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Connie Cherry

MURRAY HOUSE
FACILITY PROVIDER # 4938

PLAN OF CORRECTION

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

Survey Exit
February 12,2026

Submitted by:
Andrea Gravely, Administrator

Andrea Gravely, LPN, ALA
Signature of Administrator

9/8/26
Date

Murray House
Facility ID: D4938
Plan of Correction: Statement of Deficiencies 02/12/2026
Administrator: Andrea Gravely

1. **A102 General:**
   420-5-4-.01: An individual who was identified by the facility as a "resident" did not reside in the assisted living facility.

2. **Corrective Action:**
   RI#1 moved to a new room in the ALF on 08/21/2026.
   The Administrator / Designee will not allow an ALF appropriate resident to reside in the SCALF unless the resident signs a SCALF agreement and agrees to live there as a resident.

3. **Steps taken to identify other residents or concerns:**
   An audit of the census revealed no other residents were identified as being affected.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Assisted Living appropriate residents will not be allowed to reside in the SCALF without being admitted as a SCALF resident.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days beginning 08/24/2026. After 90 days, management will review the need for onsite visits.
   The Administrator / Designee will review the ALF / SCALF census for 90 days to ensure that no ALF appropriate residents are living in the SCALF. Any resident found to be living in the SCALF as an ALF appropriate resident will have the option to move back to the ALF or agree to sign SCALF paperwork and become a SCALF resident. If they choose to stay in the SCALF, they will be given a code to allow for free egress.

5. **Monitoring of corrective actions:**
   The COO of 3H Management/Designee will provide weekly meetings for 3 months from 08/24/2026 to 10/24/2026 with the Administrator/Designee to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. The Administrator will audit the census for 3 months beginning 08/24/2026 and ending 10/24/2026 to ensure no ALF appropriate residents are living in the SCALF unless they are residents of the SCALF. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A 302 Administration**
   420-5-4-.03 (1) (e): the facility failed to follow its own policies for daily operation of the facility. In addition, the facility failed to provide policy for use of the residents call lights.

2. **Corrective Action:**
   A new policy will be written by the Administrator / Designee for the use of resident call lights on or before 08/21/2026.
   Refer to deficiencies 402, 405, 508, 602, 604, 606, 611, 613, 618,621, and 1203 for further corrective action. The Administrator will ensure that staff follow the policies for the facility.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected. Refer to deficiencies 402, 405, 508, 602, 604, 606, 611, 613, 618,621, and 1203 to see how other residents were identified.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days. After 90 days, management will review the need for onsite visits.
   Staff will be trained by the Administrator / Designee on or before 09/30/2026 on the policies mentioned in the SOD, the policy for answering call lights, and use of the new call light system on or before 09/30/2026.
   The Administrator / Designee will conduct a review of all policies and facility practices to ensure the facility is following the policies correctly on or before 09/30/2026. Any gaps will be corrected.

5. **Monitoring of corrective actions:**
   The Administrator / Designee will conduct monthly audits of policy compliance for 3 months beginning 08/24/2026 to 10/24/2026.
   The COO / Designee of 3H Management/Designee will provide weekly meetings for 3 months beginning 08/24/2026 and ending 10/24/2026 with the Administrator/Designee to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A 303**
   420-5-4-.03 (2) (a): Administration: The Administrator failed to perform her duties to ensure the care and safety needs of all residents were met.

2. **Corrective Action:**
   The Administrator will perform her duties to ensure the care and safety needs of the residents are met. Refer to deficiencies 102, 302, 402, 405, 504, 508, 601, 602, 604, 606, 611, 612, 613, 618, 621, 1001, 1002, and 1203 for further corrective action.

3. **Steps taken to identify other residents or concerns:**
   All residents have the potential to be affected. Refer to deficiencies 102, 302, 402, 405, 504, 508, 601, 602, 604, 606, 611, 612, 613, 618, 621, 1001, 1002, and 1203 to see how other residents were identified.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days. After 90 days, management will review the need for onsite visits.
   The Administrator will be trained by a member of the corporate team on the expectations and administrator duties on or before 08/31/2026.

