued a discharge notice. All residents, with the exception of RI#1 have been discharged from the facility. The Administrator and HSD were educated on 5/5/2025 and 5/6/2025 by the Regional Director of Operations and Regional Director of Health Services about the admission and retention of residents based on SCALF rules.
   9. The previous administrator was replaced by a permanent administrator on 06/02/2025. The current Administrator and new RN will be educated on safe and decent environment, medications and unsafe materials in resident rooms, restraints, staff training, admission and continued stay criteria, chemicals and flammable materials, odors by 8/20/25 by the IGH consultant. A new RN was hired and will start on 7/21/25 to ensure clinical duties will be completed timely and accurately.
   11. HIPPA training for all current nursing staff will be conducted and completed by 7/31/25 by Health Services Clinical Specialist.
   12. POC training will be developed and added to new hire onboarding topics by the Administrator and IGH Consultant. This training will be put into use by 8/20/25.

10. An industrial cleaning company was hired and will be onsite and will be onsite by 5/31/25 to deep clean the interior of the community. The Maintenance Team power washed outside community, sidewalks and beginning 6/9/25 through 7/10/25.

3. **Steps taken to identify other residents or concerns:**
All residents have the potential to be affected. All residents will be re-evaluated for appropriateness by 5/15/2025 by the Administrator and Health Services Director. PSMS will be updated on all residents again beginning 7/1/25 and completed by 7/3/25. The Administrator/designee is responsible for discharging and assisting with appropriate placement for any resident identified as inappropriate.

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
The previous Administrator was replaced by current Administrator on 6/2/25. A new RN has been hired and will start on 7/21/25. Random room rounds and safety sweeps will be conducted monthly by various department heads/designee. Documentation turned into the Administrator/Designee. Rounds will include the above-mentioned items found during the survey.

5. **Monitoring of corrective actions:**
The Administrator/Designee will review the rounding forms beginning 8/1/25 and ending 5/31/26 to ensure a safe and decent environment. Documentation of the monitoring will be kept in the POC binder located in the Administrator's Office.

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1. **A 508 Records and Reports**
   420-5-20-.05 (3) (h) Records and Reports: the facility failed to report incidents to the ADPH online incident reporting system and failed to investigate the incidents.

2. **Corrective Action:**
   RI#1 currently resides in the facility and working through a discharge notice. RI#4 no longer resides in the facility. RI#10 no longer resides in the facility. The previous administrator was replaced by a permanent administrator on 06/02/2025. A new RN has been hired and will start on 7/21/25. The Nursing Team/Administrator/Designee will be responsible to report incidents promptly to ADPH.

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:**
   Incident reports will be discussed daily in the Stand-Up Meeting. The HSD/AHSD/designee will forward the incident report to the Administrator/Designee immediately upon completion. The HSD/AHSD/Designee will complete the initial report to the ADPH online reporting system within 24 hours. Any additional investigation paperwork to be forwarded within 72 hours to the Administrator. The IGH Consultant will educate the current Administrator and new RN on incident reports no later than 8/20/25. All documentation and any further information pertaining to the investigation will be kept in the Administrator's office.

5. **Monitoring of corrective actions:**
   The Administrator/designee will audit Incident Reports monthly to ensure they are completed and reported timely. Audits will occur beginning 8/1/25 and ending 5/31/26. Documentation of these audits will be kept in the POC binder located in the Administrator's office.

Briar Glen Alzheimer's Special Care Center
Facility ID: P3701
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1. **A 602 Care of Residents**
   420-5-20-.06 (2) (a) (b) (c) Care of Residents: Resident medical examinations were incomplete.

2. **Corrective Action:**
   RI#5 still resides in the facility. RI#6 no longer resides in the facility. RI#13 no longer resides in the facility. The previous administrator was replaced by a permanent administrator on 06/02/2025. A new RN was hired and will start on 7/21/25. The current Administrator will ensure the initial admission medical exam is complete before the resident is admitted.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected. An audit of all admission medical exams will be conducted by RCC/Charge Nurse on 7/09/2025.

