POC Accepted 12.26.25

Connie Cherry

The following is the Plan of Correction for Truewood by Merrill at Riverchase SCALF regarding the Statement of Deficiencies dated 10/28/2025. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality healthcare services and will continue to make changes and improvements to satisfy that objective.

Facility Name: Truewood by Merrill at Riverchase - SCALF Facility ID #: P3725

Survey Exit Date: 10/28/2025 Administrator: Eric Sharp

Deficiency Number: 420-5-20-05 (3)(a)(b)(c) Records and Reports
A 503-

1. The Business Office Director or designee will complete an audit of the Memory Care residents' business files to ensure every memory care resident/resident's power of attorney have signed the Resident's Rights, completed an inventory sheet and a pre-arranged discharge plan on or before December 19, 2025. Copies will be placed in a binder in Memory Care by resident, in alphabetical order.
2. The Business Office Manager or designee will ensure copies of all new residents' signed Resident's Rights and Inventory Sheets going forward will be given to the Garden House Director or designee to be placed in the binder under the resident's name.
3. The General Manager, or designee, will perform random audits every week x 4 weeks, then every month x 4 months, to ensure these items are signed during lease signing and are placed in the binder in Memory Care.

Deficiency Number: 420-5-20-05 (3) (g) Records and Reports
A507-

1. The Business Office Director or designee will complete an audit of the Memory Care residents' business files to ensure every memory care resident/resident's power of attorney have signed the Resident's Rights, completed an inventory sheet and a pre-arranged discharge plan on or before December 19, 2025. Copies will be placed in a binder in Memory Care by each resident, in alphabetical order.
2. The Business Office Manager or designee will ensure copies of any new resident's going forward will be given to the Garden House Director or designee to be placed in the binder under the resident's name for ease of
3. The General Manager, or designee, will perform random audits every week x 4 weeks, then every month x 4 months, to ensure these items are signed during lease signing and are placed in the binder in Memory Care

Deficiency Number: 420-5-20-06 (2) (a) (b) (c) Care of Residents
A602-Medical Examination Records-

1. An audit was completed by the Regional Nurse of all the residents' clinical charts to ensure a medical examination record (medical health statement) was completed for each resident upon admission and annually. Any medical health statement that was incomplete or did not include the residents' vital signs was flagged and their primary care physician was notified to complete a new medical health statement in its entirety.
2. New residents' medical health statements will be sent to the regional nurse to ensure it is complete, and vital signs are present before moving in.
3. The regional nurse has developed a schedule for the Garden House Director of when the annual medical statements are due to ensure compliance.
4. The General Manager, or designee, will complete random audits of the Memory Care residents' clinical charts

Deficiency Number: 420-5-20-06 (3) (a) (b) (c) (d) (e) Care of Residents
A604-Health Supervision

1. The Regional Nurse completed an audit of all the residents' charts to ensure all residents had the required monthly assessments completed monthly. Any residents without the required assessments (Physical Self Maintenance Scale, Geriatric Depression Scale, Aphasia screening, Behavior screening, and RN assessment with vital signs and weight) were flagged and the required health assessments were completed on or before November 30, 2025, for the month of November, by the Garden House Director and Regional Nurse. The Garden House Director, or designee, will be responsible for ensuring all pre-admission assessments, admission assessments, every six months and/or change in condition assessments.
2. The General Manager, or designee, will do spot audits to ensure the required assessments have been completed monthly x 6 months, then as needed.
3. Resident RI #2 required a higher level of care and received a 30-day notice during a care conference on November 5, 2025. The resident's family moved the resident out of the community on December 11, 2025.

Deficiency Number: 420-5-20-06 (4) (a) (b) Care of Residents
A611-Personal Care and Services-Updated Monthly Care Plans

1. The Regional Nurse completed an audit of the Memory Care monthly care plan addendums on or before December 19, 2025.
2. December monthly care addendums will be completed on or before December 31, 2025, by the Garden House Director, Regional Nurse, or designee.
3. The General Manager, or designee, will complete an audit of all care plan addendums every month x 6 months to ensure compliance.
4. An in-service was conducted on or before December 23, 2025, by a licensed nurse, with the Memory Care care-team on providing nail care. Fingernails will be cleaned during showers and during morning and evening care as

needed. Fingernails that become long will be filed to an appropriate length as needed. Toenails will be monitored and trimmed by the podiatrist who comes to the community every 6 weeks.