5. **Monitoring of corrective actions:**
   The COO of 3H Management/Designee will provide weekly meetings for 3 months beginning 08/24/2026 and ending 10/24/2026 with the Administrator/Designee to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A 402**
   420-5-4-.04 (3): Personnel: The facility failed to screen potential employees prior to hire and resident contact.

2. **Corrective Action:** The Administrator / Designee will ensure all potential employees have been screened prior to hire and resident contact.
   EI#1, EI#3, EI#6, EI#5, EI39and EI#12 were screened through the Alabama Nurse Aid Abuse Registry by the Administrator during the survey.

3. **Steps taken to identify other residents or concerns:**
   All residents had the potential to be affected. An audit of employee files was completed by the Administrator on 08/20/2026 to ensure all employees have been screened through the Alabama Nurse Aid Abuse Registry.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days. After 90 days, management will review the need for onsite visits.
   The Administrator / Designee will be responsible for ensuring each new employee is screened through the abuse Registry. A member of the corporate team / designee will review the employee file prior to hire to ensure the employee has been screened through the Abuse Registry.

5. **Monitoring of corrective actions:**
   The COO of 3H Management/Designee will provide weekly meetings for 3 months beginning 08/24/2026 and ending 10/24/2026 with the Administrator/Designee to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. The Administrator / Designee will review the new employee files monthly beginning 08/24/2026 and ending 10/24/2026 to ensure that each employee has an abuse registry check. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A 405**
   420-5-4-.04 (6): Personnel: The facility did not complete required training.

2. **Corrective Action:** EI#1 will be trained by a member of the corporate team regarding Special Needs to include Diabetes, Glucose Monitoring Systems, and the Pure Wick urine collection system by the Administrator / Designee on or before 08/31/2026. EI#3's employment ended 07/24/2026. EI#6's employment ended 02/20/2026. EI#12's employment ended on 03/23/2026. EI#7 and EI#9 will be trained by the Administrator / Designee regarding Special Needs to include Diabetes, Glucose Monitoring Systems, and the Pure Wick urine collection system on or before 09/30/2026.
   EI#10's and EI#11's employment ended 05/11/2026.
   The Administrator / Designee will ensure all required employee training is completed timely.

3. **Steps taken to identify other residents or concerns:**
   All residents had the potential to be affected. An audit of all employee files was completed by the Administrator on 08/20/2026 to ensure all required training was completed prior to hire and resident contact.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days. After 90 days, management will review the need for onsite visits. The Administrator / Designee will be responsible for ensuring each new employee has the required Special Needs training. A member of the corporate team will review the employee file prior to hire. The Administrator / Designee will train staff on Special Needs including the topics cited in the survey on or before 09/30/2026.

5. **Monitoring of corrective actions:**
   The COO of 3H Management/Designee will provide weekly meetings for 3 months from 08/24/2026 to 10/24/2026 with the Administrator/Designee to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. The Administrator / Designee will review the new employee files monthly beginning 08/24/2026 and ending 10/24/2026 to ensure that each employee has the required training. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A 504**
   420-5-4-.05 (3): Personnel: A resident was not allowed to freely come and go from the facility and did not have free access to all areas of the facility including day rooms, dining and common areas. Also, the facility failed to treat residents with consideration and recognition regarding lack of communication.

2. **Corrective Action:** During the survey on 02/09/2026 RI#1 was provided a code to allow free egress from the SCALF into the ALF. RI#1 moved to a new room in the ALF on 08/21/2026.
   The Administrator / Designee will not allow an ALF appropriate resident to reside in the SCALF unless the resident signs a SCALF agreement and agrees to live there as a resident.
   The Administrator / Designee will respond to messages regarding resident concerns within 48hours.
   The issue involving RI#17 was resolved by the administrator.

