Accepted June 16, 2026 19:32 PM
Legacy Griffin, RN, MSHAI

Legacy Ridge Trussville
P3730
Caleb Brink, ALA
Exit Survey: 01/14/2026

Deficiency: 420-5-20-.06 (3)(a)(b)(c)(d)(e) Care of Residents

Monthly assessments of residents were not completed as required.

Corrective action taken in response to each resident or example identified in the statement of deficiencies:

RI#15's Assessments were brought up to date on 01/02/2026 and again on 02/02/2026 following the survey.
RI#15 no longer resides in our community.
As of 12/4/2025, Upon noticing that our assessments were not firing correctly in our system our regional and corporate clinical teams were contacted, as well as IT for Point Click Care. They found a glitch in the timing of the assessments associated with those residents going out to the hospital. The system received a hard reset fixing the glitch and allowing assessments to fire appropriately.

Steps the facility will take to identify other residents or concerns not identified by the survey team, similar to those of the residents or concerns listed in each example

To ensure quality and compliance we are implementing a secondary monthly check by the wellness director to ensure all forms are continuing to fire appropriately.

Measures put into place or systemic changes made to ensure the same deficiency will not recur in the facility.

A new form has been created to be signed off and dated by the Director of Nursing upon the completion of the secondary monthly check. The form associated with this check will reside in the Nursing Monthly Audit Binder in the Director of Nursing's office.

How the proposed corrective actions will be monitored to ensure they are implemented, that the corrective actions adequately address the identified problems, and that the corrective actions are effective and will continue to be effective.

A representative of the governing authority will visit the community quarterly for the next year to ensure compliance. Sign off sheet will be in the Plan of Correction Binder at the nurse's station.

Administrator's Signature: _____ **Date:** 6/15/2026

MONTHLY ASSESSMENT COMPLIANCE

YEAR: _____

Date	All Assessments Complete	Signature
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		

Legacy Ridge Trussville
P3730
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Deficiency: 420-5-20-.06 (8) Care of Residents

First Aid Kit expired.

Corrective action taken in response to each resident or example identified in the statement of deficiencies:

As of 01/15/2026, First Aid Kit have been updated with compliant expiration dates.

Steps the facility will take to identify other residents or concerns not identified by the survey team, similar to those of the residents or concerns listed in each example.

Quarterly checks are to be implemented by the Director of Nursing to ensure that all first aid kits are in compliance

Measures put into place or systemic changes made to ensure the same deficiency will not recur in the facility.

A form has been created and placed next to the first aid kit for sign off by the provider. This form will reside in the Monthly Nursing Audit Binder in the Director of Nursing's office.

How the proposed corrective actions will be monitored to ensure they are implemented, that the corrective actions adequately address the identified problems, and that the corrective actions are effective and will continue to be effective.

A representative of the governing authority will visit the community quarterly for the next year to ensure compliance. Sign off sheet will be in the Plan Of Correction Binder at the nurse's station.

Administrator's Signature: _____ **Date:** 01/15/2026

MONTHLY FIRST-AID KIT SIGN OFF

Year: _____

	Checked	Signature
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		

Legacy Ridge Trussville
P3730
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Deficiency: 420-5-20-.07 (2) Food Service

Garbage Containers did not have tightly fitting lids.

Corrective action taken in response to each resident or example identified in the statement of deficiencies:

As of 01/15/2025, tight fitting lids with signage stating " Lid must be in place at all times before and after use" are now in place in the kitchen/dining area.

Steps the facility will take to identify other residents or concerns not identified by the survey team, similar to those of the residents or concerns listed in each example

Dining Director to supervise and train proper usage of the garbage lids going forward. The form associated with this training/supervision will reside in the Dining Training Binder in the kitchen.

Measures put into place or systemic changes made to ensure the same deficiency will not recur in the facility.

The Dining staff will have a semi-annual in-service on cleanliness and the state regulations.

How the proposed corrective actions will be monitored to ensure they are implemented, that the corrective actions adequately address the identified problems, and that the corrective actions are effective and will continue to be effective.

A representative of the governing authority will visit the community quarterly for the next year to ensure compliance. Sign off sheet in the Plan Of Correction Binder at the nurse's station.

Administrator's Signature: _____ **Date:** 01/15/2026

PROPER GARBAGE USE IN THE KITCHEN

Date _____

Employee	Dining Director	Admin signature

Legacy Ridge Trussville
P3730
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Deficiency: 420-5-20-.07 (4) Food Service

Left over food was not properly dated.

Corrective action taken in response to each resident or example identified in the statement of deficiencies:

As of 01/15/2026, All food and beverage items in kitchen areas have proper dates for start of use and expiration.

Steps the facility will take to identify other residents or concerns not identified by the survey team, similar to those of the residents or concerns listed in each example.

The Dining Director will now conduct bi-weekly sweeps of all food storage areas to ensure that goods are dated and current.

Measures put into place or systemic changes made to ensure the same deficiency will not recur in the facility.