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   The previous Health Services Director and the previous Administrator were educated by the Regional Director of Operations and the Regional Director of Health Services on 5/5/2025 and 5/6/2025 about initial medical evaluations and assessments of potential residents. The current Administrator and new HSD will be trained by the consultant on Medical Exams no later than 8/20/25.

   A new RN was hired and will start on 7/21/25.

   The ED/HSD/AHS/Designee will review all medical exams for completeness prior to admission. The HSD/AHSD/Designee will review and initial the medical exam to ensure it is complete and then forward to the Administrator for review. The Administrator/Designee will ensure medical exams are complete prior to resident admission. A consulting company, as approved by ADPH, was contracted effective 07/01/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will review medical exams to ensure they are complete and completed timely for beginning 8/1/25 and ending in 5/31/26. Documentation will be kept in the POC binder in the Administrator's office.

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1. **A 604 Care of Residents**
   420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents: residents were not properly assessed prior to admission, monthly and with significant changes and condition to evaluate the need for implementation of additional interventions for the care of the residents.

2. **Corrective Action:**
   The previous administrator was replaced by a permanent administrator on 06/02/2025. A new RN was hired and will start on 7/21/25 to ensure clinical duties will be completed timely and accurately.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected. All residents' assessments will be audited by the Health Services Director and Regional Director of Health Services by 5/30/2025 for accurateness. All resident PSMS were updated by the facility RN and the Clinical HSD Specialist on 7/1/25.

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   A new RN was hired and will start on 7/21/25 to ensure clinical duties will be completed timely and accurately. The previous administrator was replaced by a permanent administrator on 06/02/2025. The previous Health Services Director and the Administrator were educated on 5/6/2025 by the Regional Director of Operations, and the Regional Director of Health Services regarding resident assessments. A consulting company, as approved by ADPH, was contracted effective 07/01/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight. The current Administrator and new HSD will be trained on completing assessments by the IGH consultant no later than 8/20/2025. The new RN/Designee will ensure the assessments are completed appropriately and timely. The HSD/AHSD/Designee will complete resident assessments prior to admission, monthly and with significant changes.

5. **Monitoring of corrective actions:**
   The Administrator/designee will conduct random monthly chart audits to ensure assessments are being completed appropriately from 8/1/25 and ending in 5/31/26. Documentation will be kept in the POC binder located in the Administrator's office.

Briar Glen Alzheimer's Special Care Center
Facility ID: P3701
Plan of Correction: Statement of Deficiencies dated 03/20/2025
Administrator: Callie Simmons

1. **A 605 Care of Residents**
   420-5-20-.06 (3) (f) Care of Residents: The facility failed to provide general observation and health supervision of the residents to ensure arrangements were made for the residents to obtain necessary services.

2. **Corrective Action:**
   Please refer to A501 and A604
   A new RN was hired and will start on 7/21/25 to ensure clinical duties will be completed timely and accurately. The previous administrator was replaced by a permanent administrator on 06/02/2025. Residents (RI#1, RI#2, RI#17, RI#4, RI#13) were issued discharge notices. All geriatric chairs have been removed from the building.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected. All residents' evaluations will be audited by the Health Services Director and Regional Director of Health Services by 5/30/2025 for accurateness. Any resident deemed to be ineligible will be given a 30-day discharge notice. All resident PSMS were updated by the facility RN and the Clinical HSD Specialist on 7/1/25.

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   The Health Services Director and the Administrator were educated on 5/6/2025 by the Regional Director of Operations, and the Regional Director of Health Services regarding resident assessments. A consulting company, as approved by ADPH, was contracted effective 07/01/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight. A new RN was hired and will start on 7/21/25 to ensure clinical duties will be completed timely and accurately. The previous administrator was replaced by a permanent administrator on 06/02/2025. IGH consultant will train Administrator/HSD/AHSD on providing general observation, health supervision of the residents, and identifying changes in condition no later than 08/20/2025.

5. **Monitoring of corrective actions:**
   The HSD/AHSD/Administrator/Designee will audit resident evaluations for accuracy monthly for beginning 8/1/25 and ending 5/31/26. Documentation will be kept in the POC binder located in the Administrator's office.