3. **Steps taken to identify other residents or concerns:**
   All ALF appropriate residents residing in the SCALF had the potential to be affected.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Assisted Living appropriate residents will not be allowed to reside in the SCALF without being admitted as a SCALF resident.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days beginning 08/24/2026. After 90 days, management will review the need for onsite visits.
   The Administrator / Designee will review the ALF / SCALF census for 90 days to ensure that residents listed on the ALF census live in the ALF. Any resident found to be living in the SCALF as an ALF appropriate resident will have the option to move back to the ALF or agree to sign SCALF paperwork and become a SCALF resident. If the resident chooses to stay in the SCALF, a code will be given to the resident to allow free egress.
   The Administrator will be trained by a member of the corporate team on the expectations and administrator duties to include communication and response to resident concerns on or before 08/31/2026.

5. **Monitoring of corrective actions:**
   The COO of 3H Management/Designee will provide weekly meetings for 3 months beginning 08/24/2026 and ending 10/24/2026 with the Administrator/Designee to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's.
   The Administrator will audit the census for 3 months beginning 08/24/2026 and ending 10/24/2026 to ensure any ALF appropriate residents living in the SCALF have free egress.
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1. **A 508**
   420-5-4-.05 (3) (h): Records and Reports: The facility failed to report an incident to the ADPH Online Reporting System as required.

2. **Corrective Action:** The administrator will ensure that all reportable incidents are sent in to the ADPH Online Reporting System as required. The administrator will be trained on the incident reporting policy including what information must be reported to ADPH on or before 08/31/2026.

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

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days beginning 08/24/2026. After 90 days, management will review the need for onsite visits. All incidents will be discussed in daily stand-up meetings. Reportable incidents will be identified and communicated to the COO / Designee as they occur to ensure they have been reported timely to the ADPH Online Reporting System.

5. **Monitoring of corrective actions:**
   The COO of 3H Management/Designee will provide weekly meetings for 3 months beginning 08/24/2026 and ending 10/24/2026 with the Administrator/Designee to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. The Administrator / Designee will audit the reportable incidents for 3 months beginning 08/24/2026 and ending 10/24/2026 to ensure incidents have been reported timely to ADPH. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A 601**
   420-5-4-.06 (1): Care of Residents: The facility failed to follow a physician's order for a resident's blood pressure.

2. **Corrective Action:** RI#3 remains a resident in the facility. The issue with B/P has been resolved by the Administrator. The Administrator will ensure all physician's orders are followed as written.

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

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days beginning 08/24/2026. After 90 days, management will review the need for onsite visits. All nurses will be trained by the Administrator / Designee on adding physician's orders to include blood pressure checks, to the EMAR system on or before 09/30/2026.

5. **Monitoring of corrective actions:**
   The COO of 3H Management/Designee will provide weekly meetings for 3 months beginning 08/24/2026 and ending 10/24/2026 with the Administrator/Designee to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. The Administrator / Designee will audit new orders weekly for 3 months beginning 08/24/2026 and ending 10/24/2026 to ensure the physician orders are being followed. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A 602**
   420-5-4-.06 (2) (a) (b) (c): Care of Residents: Resident' physical examinations were not documented annually as required.

2. **Corrective Action:** RI#11 remains a resident in the facility. The Administrator / Designee will ensure all annual physical examinations are completed timely.

3. **Steps taken to identify other residents or concerns:**
   All residents had the potential to be affected. An audit of all medical exams was completed by the Administrator / Designee by 08/21/2026.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days beginning 08/24/2026. After 90 days, management will review the need for onsite visits.
   The Administrator / Designee will pull the report from the new August Health system implemented in July 2026, each month identifying which residents need a new MEPOC to ensure they are being completed timely.

5. **Monitoring of corrective actions:**
   The COO of 3H Management/Designee will provide weekly meetings for 3 months beginning 08/24/2026 and ending 10/24/2026 with the Administrator/Designee to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. The Administrator / Designee will review the MEPOC list for completion for 3 months beginning 08/24/2026 and ending 10/24/2026 to ensure the MEPOC's are being completed timely. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A 604**
   420-5-4-.06 (3) (a) (b): Care of Residents: Residents were not assessed monthly as required including weights.

