Accepted POC 1/26/26

Theresa Gamble

GREENSPRINGS II

ASSISTED LIVING

ID# D0107

PLAN OF CORRECTION

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

Assisted Living Facilities Unit

Survey Exit Date: 12/11/2025

Submitted by:

Earnestine Rhodes, Administrator

Earnestine Rhodes, ALA
Signature

01/26/2026
Date:

Facility Name: Greensprings II
Facility ID: D0107
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

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

2. **Corrective Action:** The Governing Authority will ensure the facility is in compliance with the SBOH rules for Assisted Living Facilities.
   Please see the plan of correction for the referenced deficiencies for specific corrective actions taken to each resident or example identified.
   A representative of the governing authority will provide routine visits each month to ensure the facility operated in compliance with the SBOH rules.

3. **Steps taken to identify other residents or concerns:** All residents had the ability to be affected. Please see the plan of correction for the referenced deficiencies for specific steps the community took to identify other residents or concerns not identified by the survey team who may have problems similar to those of the residents or concerns listed.

4. **Measures put into place or systemic changes made to ensure the deficiency will not recur:** A representative of the governing authority will provide routine visits each month to ensure the facility operates in compliance with the SBOH rules.

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

Facility Name: Greensprings II
Facility ID: D0107
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A302 * 420-5-4- 03 (1) (e) Administration:** The facility failed to follow its own policies and procedures for operation of the facility.

   Corrective action: The facility will follow its own policies and procedures. All staff training on specific policies will be completed by management department heads / designees by 01/30/2026. Please see plan of correction for the referenced deficiencies for specific corrective actions taken for each deficiency.

2. **Steps taken to identify other residents or concerns:**
   All residents had the ability to be affected. Please see the plan of correction for referenced deficiencies for specific steps the facility took to identify other residents or concerns not identified by the survey team who may have similar problems.

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

5. **Monitoring of corrective actions:** The governing authority and the administrator / designee will provide oversight and properly operate the community. Routine monthly visits will be made by a representative of the governing authority to ensure the facility is in compliance with the SBOH rules beginning 01/15/2026 to 075/2026. Documentation of the visits will be documented in the POC binder located in the administrator's office.

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

1. **A303* 420-5-4-.03 (2) (a) Administration:** The administrator failed to perform her duties to ensure the care needs of all residents were met. The administrator failed to ensure the facility was in compliance with the rules of the Alabama State Board of Health.

2. **Corrective action:** The administrator will perform her duties to ensure the care needs of all residents will be met.
   A representative of the Governing Authority will train the administrator on the SBOH rules, the role and responsibilities of an administrator, and facility policies beginning 01/14/2026 and ending no later than 01/30/2026.

3. **Steps taken to identify other residents or concerns:** All residents had the ability to be affected.
   Please see the plan of correction for referenced deficiencies for specific steps the facility took to identify other residents or concerns not identified by the survey team who may have similar problems.
   A representative of the Governing Authority will train the administrator on the SBOH rules, the role and responsibilities of an administrator, and facility policies identified in the survey beginning 01/14/2026 and ending no later than 01/30/2026.
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4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   All staff training on the specific policies, deficits, and deficiencies mentioned in the survey will be completed by management department heads / designees by 01/30/2026.
   A representative of the Governing Authority will train the administrator on the SBOH rules, her role and responsibilities as the administrator, and facility policies identified in the survey beginning 01/14/2026 and ending no later than 01/30/2026.

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

Facility Name: Greensprings II
Facility ID: D0107
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A405* 420-5-4-.04 (6) Personnel:** The facility failed to ensure staff received required training on the special needs training.

2. **Corrective action:** The facility will train staff on the special needs of residents. RI#2 remains in the facility and maintains control of the glucose monitoring system. RI#2 discharged from the facility on 01/09/2026. The nurses will be trained on diabetes and blood glucose monitoring systems no later than 01/30/2026.

3. **Steps taken to identify other residents or concerns:**
   All residents had the ability to be affected. An audit was performed by the nurse on all residents with diabetes on 01/06/2026. Currently there are no other residents on a glucose monitoring system.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   Topics for blood glucose monitoring, and diabetes have been added to the new employee training form to ensure new employees get the training when hired. Training information on the above titles was added to the new hire orientation binder by the Administrator on 01/06/2026.