Briar Glen Alzheimer's Special Care Center
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Administrator: Callie Simmons

1. **A 608 Care of Residents**
   420-5-20-.06 (3) (j) Care of Residents: physical restraints were applied to residents of the facility.

2. **Corrective Action:**
   RI#14 was discharged 3/16/25. RI #1 – has been issued a 30-day discharge notice. The care plan was updated to reflect appropriate interventions and remains in the facility, RI #2- care plan was updated to reflect appropriate interventions and was discharged on 4/21/25. All geri-chairs have been removed from the facility. A new RN was hired and will start on 7/21/25 to ensure clinical duties will be completed timely and accurately and that there are no restraints in the facility. The previous administrator was replaced by a permanent administrator on 06/02/2025.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected. A room to room sweep to identify physical restraints was completed on 3/24/2025 by the HSD Specialist. Resident care plans that these affected were reviewed and updated to reflect appropriate interventions. All resident PSMS were updated by the All resident PSMS were updated by the facility RN and the Clinical HSD Specialist on 7/1/25.

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   All staff were educated on restraint free environment on 4/15/2025 by the RDHS, RDO, and HSD Specialist. The previous administrator was replaced by a permanent administrator on 06/02/2025. The Lead Caregiver/designee will complete room rounds in resident rooms and common areas of the community to identify any restraint use by 7/14/25. POC training will be added to new employee orientation to include training on restraints. A consulting company, as approved by ADPH, was contracted effective 07/01/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight. A new RN was hired and will start on 7/21/25 to ensure clinical duties will be completed timely and accurately and that there are no restraints in the facility. The IGH Consultant will train the Administrator/HSD/AHSD on restraints no later than 8/20/25.

5. **Monitoring of corrective actions:**
   The Administrator/designee will audit room round checks beginning 8/1/2025 and ending 5/31/2026 to ensure physical restraints are not applied to residents of the facility there are no restraints in the facility. Documentation of these audits will be kept in the POC binder located in the Administrator's office.

Briar Glen Alzheimer's Special Care Center
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1. **A 611 Care of Residents**
   420-5-20-.06 (4) (a) (b) Care of Residents: resident care plans were not current and did not contain the appropriate interventions to meet the care needs of the residents.

2. **Corrective Action:**
   Please refer to A501.
   The previous administrator was replaced by a permanent administrator on 06/02/2025. A new RN was hired and will start on 7/21/25 to ensure clinical duties will be completed timely and accurately. All resident service plans will be updated with correct information by 7/31/2025. The Health Services Director and/or designee is responsible for this. The service plans will provide clear instructions on what care the resident needs for Activities of Daily Living, including but not limited to: transfer assistance, eating, toileting/incontinence care, vision, dressing/grooming and mobility, and 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:**
   All staff will be educated by 4/4/2025, by the previous Administrator and previous Health Services Director about their responsibility in reporting changes to the condition or needs of residents so that the care plan can be updated accordingly. A new RN was hired and will start on 7/21/25 to ensure clinical duties will be completed timely and accurately. The previous administrator was replaced by a permanent administrator on 06/02/2025. Retraining regarding care plans/service plans will be completed with all staff by the current Administrator/RN by 8/31/25. A consulting company, as approved by ADPH, was contracted effective 07/01/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight. The IGH Consultant will train the Administrator/HSD/AHSD on care plans no later than 8/20/25.
   Care plans will be printed and added to the resident charts.

5. **Monitoring of corrective actions:**
   HSD/AHSD/Designee will audit residents care plans monthly beginning 8/1/25 and ending 5/31/2026. Documentation of these audits will be kept in the POC binder located in the Administrator's office.

Briar Glen Alzheimer's Special Care Center
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1. **A 613 Care of Residents**
   420-5-20-.06 (5) (a) (b) (c) (d) (e) Care of Residents: the facility failed to obtain physician's bedside medication orders for over-the-counter medication (OTC) and physician's orders for custody of prescription medications.