2. **Corrective Action:** RI#1, RI#3, RI#4, RI#6, RI#7, RI#11, RI#13, RI#14, RI#15, RI#16, and RI#17 remain in the facility. RI#2 discharged to Memory Care on 02/23/2026. RI#5 was discharged on 05/29/2026, RI#8 discharged to Memory Care on 08/06/2026, RI#10 discharged to Memory Care 03/24/2026, and RI#12 discharged to Memory Care on 04/15/2026. The residents remaining have had their monthly assessments updated by the Administrator. The Administrator will ensure all monthly assessments including weights will be completed as required.

3. **Steps taken to identify other residents or concerns:**
   All residents had the potential to be affected. All resident assessments will be audited by the Administrator / Designee to ensure no other assessments are missing. Those missing will be updated by 08/31/2026.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days beginning 08/24/2026. After 90 days, management will review the need for onsite visits.
   The Administrator / Designee will train the nurses on how to complete a monthly assessment on or before 09/30/2026.

5. **Monitoring of corrective actions:**
   The COO of 3H Management/Designee will provide weekly meetings for 3 months beginning 08/24/2026 and ending 10/24/2026 with the Administrator/Designee to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. The Administrator / Designee will pull reports from August Health each month for 3 months beginning 08/24/2026 and ending 10/24/2026 to ensure the monthly assessments are being completed timely. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A 611**
   420-5-4-.06 (4) (a) (b): Care of Residents: Facility care plans were not current and did not contain appropriate interventions to meet the care and safety needs of the residents. In addition, the resident's care plan was not followed for the resident's care.

2. **Corrective Action:** RI#2 was discharged to Memory Care on 03/23/2026. RI#10 discharged to Memory Care on 03/24/2026. RI#11 remains in the facility. The care plan was updated by the Administrator / Designee on 08/21/2026. R#12 discharged to Memory Care on 04/15/2026. RI#13 remains in the facility. The care plan was updated by the Administrator / Designee by 08/20/2026. RI#16 remains in the facility. The care plan was updated by the Administrator / Designee by 08/21/2026. The Administrator / Designee will ensure all care plans are updated, contain appropriate interventions, and is being followed by the staff.

3. **Steps taken to identify other residents or concerns:**
   All residents had the potential to be affected. The Administrator / Designee will audit all care plans to ensure they are updated on or before 09/30/2026.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days beginning 08/24/2026. After 90 days, management will review the need for onsite visits.
   The Administrator / Designee will train care staff on care plans and how to use them when providing resident care on or before 09/30/2026.

5. **Monitoring of corrective actions:**
   The COO of 3H Management/Designee will provide weekly meetings for 3 months beginning 08/24/2026 and ending 10/24/2026 with the Administrator/Designee to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. The Administrator / Designee will review the care plans for accuracy for 3 months beginning 08/24/2026 and ending 10/24/2026 to ensure the care plans are updated and being used appropriately by staff. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A 612**
   420-5-4-.06 (4) (c) (d) (e) (f): Care of Residents: The facility failed to offer an appropriate activities program.

2. **Corrective Action:** An offer was extended to a new activity director 08/20/2026. She accepted and will have the required information received before the hire date of 09/01/2026. The Administrator will ensure there is an activity calendar available to all residents that include activities every day of the week.

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

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days beginning 08/24/2026. After 90 days, management will review the need for onsite visits.
   The Administrator / Designee will monitor the activity calendar daily to ensure all activities are being done. If the activity director is unavailable, the Administrator / Designee will delegate the activities for the day to other staff to ensure the residents receive the activities.

5. **Monitoring of corrective actions:**
   The COO of 3H Management/Designee will provide weekly meetings for 3 months beginning 08/24/2026 and ending 10/24/2026 with the Administrator/Designee to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. The Administrator / Designee will review the activity calendar for 3 months beginning 08/24/2026 and ending 10/24/2026 to ensure activities are completed according to the posted calendar. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A 613**
   420-5-4-.06 (5) (a) (b) (c) (d) (e): Care of Residents: Resident of the facility were unable to utilize the unit dose medication packaging system and protect themselves from a medication error.