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

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

Facility Name: Greensprings II
Facility ID: D0107
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A504* 420-5-4-.05 (3) (d) Records and reports:** The facility failed to maintain the security of the residents' medical information.

2. **Corrective action:**
   The facility will maintain the security of residents' medical information. The empty medication cards were removed from the cart, HIPAA info was removed and the cards were thrown away.

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

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   All staff training on the specific policies, deficits, and deficiencies mentioned in the survey, including HIPAA will be complete by Management department head / designees by 01/30/2026.

   Any medication cards removed from inside of the cart, will have HIPAA information scratched through with a permanent marker and then disposed of.

5. **Monitoring of corrective actions:** The administrator / designee will make random facility rounds monthly to ensure no HIPAA information is being left exposed beginning 01/15/2026 and ending 07/15/2026. Documentation of the rounds will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings II
Facility ID: D0107
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A507* 420-5-4-.05 (3) (g) Records and reports:** The facility failed to ensure the admission record included the required information.

2. **Corrective action:** The facility will ensure that all admission records have the required information.
   RI#1 and RI#3 charts were corrected on 01/07/2026.

3. **Steps taken to identify other residents or concerns:**
   All residents had the ability to be affected. An audit of all resident charts will be completed by the facility nurse / designee no later than 01/30/2026 to ensure they have all discharge preferences documented, veteran status listed, and all inventory forms are completed and signed.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   The nurse / designee will be responsible for ensuring the required admission information is completed in a new resident chart.
   The administrator / designee will review the admission paperwork before the resident moves in to ensure the admission paperwork is completed.

5. **Monitoring of corrective actions:** The administrator / designee will audit 5 resident charts a month to ensure admission paperwork is completed appropriately from 01/15/2026 and ending 07/15/2026. Documentation of the rounds will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings II
Facility ID: D0107
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

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

2. **Corrective action:** The facility will provide adequate health supervision for residents with weight loss. The facility will perform monthly assessments on all residents as required.
   An RN consultant was hired on 12/16/2025 to assist with health supervision of residents.
   RI# was discharged from the facility on 01/09/2026.
   RI#2 was discharged on 01/09/2026.
   RI#3 remains in the facility.
   The RN consultant / designee will have the monthly assessment and weight loss care plans completed by 01/30/2026.

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

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

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

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

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

Facility Name: Greensprings II
Facility ID: D0107
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

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

2. **Corrective Action:** The facility will develop current care plans with interventions to meet the care needs to meet care and safety needs of each resident.

   An RN consultant was hired on 12/16/2025 to assist with health supervision of residents and ensure care plans are developed and accurate.
   RI#1 discharged from the facility on 01/09/2026.
   RI#2 discharged from the facility on 01/09/2026.
   RI#3 remains in the facility. Please refer to deficiencies 406, 604, and 614 for specific corrective action taken by the facility. The care plan will be updated to include information on Eliquis and the risk of bleeding no later than 01/15/2026.

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

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

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

Facility Name: Greensprings II
Facility ID: D0107
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A614* 420-5-.06 (5) (f) (g) (6) (7) (a)- (i) Care of Residents:** Residents were not given the opportunity to correctly utilize the unit dose packaging system at every opportunity for medication use.

2. **Corrective Action:** All residents will be given the opportunity to correctly utilize the unit dose packaging system at every opportunity for medication use.
   EI#4 will be trained along with other care staff on the med assistance policy and regulations related no later than 01/30/2026.
   EI#10 will be trained along with other care staff on the med assistance policy and regulations related no later than 01/30/2026.

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

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:** All staff training on the specific policies and deficits mentioned in the survey including medication assistance will be completed by management department heads / designees by 01/30/2026. The pharmacy staff will observe the facility staff with med assistance monthly for 4 months to ensure the staff is giving the resident's an opportunity to use the unit dose system and identify their medications. The observations will be documented and kept in the POC binder.