2. **Corrective Action:**
   RI# 1 – medication was removed from the resident's room. RI# 5 – medication was removed from the resident's room. A new RN was hired and will start on 7/21/25 to ensure clinical duties will be completed timely and accurately. The previous administrator was replaced on by a permanent administrator on 06/02/2025. The Administrator and the HSD were educated by the Regional team on 3/20/2025 on the expectation that all medications require a physician order and are stored in the medication cart, locked appropriately.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected. A room-to-room sweep was conducted by the HSD Specialist on 3/24/2025 for any OTC medications, or prescription medications. Any resident found to have OTC's needed at bedside, a physician order will be obtained.

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   The ED and the HSD were educated by the regional team on 3/20/2025 on the expectation that all medications require a physician order and are stored in the medication cart, locked appropriately. The previous Administrator educated family members regarding resident belongings and safety. Room rounds will be conducted by various department heads in resident rooms weekly to identify any medication found in resident's rooms. POC training will be added to new employee orientation to include training on bedside medications and appropriate storage. All staff will be educated on beside medications and the proper storage by the Administrator/HSD/AHSD/Designee by 7/31/2025. A new RN was hired and will start on 7/21/255 to ensure clinical duties will be completed timely and accurately. The previous administrator was replaced by a permanent administrator on 06/02/2025. A consulting company, as approved by ADPH, was contracted effective 07/01/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight. The IGH Consultant will educate the Administrator/HSD/AHSD on bedside medications no later than 8/20/25.

5. **Monitoring of corrective actions:**
   HSD/AHSD/Designee will review audits weekly completed by various department heads beginning 8/1/25 and ending 5/31/2026. Documentation of these audits will be kept in the POC binder located in the Administrator's office.

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1. **A 617 Care of Residents**
   420-5-20-.06 (6) Care of Residents: disposition of resident's medication upon discharge of the resident from the facility was not properly documented or not documented at all

2. **Corrective Action:**
   Nursing staff was educated on 3/27/2025 by the HSD/regional team regarding medication disposition forms and the required elements.

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 HSD/AHSD/Designee will be responsible for completing medication disposition on or before the day of discharge and initial the form verifying completion. A new RN was hired and will start on 7/21/25 to ensure clinical duties will be completed timely and accurately. The previous administrator was replaced by a permanent administrator on 06/02/2025. The IGH consultant will educate the ED, HSD, AHSD on medication disposition no later than 8/20/25. A consulting company, as approved by ADPH, was contracted effective 07/01/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The ED/Designee audit all discharged resident files monthly to ensure the med disposition form has been completed and filed in resident chart beginning 8/1/25 through 5/31/26. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A 621 Care of Residents**
   420-5-20-.06 (9) (b) Care of Residents: residents were retained at the facility who did not meet the criteria for retention in a SCALF.

2. **Corrective Action:**
   Resident #1 was issued a discharge notice from the community on 3/14/2025.
   Resident #2 was discharged from the community on 5/1/2025 to a nursing home.
   Resident #8 passed away on 3/28/2025.
   Resident #13 is being issued a discharge notice by 5/20/2025. (this resident was not mentioned in the exit conference).
   Resident #14 had passed away prior to the survey on 3/16/2025. See A504 for education provided on admission and retention of residents.
   All thickened liquids have been removed from the facility.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected. All resident PSMS were updated by the facility RN and the Clinical HSD Specialist on 7/1/25 to identify any residents who do not meet continued stay criteria.

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   The HSD / designee is responsible for updating the PSMS upon admission, any change in condition, or at least annually. Any scores on the PSMS that would preclude a resident from being retained at the community will be reported to the Administrator/designee and the Regional Team by the HSD/Designee and a 30- day discharge notice will be issued.

   A new RN was hired and will start on 7/21/25 to ensure clinical duties will be completed timely and accurately.
   The previous administrator was replaced by a permanent administrator on 06/02/2025.
   The IGH consultant will educate the ED, HSD, AHSD on admission, continued stay and discharge criteria no later than 8/20/25. A consulting company, as approved by ADPH, was contracted effective 07/01/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will audit of PSMS scores monthly to ensure residents are not retained at the facility who do not meet the criteria for retention in a SCALF beginning 8/1/25 through 5/31/26. Documentation will be kept in the POC binder located in the Administrator's office.