2. **Corrective Action:** RI#2 discharged to the Memory Care on 03/23/2026. RI#12 was discharged to Memory Care on 04/15/2026. RI#10 discharged to Memory Care on 03/24/2026. The Administrator / Designee will ensure that all residents can utilize the unit dose packaging system.

3. **Steps taken to identify other residents or concerns:**
   All residents had the potential to be affected. All residents were tested to ensure no one else could not identify their medications.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days beginning 08/24/2026. After 90 days, management will review the need for onsite visits.
   The Administrator / Designee will train care staff on Medication Awareness to include notifying the Administrator / Designee immediately when a resident can no longer identify their medications on or before 09/30/2026.
   The pharmacy will provide med pass observations with all nurses over the next 90 days beginning in September to ensure the nurses are providing med assistance correctly.

5. **Monitoring of corrective actions:**
   The COO of 3H Management/Designee will provide weekly meetings for 3 months beginning 08/24/2026 and ending 10/24/2026 with the Administrator/Designee to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. The Administrator / Designee will monitor the med awareness tests monthly for 3 months beginning 08/24/2026 and ending 10/24/2026 to ensure there are no residents that cannot identify their medications. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A 618**
   420-5-4-.06 (9) Care of Residents: An oxygen tank was not safely and securely stored.

2. **Corrective Action:** RI#6 remains in the facility. The oxygen tank was securely stored by the nurse.

3. **Steps taken to identify other residents or concerns:**
   All residents had the potential to be affected. An audit of all residents on oxygen was completed by the Administrator / Designee on 08/21/2026 to ensure the tanks are being stored properly.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days beginning 08/24/2026. After 90 days, management will review the need for onsite visits.
   The Administrator / Designee will incorporate checking on residents with oxygen during rounds to ensure the oxygen is stored properly.
   The Administrator / Designee will train staff on the proper storage of oxygen tanks on or before 09/30/2026.

5. **Monitoring of corrective actions:**
   The COO of 3H Management/Designee will provide weekly meetings for 3 months beginning 08/24/2026 and ending 10/24/2026 with the Administrator/Designee to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. The Administrator / Designee will monitor resident oxygen tanks weekly for 3 months beginning 08/24/2026 and ending 10/24/2026 to ensure the oxygen tanks are stored properly. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A 621**
   420-5-4-.06 (11) (b) Care of Residents: The facility retained a resident who required skilled wound care for greater than 90 days and a resident with unmanageable behaviors.

2. **Corrective Action:**
   RI#4 remains in the facility. RI#11 remains in the facility.
   Refer to Deficiency 604 for additional corrective action. The Administrator / Designee will ensure there are no residents receiving skilled care longer than 90 days.

3. **Steps taken to identify other residents or concerns:**
   All residents receiving skilled care had the potential to be affected.
   The Administrator / Designee will audit all residents receiving skilled care, have behaviors concerns and other needs that may exceed the facility's capabilities by 08/31/2026.. Those not meeting criteria will receive a 30-day discharge notice.

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days beginning 08/24/2026. After 90 days, management will review the need for onsite visits.
   Administrator / Designator will have a weekly clinical meeting to discuss at risk residents including those with wounds and behaviors.
   The Administrator / Designee will train care staff on Admission, Retention, and discharge criteria for an assisted living facility on or before 09/30/2026.

5. **Monitoring of corrective actions:**
   The COO of 3H Management/Designee will provide weekly meetings for 3 months beginning 08/24/2026 and ending 10/24/2026 with the Administrator/Designee to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. The Administrator / Designee will monitor all residents receiving skilled care weekly for 3 months beginning 08/24/2026 and ending 10/24/2026 to ensure no resident has skilled care longer than the regulations require. Documentation will be kept in the POC binder located in the Administrator's office.

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1. **A 1001**
   420-5-4-.06 (10) (1) Sanitation and Housekeeping: Objectional odors were present in the facility.

2. **Corrective Action:**
   RI#6 remains in the facility. A deep cleaning of the room, including scrubbing the floor, was completed by maintenance and housekeeping. The Administrator ordered a mattress and chair cover on 08/26/2026 to help protect the furniture. Order was received on 08/31/2026. The Administrator / Designee will ensure the building does not have any objectional odors.