Deficiency Number: 420-5-20-06 (5) (i) (j) (k) (l) (m) Care of Residents
A616-Controlled Substances

1. An in-service was completed to the nurses in Memory Care on the policy of counting narcotics at the end of and the beginning of each shift on October 28, 2025.
2. A licensed nurse was added to the night shift for oversight of the memory care neighborhood, and to complete the narcotic counts with evening and morning nurses.
3. The Garden House Director, or designee, will review the narcotic count sheets weekly x 4 weeks, then monthly x 3 months to ensure compliance.

Deficiency Number: 420-5-20-06 (6) Care of Residents
A617-Disposal of Medications

1. An in-service was completed with the nurses in Memory Care on the use of the Release or Destruction of Medications form by October 28, 2025, to ensure the Pharmacy name and prescription number was entered on the form.
2. The Garden House Director, or designee, will ensure the form is completed correctly prior to a resident being discharged from the community.

Deficiency Number: 420-5-20-06 (8) Care of Residents
A619-Storage of Medical Supplies

1. The expired first aid kit was removed from the Memory Care kitchen and replaced with a new first aid kit on December 16, 2025. The new first aid kits expiration is March 31, 2027.
2. Every first aid kit was inspected on or before December 19, 2025, to ensure the kit was not expired and fully stocked by the General Manager.
3. The General Manager, or designee, will complete spot audit checks on all first aid kits in Memory Care to ensure compliance.

Deficiency Number: 420-5-20-07 (3) Food Service
A703-Meal times

1. The Executive Chef adjusted the mealtimes for Memory Care on October 27, 2025. The hours for each meal were changed to:
   Breakfast 7:00am
   Lunch 12:00pm
   Dinner 5:00pm
2. The new mealtimes were posted in the Memory Care on October 27, 2025.
3. The Garden House Director, or designee, will in-service the staff on or before October 27, 2025, on the new mealtimes and the importance of ensuring there is not more than 14 hours between dinner and breakfast the next day.

4. The General Manager or designee will ensure the kitchen is adhering to the scheduled mealtimes by doing spot audits every week x 4 weeks, then monthly to ensure compliance.

Deficiency Number: 420-5-20-11 (1) Fire and Safety

A1101-Fire and Safety-Fire Drills and Fire System Inspections

1. The Fire Alarm Safety inspection was completed on October 28, 2025, by Eagle Fire.
2. A fire drill was completed on October 31, 2025, November 30, 2025, and December 5, 2025.
3. The General Manager, or designee, will ensure a fire drill is completed monthly.

Deficiency Number: 420-5-20-12 (5) Physical Environment

A1203-Physical Environment-General Building Requirements

1. The Memory Care laundry room walls were cleaned and repaired on December 17, 2025.
2. The fire extinguisher in the Memory Care laundry room was inspected on October 31, 2025.
3. The General Manager or designee will complete spot audits of the memory care laundry room every week x 4 weeks and monthly to ensure the walls and room are clean and in good repair.

Deficiency Number: 420-5-20-12 (7) Physical Environment
A1205 Physical Environment

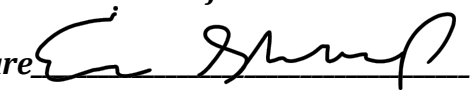
1. The General Manager ordered a fire door strip for the smoke barrier fire doors during the survey.
2. The Senior Maintenance Director installed a smoke barrier door strip to the bottom of the door to decrease the clearance to ¼ inch to maintain compliance on December 4, 2025.
3. The Maintenance Director or designee will inspect the Memory Care smoke barrier fire doors every week x 4 weeks, then monthly to ensure the clearance remains ¼ in or less.

Deficiency Number: 420-5-20-12 (8) Physical Environment
A1206 Additional Requirements for Specialty Care Assisted Living Facilities

1. The gate in the Memory Care courtyard was changed to a keypad lock on December 4, 2025, by the Senior Maintenance Director.
2. Team members were in-serviced on the new keypad lock and how to use it on December 4, 2025.
3. The Maintenance Director, or designee, will inspect the lock every week x 2 weeks, then every week x 4 weeks, then every month and as needed to ensure it is in good working order, and the code works to open the gate.

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

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

Administrator Signature  ***Date _12/26/25_____***

Prepared by:
Eric Sharp, General Manager
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