Briar Glen Alzheimer's Special Care Center
Facility ID:P3701
Plan of Correction: Statement of Deficiencies dated 03/20/2025
Administrator: Callie Simmons

1. **A 702 Food Service**
   420-5-20-.07 (2) Food Service: the facility failed to protect food from contamination and failed to ensure dishes were properly sanitized.

2. **Corrective Action:**
   The dishwasher is a low temperature dishwasher and now reaches 120 degrees during sanitation/rinse cycle. A three-compartment sink is available for use to properly sanitize dishes, with appropriate chemicals and chemical testing strips to ensure the correct levels of sanitizer. Directions for the 3 compartment sink will be posted in the kitchen for staff assistance by 07/31/2025.

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 Culinary Staff was educated by the Registered Dietitian on 4/9/2025 regarding labeling, covering and dating food items. The Culinary Services Director was educated by the previous Administrator on 5/5/2025 on Infection Control and Cleanliness. The Registered Dietician trained the dietary staff on Dish machine Temperatures on 4/9/25. The current Administrator will train all dietary staff regarding Food Safety Policy, Dish Machine Temp Policy, sanitation and PPM testing, how to utilize the three-compartment sink appropriately by 7/16/25. Directions for utilizing the 3-compartment sink will be posted in the kitchen by 07/31/2025. The previous administrator was replaced by a permanent administrator on 06/02/2025. A consulting company, as approved by ADPH, was contracted effective 07/01/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will audit the kitchen to ensure the facility protects food from contamination and ensures dishes are properly sanitized weekly beginning 8/1/25 through 5/31/26. Documentation will be kept in the POC binder located in the Administrator's office.

Briar Glen Alzheimer's Special Care Center
Facility ID: P3701
Plan of Correction: Statement of Deficiencies dated 03/20/2025
Administrator: Callie Simmons

1. **A 703 Food Service**
   420-5-20-.07 (3) Food Services: the facility failed to provide less than 14 hours between the evening and breakfast meals.

2. **Corrective Action:**
   The mealtimes were updated and posted during survey by ED to the following times: 7:30am, 12:30pm, and 5:30pm, making sure there are not more than 14 hours between the evening and breakfast meals.

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 Culinary Services Director was educated on appropriate meal-time requirements by the current Administrator on 7/11/25. The previous administrator was replaced by a permanent administrator on 06/02/2025. A consulting company, as approved by ADPH, was contracted effective 07/01/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will monitor meal service at random times weekly beginning 8/1/25 through 5/31/26 to ensure meals are being served at the appropriate times as required by regulations. Documentation of audits will be placed in the POC binder located in the Administrator's office.

Briar Glen Alzheimer's Special Care Center
Facility ID: P3701
Plan of Correction: Statement of Deficiencies dated 03/20/2025
Administrator: Callie Simmons

1. **A804 Physical Facilities**
   420-5-20-.08 (4) Physical Facilities: the facility's food, service area, and kitchen were not properly maintained and clean.

2. **Corrective Action:**
   The new hot box for meal delivery arrived on 5/2/2025 and was put into use. The kitchen lights were replaced on 4/14/2025 by the Maintenance Director. A deep clean of the kitchen was completed by dietary staff members by 5/31/2025.

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 Culinary Services Director will be educated by the current ED by 7/11/25 on the proper cleaning schedules and auditing of those cleaning schedules. The CSD will educate all culinary staff on expectations of cleanliness and schedules by 7/31/25. The previous administrator was replaced by a permanent administrator on 06/02/2025.
   A consulting company, as approved by ADPH, was contracted effective 07/01/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will review kitchen audits beginning 8/1/25 through 5/31/26 to ensure the facility's food, service area and kitchen is properly maintained and clean. Documentation of audits will be placed in the POC binder located in the Administrator's office.