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

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days beginning 08/24/2026. After 90 days, management will review the need for onsite visits.
   Housekeeping will increase cleaning to RI#6's room to multiple times a week.
   Shampooing of the resident's cloth chair will be performed weekly by maintenance staff.
   The Administrator / Designee will include checking for odors during daily rounds in the facility. The Administrator / Designee will train all staff on or before 09/30/2026 to report any odors to the Administrator / Maintenance Director / Designee immediately.

5. **Monitoring of corrective actions:**
   The COO of 3H Management/Designee will provide weekly meetings for 3 months beginning 08/24/2026 and ending 10/24/2026 with the Administrator/Designee to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. Maintenance Director / Designee will round the building weekly for 3 months beginning 08/24/2026 and ending 10/24/2026 to ensure there or no objectional odors in the building. Documentation will be kept in the POC binder located in the Administrator's office.

Murray House
Facility ID: D4938
Plan of Correction: Statement of Deficiencies 02/12/2026
Administrator: Andrea Gravely

1. **A 1002**
   420-5-4-.10 (2) Sanitation and Housekeeping: A sanitary and decent environment was not maintained in one resident's room.

2. **Corrective Action:**
   RI#6 remains in the facility. A deep cleaning of the room, including scrubbing the floor, was completed by maintenance and housekeeping. The Administrator ordered a mattress and chair cover on 08/26/2026 to help protect the furniture. Order was received on 08/31/2026. The Administrator / Designee will ensure the building does not have any objectional odors.

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

4. **Measures put into place or systemic changes made to ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days beginning 08/24/2026. After 90 days, management will review the need for onsite visits.
   Housekeeping will increase cleaning to RI#6's room to multiple times a week.
   Shampooing of the resident's cloth chair will be performed weekly by maintenance staff.
   The Maintenance Director / Designee will include checking for odors during daily rounds in the facility and report any odors to the Administrator / Designee immediately. The Administrator / Designee will train all staff on or before 09/30/2026 to report any odors to the Administrator / Maintenance Director / Designee immediately.

5. **Monitoring of corrective actions:**
   The COO of 3H Management/Designee will provide weekly meetings for 3 months beginning 08/24/2026 and ending 10/24/2026 with the Administrator/Designee to monitor this Plan of Correction and to ensure the facility is operated in compliance with the SBOH rules for SCALF's. Maintenance Director / Designee will report to the Administrator / Designee any objectional odors weekly for 3 months beginning 08/24/2026 and ending 10/24/2026 to ensure there or no objectional odors in the building. Documentation will be kept in the POC binder located in the Administrator's office.

Murray House
Facility ID: D4938
Plan of Correction: Statement of Deficiencies 02/12/2026
Administrator: Andrea Gravely

1. **A 1203**
   420-5-4-.12 (5) Sanitation and Housekeeping: The facility failed to maintain a usable call system available to residents at all times.

2. **Corrective Action:**
   A new call light system was installed on 04/30/2026 by RFT Technologies.
   A new policy will be written by the Administrator / Designee for the use of resident call lights on or before 09/30/2026.

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 ensure deficiency will not recur:**
   IGH, a consulting company was contracted effective 02/05/2026 to provide routine monthly visits and assist with regulatory compliance and POC oversight.
   Ongoing corporate on-site support will be provided weekly by management for a minimum of 90 days. After 90 days, management will review the need for onsite visits.
   Staff will be trained by the Administrator / Designee on or before 09/30/2026 on the policies mentioned in the SOD, the policy for answering call lights, and use of the new call light system on or before 09/30/2026.
   The Administrator / Designee will conduct a review of all policies and facility practices to ensure the facility is following the policies correctly on or before 09/30/2026. Any gaps will be corrected.

5. **Monitoring of corrective actions:**
   The Administrator / Designee will conduct monthly audits of policy compliance for 3 months beginning 08/24/2026 to 10/24/2026.
   The COO / Designee of 3H Management/Designee will provide weekly meetings for 3 months beginning 08/24/2026 and ending 10/24/2026 with the Administrator/Designee 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.