5. **Monitoring of corrective actions:** The administrator / designee will review the med assistance observation forms monthly to ensure they are being completed beginning 01/15/2026 and ending 04/15/2026. Documentation of the audits will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings II
Facility ID: D0107
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A702* 420-5-4-.07 (2) Food Service:** The facility failed to ensure dishes were properly sanitized, monitor and record water temperatures and chemical concentrations, ensure the only sink in the kitchen had soap and paper towel towels for hand hygiene, and have the thermometers in two freezers with documentation logs demonstrating that the facility was monitoring for proper food storage temperatures.

2. **Corrective action:** The facility will ensure dishes are properly sanitized and water temperatures are completed along with chemical concentrations. The facility will ensure the sink in the kitchen has soap and paper towels for hand hygiene. The facility will ensure thermometers are kept in the refrigerators and freezers, and temps are documented.

   New thermometers were purchased on 01/08/2026 by the maintenance director and placed in the freezers and refrigerators. Soap and paper towels have been replaced for the handwashing sink by the maintenance director. Water temps, chemical concentrations, and freezer and refrigerator temperature forms have been posted in the kitchen for daily documentation by the administrator.

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

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:** The administrator / designee will train the dietary manager on the freezer and refrigerator temps, how to sanitize the dishes properly, and documenting water temps and chemical concentrations by 01/20/2026. The dietary manager / designee will train all dietary staff on the same topics no later than 01/30/2026. The dietary manager / designee will be responsible for ensuring the above items are being done accurately and timely.

5. **Monitoring of corrective actions:** The administrator/designee will make rounds in the kitchen monthly and audit water temperatures, freezer and refrigerator temps with the use of thermometers, chemical concentrations beginning 01/15/2026 and ending 07/15/2026. Documentation of the audits will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings II
Facility ID: D0107
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A703* 420-5-4-.07 (3) Food Service:** The facility failed to ensure a sufficient quantity of non-perishable food and potable water was maintained for all the residents for three days.

2. **Corrective action:** The facility will maintain a sufficient amount of non-perishable food and potable water as required.

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

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

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

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

Facility Name: Greensprings II
Facility ID: D0107
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A804* 420-5-4-.08 (4) Physical Facilities:** The kitchen and ice machine had not been cleaned and maintained as required, which placed all the residents served from the kitchen at risk for foodborne illness.

2. **Corrective action:** The facility will ensure the kitchen and ice machine are kept clean and maintained. New hoods were ordered from Lowes. The hoods were replaced by the maintenance director on 01/06/2026.
   The kitchen was deep cleaned by the dietary manager on 12/12/2025. The ice machine was cleaned by the maintenance director on 12/12/2025.

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

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:** The administrator / designee will train the dietary manager / designee on regulations and policies regarding cleaning the kitchen and equipment used in the kitchen. A cleaning schedule will be created by the dietary manager / designee to document when the cleaning has happened and by who. These forms shall be maintained in the dietary binder located in the kitchen. The dietary manager / designee will train the dietary staff on the same topics no later than 01/30/2026.

5. **Monitoring of corrective actions:** The administrator / designee will monitor the cleaning forms monthly to ensure the kitchen, hoods, and ice machine are being cleaned properly and timely beginning 01/15/2026 and ending 07/15/2026. Documentation of the audits will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings II
Facility ID: D0107
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A1101* 420-5-4-.11 (1) Fire Safety:** The facility failed to conduct fire drills monthly and quarterly on each shift. The facility failed to ensure the sprinkler system was inspected semi-annually. Employees were not properly trained in fire safety.

2. **Corrective action:** The facility will conduct fire drills monthly and quarterly on each shift. The sprinkler system was inspected by Brendle on 12/15/2025. A fire drill was conducted on 12/31/2025.

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

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

5. **Monitoring of corrective actions:** The administrator / designee will monitor the maintenance binder monthly to ensure fire drills and sprinkler inspections are being performed accurately beginning 01/15/2026 and ending 07/15/2026. Documentation of the audits will be documented in the POC binder located in the administrator's office.

Facility Name: Greensprings II
Facility ID: D0107
Administrator: Earnestine Rhodes
Survey Exit Date: 12/11/2025

1. **A1203* 420-5-4-.12 (5) Physical Environment:** The facility failed to maintain the kitchen in good repair.

2. **Corrective action:** The facility will maintain the kitchen in good repair. Wood laminate was placed in the kitchen on 12/17/2026.

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

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

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