Briar Glen Alzheimer's Special Care Center
Facility ID: P3701
Plan of Correction: Statement of Deficiencies dated 03/20/2025
Administrator: Callie Simmons

1. **A 901 Laundry**
   420-5-20-.09 (1) (2) Laundry: the facility's laundry room was not properly maintained.

2. **Corrective Action:**
   The Lint was removed from dryers, underneath dryers, flooring, and vents by the previous Maintenance Director during survey. A new Maintenance Director was hired on 6/9/25.

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 members were educated on the removal of lint from the dryer lint trap after every load of laundry by the previous Administrator on 4/15/2025. The previous administrator was replaced by a permanent administrator on 06/02/2025. A new Maintenance Director was hired on 6/9/25. The current Administrator trained the Maintenance Director on properly maintaining the facility's laundry room and lint removal on 7/14/25. The Maintenance Director/Designee will check lint traps, vents, and flooring in the laundry room. A consulting company, as approved by ADPH, was contracted effective 07/01/2025 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 8/1/25 and ending 5/31/26 to ensure the facility's laundry room is properly maintained. Documentation will be kept in the POC binder located in the Administrator's office.

Briar Glen Alzheimer's Special Care Center
Facility ID: P3701
Plan of Correction: Statement of Deficiencies dated 03/20/2025
Administrator: Callie Simmons

1. **A 1001 Sanitation and Housekeeping**
   420-5-20-.10 (1) Sanitation and Housekeeping: the facility failed to keep the premises, neat and clean. In addition, odors were present inside and outside the building.

2. **Corrective Action:**
   An industrial cleaning company was hired and will be onsite by 5/31/2025 to deep clean the entire interior of the community. The outside of the building was power washed on 4/8/2025 by the Maintenance Director, and a third-party vendor will be onsite by 5/31/2025 to power wash the entire exterior of the community again. Quotes will be obtained for fence replacement by 5/31/2025, with the replacement to be done by 7/31/25. Items found near the dumpster and behind the dumpster wall during the survey have been removed.

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 previous Administrator was educated by the RDO on 5/5/2025 regarding the responsibility of maintaining a clean and odor free environment. The ED educated the MTD on 5/5/2025 regarding the responsibility of maintaining a clean and odor free environment. The Maintenance Director /designee will make rounds on the building weekly to ensure the building is clean and free from odors. During rounds if any needs are identified, the MTD/designee will report those needs to the Administrator/ designee immediately. The Administrator/designee will implement weekly leadership rounds to monitor cleanliness and odors by 8/1/25. The previous administrator was replaced by a permanent administrator on 06/02/2025. A consulting company, as approved by ADPH, was contracted effective 07/01/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will make weekly rounds in the building to monitor cleanliness and odors beginning 8/1/2025 and ending 5/31/2026. Documentation will be kept in the POC binder located in the Administrator's office.

Briar Glen Alzheimer's Special Care Center
Facility ID: P3701
Plan of Correction: Statement of Deficiencies dated 03/20/2025
Administrator: Callie Simmons

1. **A 1002 Sanitation and Housekeeping**
   420-5-20-.10 (2) Sanitation and Housekeeping: cleaning supplies and flammable materials were not secured. In addition, a sanitary and comfortable environment was not maintained throughout the facility.

2. **Corrective Action:**
   Room 13 – Clorox wipes were removed.
   Room 18 – Odoban was removed.
   Desk area by room 78 – Vinegar and Clorox wipes were removed.
   Room 60 – alcohol and wound cleanser were removed , knob on closet door was repaired.
   Room 36 – scrubbing bubbles cleaner was removed.
   Room 20 – laundry detergent was removed.
   Room 54 – bathroom was thoroughly cleaned and mopped – quilt was laundered
   Room 27 – bathroom and room was thoroughly cleaned
   Room 5 – closet door was repaired and placed back on track
   Gazebo – lighter fluid was removed.
   The facility is contracted with Ecolab for routine pest control.
   Unsecured items were removed from the resident rooms by EI#1 on 03/18/2025. Bids will be obtained to repair cracks in residents' rooms by 7/18/25. The Closet door in room 5 was fixed and placed back on the tracks. An industrial cleaning company was hired and onsite on 5/27/2025 to deep clean the entire interior of the community. Repairs to address cracks in resident rooms will begin no later than 8/29/25.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected. A sweep of rooms was conducted by the Administrator during the survey and unsecured items were removed.