A form has been created to ensure that the bi-weekly sweeps are signed off by either the Wellness Director or Administrator, as well as the Dining Director. This practice will be in place for next 6 months. The form will reside in the Dining Compliance Binder in the Kitchen.

How the proposed corrective actions will be monitored to ensure they are implemented, that the corrective actions adequately address the identified problems, and that the corrective actions are effective and will continue to be effective.

A representative of the governing authority will visit the community quarterly for the next year to ensure compliance. Sign off will be in the Plan Of Correction Binder at the nurse's station.

Administrator's Signature: _____ **Date:** 01/15/2026

BI-WEEKLY DINING COMPLIANCE SWEEP SIGN OFF

	ADMINISTRATOR/WELLNESS DIRECTOR	DINING DIRECTOR	DATE

Legacy Ridge Trussville
P3730
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Deficiency: 420-5-20-.11 (1) Fire and Safety

Semi-annual fire alarm inspection had not been completed as required.

Corrective action taken in response to each resident or example identified in the statement of deficiencies:

As of 01/15/2026, Administrator has scheduled all future fire alarm system inspections to be semi-annual with provider.

Steps the facility will take to identify other residents or concerns not identified by the survey team, similar to those of the residents or concerns listed in each example.

Administrator provided a reference sheet to the Maintenance Director for which inspections are annual, semi-annual, quarterly, and monthly.

Measures put into place or systemic changes made to ensure the same deficiency will not recur in the facility.

A form has been created for sign off upon inspection by Administrator, Maintenance Director, and Inspector. This practice will be in place for the next year. The form associated with this check will reside in the Maintenance Binder in the Maintenance Office.

How the proposed corrective actions will be monitored to ensure they are implemented, that the corrective actions adequately address the identified problems, and that the corrective actions are effective and will continue to be effective.

Governing Authority will monitor inspections quarterly for the next year to assure compliance with the state regulations. Sign off sheet will be in the Plan Of Correction Binder at the nurse's station.

Administrator's Signature: _____ **Date:** 01/15/26

FIRE INSPECTION COMPLIANCE SIGN OFF

Q1 - JAN/FEB/MAR

ADMINISTRATOR	
MAINTENANCE DIRECTOR	
INSPECTOR	
DATE	

Q2 - APR/MAY/JUN

ADMINISTRATOR	
MAINTENANCE DIRECTOR	
INSPECTOR	
DATE	

Q3 - JUL/AUG/SEP

ADMINISTRATOR	
MAINTENANCE DIRECTOR	
INSPECTOR	
DATE	

Q4 - OCT/NOV/DEC

ADMINISTRATOR	
MAINTENANCE DIRECTOR	
INSPECTOR	
DATE	

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Deficiency: 420-5-20-.08 (4) Physical Facilities

Food in the bottom of the dishwasher

Corrective action taken in response to each resident or example identified in the statement of deficiencies:

As of 01/15/2026, a new process was put in place for the dining staff to clean the dishwasher after each use as opposed to just daily.

Steps the facility will take to identify other residents or concerns not identified by the survey team, similar to those of the residents or concerns listed in each example

The Dining Director will oversee training and monitoring cleanliness of dishwasher. Assuring all staff understands the process of maintaining a clean dish area.

Measures put into place or systemic changes made to ensure the same deficiency will not recur in the facility.

The Dining staff will have a semi-annual in-service on cleanliness and the state regulations. This will be documented and stored in the Employee files for Dining Staff in the administrator's office.

How the proposed corrective actions will be monitored to ensure they are implemented, that the corrective actions adequately address the identified problems, and that the corrective actions are effective and will continue to be effective.

A representative of the governing authority will visit the community quarterly for the next year to ensure compliance. Sign off sheet will be in the Plan Of Correction Binder at the nurses station.

Administrator's Signature: _____ **Date:** 01/15/26

WEEKLY HAND SANITIZATION STATION SIGN OFF

	MAINTENANCE DIRECTOR		✓	DINING DIRECTOR		✓	DATE		✓

Legacy Ridge Trussville
P3730
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Deficiency: 420-5-4-09 (1)(2) Laundry

Lint trap on the drier was clogged with lint and required cleaning

Corrective action taken in response to each resident or example identified in the statement of deficiencies:

As of 01/15/2026, Signage has been posted on all driers throughout the community stating, "Lint Trap must be cleaned immediately after each use".

Steps the facility will take to identify other residents or concerns not identified by the survey team, similar to those of the residents or concerns listed in each example:

In-service was completed on laundry and proper drier use on 1/27/2025 to clarify and ensure staff knowledge. The in-service form resides in the staff meeting binder in the Director of Nursing's office.

Measures put into place or systemic changes made to ensure the same deficiency will not recur in the facility:

Maintenance will perform monthly checks of dryers and tubing, and deep clean. The form associated with this will reside in the Maintenance Binder in the maintenance office and will include date/signature.

How the proposed corrective actions will be monitored to ensure they are implemented, that the corrective actions adequately address the identified problems, and that the corrective actions are effective and will continue to be effective.