4. **Measures put into place or systemic changes made to assure deficiency will not recur:**
   A new Maintenance Director was hired on 6/9/25. The Maintenance Director/designee will complete weekly rounds to monitor for hazardous materials that should be kept in a secure area. The previous administrator was replaced by a permanent administrator on 06/02/2025. A consulting company, as approved by ADPH, was contracted effective 07/01/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will review the weekly rounds during the probationary period beginning 8/1/25 and ending 5/31/26 to ensure that cleaning supplies and flammable materials are secured and that a sanitary and comfortable environment is maintained throughout the facility. Documentation will be kept in the POC binder located in the Administrator's office.

Briar Glen Alzheimer's Special Care Center
Facility ID: P3701
Plan of Correction: Statement of Deficiencies dated 03/20/2025
Administrator: Callie Simmons

1. **A 1101 Fire Safety**
   420-5-20-.11 (1) Fire Safety: the facility failed to conduct and document fire drills monthly and quarterly on each shift.

2. **Corrective Action:**
   The previous Administrator and previous Maintenance Director were educated on 5/6/2025 by the Regional Director of Operations on Fire and Life Safety. The previous administrator was replaced by a permanent administrator on 06/02/2025. The previous Maintenance Director was replaced by a permanent Maintenance Director on 06/09/2025. The IGH Consultant will train the current Administrator and current Maintenance Director no later than 8/20/25.

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:**
   The previous Administrator and previous Maintenance Director were educated on 5/6/2025 by the Regional Director of Operations on Fire and Life Safety. The previous administrator was replaced by a permanent administrator on 06/02/2025. The previous Maintenance Director was replaced by a permanent Maintenance Director on 06/09/2025. Fire drills are to be conducted monthly. Each shift will have a fire drill 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 the Fire and Life Safety binder and uploading it to TELS. The Administrator is responsible for ensuring that fire drills occur as required. A consulting company, as approved by ADPH, was contracted effective 07/01/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight. The IGH Consultant will train the current Administrator and current Maintenance Director on conducting fire drills appropriately
   No later than 8/20/25.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will review the fire drills monthly during the probationary period beginning 8/1/25 and ending 5/31/26 to ensure the facility conducts and documents fire drills monthly and quarterly on each shift. Documentation will be kept in the POC binder located in the Administrator's office.

Briar Glen Alzheimer's Special Care Center
Facility ID: P3701
Plan of Correction: Statement of Deficiencies dated 03/20/2025
Administrator: Callie Simmons

1. **A 1206 Physical Environment**
   420-5-20-.12 (8) Physical Environment: the facility failed to provide smoke detectors in residents' bedroom areas.

2. **Corrective Action:**
   Smoke Detectors in Rooms 9, 10, and 24 were replaced on 4/2/2025. Simplex onsite 4/2/2025. On 4/28/2025 International Fire did a walkthrough and replaced 5 sprinkler heads per semi-annual contract.

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 previous administrator was replaced by a permanent administrator on 06/02/2025. The previous Maintenance Director was replaced by a permanent Maintenance Director on 06/09/2025. The current Maintenance Director/Designee will make monthly rounds throughout the building to include resident rooms, to ensure there are smoke detectors. Tests of smoke detectors will be completed monthly by the Maintenance Director/Designee to ensure they are working properly beginning 8/1/25 through 5/31/26. A consulting company, as approved by ADPH, was contracted effective 07/01/2025 to provide routine monthly visits and assist with regulatory compliance and POC oversight.

5. **Monitoring of corrective actions:**
   The Administrator/Designee will audit the documentation of the Maintenance Director smoke detector checks and tests monthly beginning 08/01/2025 through 05/31/2026 to ensure the facility provides smoke detectors in residents' bedroom areas. Documentation will be kept in the POC binder located in the Administrator's office.

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