A representative of the governing authority will visit the community quarterly for the next year to ensure compliance. Sign off sheet in the Plan Of Correction Binder at the nurse's station.

Administrator's Signature: _____ **Date:** 01/15/26

MONTHLY DRYER CHECK

DATE:	MAINTENANCE SIGNATURE

Legacy Ridge Trussville
P3730
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Deficiency: 420-5-20-.10 (1) Sanitation and Housekeeping

Water Temperature exceeded 110 degrees Fahrenheit.

Corrective action taken in response to each resident or example identified in the statement of deficiencies:

The water heater was turned down across the community from 110 degrees to 107 degrees to prevent any overages or spikes between rooms

Steps the facility will take to identify other residents or concerns not identified by the survey team, similar to those of the residents or concerns listed in each example

The maintenance director has a weekly check of all temps for the next 3 months to ensure that we do not have any overages or spikes in temperature.

Measures put into place or systemic changes made to ensure the same deficiency will not recur in the facility.

A form has been created with sign off by both the Maintenance Director and Administrator to confirm the weekly check has been completed and that we are compliant. This process will continue for the next 3 months. The form will reside in the maintenance binder in the maintenance office.

How the proposed corrective actions will be monitored to ensure they are implemented, that the corrective actions adequately address the identified problems, and that the corrective actions are effective and will continue to be effective.

A representative of the governing authority will visit the community quarterly for the next year to ensure compliance. Sign off sheet will be in the Plan Of Correction binder at the nurse's station.

Administrator's Signature: _____ **Date:** 01/15/2026

WEEKLY WATER TEMPERATURE SIGN OFF

	MAINTENANCE DIRECTOR		✓	ADMINISTRATOR		✓	TEMP/DATE		✓

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P3730
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Exit Survey: 01/14/2026

Deficiency: 420-5-20-.10 (1) Sanitation and Housekeeping

Facility was not free of objectionable odors

Corrective action taken in response to each resident or example identified in the statement of deficiencies:

The Resident room in question was on a 30 day notice and has since moved out of the community.

Housekeeper and clinical team were made aware that objectionable odors must be dealt with immediately to ensure compliance.

Steps the facility will take to identify other residents or concerns not identified by the survey team, similar to those of the residents or concerns listed in each example

Housekeeper has a new scheduled check of every room for objectionable odors upon beginning of shift.

Measures put into place or systemic changes made to ensure the same deficiency will not recur in the facility.

A form has been created with sign off by both the housekeeper and Memory Care Nurse to confirm scheduled check of each room following the weekend. This practice will continue weekly for 2 months. The form will reside in the plan of correction binder at the nurses station.

How the proposed corrective actions will be monitored to ensure they are implemented, that the corrective actions adequately address the identified problems, and that the corrective actions are effective and will continue to be effective.

A representative of the governing authority will visit the community quarterly for the next year to ensure compliance. Sign off sheet will be in the Plan Of Correction binder at the nurse's station.

Administrator's Signature: _____ **Date:** 01/15/2026

WEEKLY ROOM ODOR CHECK SIGN OFF

	HOUSEKEEPER	MC NURSE	DATE

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P3730
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Deficiency: 420-5-20-.12 (8) Physical Environment

Device to unlock all egress doors.

Corrective action taken in response to each resident or example identified in the statement of deficiencies:

Administrator and governing authority are getting quotes on a device to immediately unlock all egress doors. Device will be placed at the nurses desk.

Steps the facility will take to identify other residents or concerns not identified by the survey team, similar to those of the residents or concerns listed in each example

The device is expected to be installed by 8/1/2026.

This device will be placed at the nurse's desk and all staff will be trained on how and when to use this device.

Measures put into place or systemic changes made to ensure the same deficiency will not recur in the facility.

An In-service will be done bi-annually on how and when to use the egress button. This In-service will be signed by all attendees, Wellness Director, and Administrator. The in-service forms will reside in the staff meeting binder in the Director of Nursing's office.

How the proposed corrective actions will be monitored to ensure they are implemented, that the corrective actions adequately address the identified problems, and that the corrective actions are effective and will continue to be effective.

A representative of the governing authority will visit the community quarterly for the next year to ensure compliance. Sign off sheet will be in the Plan Of Correction Binder at the nurse's station.

Administrator's Signature: _____ **Date:** 1/15/26

PLAN OF CORRECTION COMPLIANCE SIGN OFF

Q1 - JAN/FEB/MAR

ADMINISTRATOR	
GOVERNING BODY REPRESENTATIVE	
DATE	

Q2 - APR/MAY/JUN

ADMINISTRATOR	
GOVERNING BODY REPRESENTATIVE	
DATE	

Q3 - JUL/AUG/SEP

ADMINISTRATOR	
GOVERNING BODY REPRESENTATIVE	
DATE	

Q4 - OCT/NOV/DEC

ADMINISTRATOR	
GOVERNING BODY REPRESENTATIVE	
DATE	