POC Accepted 9.5.25
Connie Cherry

The Ridge at Grandeview ALF

Facility Identification Number: D5987

Administrator: Susan Melvin

Survey Exit Date: 7/31/2025

Please note that The Ridge at Grandeview has submitted this Plan of Correction in order to comply with state regulatory provisions. The preparations and submission of this Plan of Correction does not constitute an admission of fault or liability or agreement regarding the truth or accuracy of the facts alleged or conclusions drawn.

A602

420-5-4-.06 (2) (a) (b) (c) Care of Residents: Medical Examination Record

With Respect to the specific deficiency cited:

Resident #7 and Resident #11

With Respect to how the community will identify other concern:

The DHW auditing resident medical examination record for required information. Issues identified were address by obtaining new updated medical examinations.

With Respect to Systemic Measures that have been put into place to address the stated concern:

Beginning 9/3/2025 Executive Director (ED) /Director of Health and Wellness (DHW) or designee will review physician physical examination reports prior to resident admission to validate completion of required information. DHW will obtain and review updated annual Medical Examinations for required information.

With Respect to How the Plan of Corrective Measures will be Monitored:

The ED will complete a review of the medical examination record weekly x 4 weeks, biweekly x 2 and monthly x 1 month validate compliance with the medical examination records. The ED will report the results of the auditing to the QA committee monthly x 3 months for review and further recommendations.

Date of Compliance: 10/03/2025

A611

420-5-4-.06 (4) (a) (b) Care of Residents

With Respect to the specific deficiency cited:

The assessment and service plans for residents #4, #5 and #6 have been reviewed and revised to reflect the appropriate interventions necessary to meet the residents' current needs. Assessments and service plans will be updated to reflect appropriate interventions necessary to meet the residents' current needs.

With Respect to how the community will identify other concern:

On 08/01/2025 the DHW initiated an audit of current resident assessments and service plans to validate the current service plan included appropriate interventions to meet the care needs of the resident. The audit will be concluded by 9/30/2025.

With Respect to Systemic Measures that have been put into place to address the stated concern:

The DHW, as part of the DHW Morning Routine, will review incident reports, chart notes, medication dashboard, weight reports and 24 Hr Resident Report sheets to identify any change in resident care needs. Issues identified will be addressed with updates to the resident's current service plan to include appropriate interventions to meet the care needs of the resident. The DHW will discuss the results of her auditing and plan for updating service plans with the ED in clinical stand-up.

With Respect to How the Plan of Corrective Measures will be Monitored:

The ED will complete a review of 3 resident service plans weekly x 4 weeks, biweekly x 2 and monthly x 1 to validate resident service plan includes interventions to meet the care needs of the resident. Issues identified will be addressed with the DHW immediately.

The ED will report the results of the auditing to the QA Committee monthly x 3 for review and further recommendations.

Date of Compliance: 12/1/2025

A617

420-5-4-.06 (8) Care of Residents

With Respect to the specific deficiency cited:

The community was unable to locate the disposition form for resident #14 & #15's medications upon discharge.

With Respect to how the community will identify other concern:

The DHW audited discharge resident files for the past 30 days to identify status of medications upon discharge.

With Respect to Systemic Measures that have been put into place to address the stated concern:

On 08/01/2025 the DHW educated the licensed nursing staff that medications for residents discharged or transferred to another facility shall be returned to the resident.

The responsible party will sign a statement that the medications have been received. The statement will include the pharmacy, prescription number, date, medication name and the strength and the amount of medication remaining. The documentation of disposition of medications will be kept on file at the community for 3 years per state regulations.

The DHW will audit discharged resident chart upon discharge to validate compliance with the completion of the disposition form. Issues identified will be addressed immediately with retraining.

With Respect to How the Plan of Corrective Measures will be Monitored:

The ED will audit discharge resident files weekly x 4 weeks, biweekly x 2 and monthly x 1 to validate compliance with completion of the medication disposition form upon discharge or transfer. The ED will present the results of the audit to the QA committee monthly x 3 for review and further recommendation.

Date of Compliance: 12/01/2025

A901

420-5-4-.09 (1) (2) Laundry

With Respect to the specific deficiency cited:

On 7/30/2025 the community Maintenance Director cleaned the walls behind and around the dryers and the lint traps on all dryers.

With Respect to how the community will identify other concern:

On 7/30/2025 the laundry areas was audited by the ED for cleanliness, and no other issues were identified.

With Respect to Systemic Measures that have been put into place to address the stated concern:

On 07/30/2025 the ED re-educated the Director of Maintenance and the community staff regarding cleaning out the lint trap after every load of laundry.

Audits will be completed by the Director of Maintenance weekly. Issues identified will be corrected immediately and staff will be re-educated regarding standards. The audits will be reviewed with the ED during the DPO's weekly 1:1 meeting.

With Respect to How the Plan of Corrective Measures will be Monitored:

The ED will complete random spot check audits of the laundry areas weekly x 4 weeks, biweekly x 2 and monthly x 1 to validation compliance with sanitation standards. The ED will review the results of the audit with the QA Committee monthly x 3 for review and further recommendation.

Date of Compliance: 12/1/2025

A1001

420-5-4-.10 (1) Sanitation and Housekeeping

With Respect to the specific deficiency cited:

The water temperature in the salon was checked on the evening of July 30, 2025 and it read 109. The ED audited the temperature on July 31, 2025 and it read 110.

With Respect to how the community will identify other concern:

On July 31, 2025 the DPO checked the water temperature in random resident rooms and common area for appropriate temperature. No other issues were identified.

With Respect to Systemic Measures that have been put into place to address the stated concern:

The DPO will monitor the water temperature in the beauty salon and 5 other random rooms/common areas daily Monday – Friday for appropriate water temperature. The DPO will report the findings of the audits to the ED in daily stand up meeting.

With Respect to How the Plan of Corrective Measures will be Monitored:

The ED will review the results of the auditing with the QA Committee monthly x 3 for review and further recommendation.

Date of Compliance: 12/01/2025

A1101

420-5-4-.11 (1) Fire and Safety

With Respect to the specific deficiency cited:

On July 28, 2025, The ED re-educated the DPO (Director of Plant Operations) on the required monthly fire drill schedule and recording policy and procedures.

With Respect to how the community will identify other concern:

NA

With Respect to Systemic Measures that have been put into place to address the stated concern:

On 07/28/2025 the ED met with the newly hired Director of Plant Operations (DPO) to review the Alabama Department of Public Health regulation regarding fire drills. DPO will utilize the TELS system to document fire drills. Drills will be completed monthly. A fire drill will be completed on each shift quarterly.

With Respect to How the Plan of Corrective Measures will be Monitored:

The DPO will review the fire drill report with the ED monthly post drill during the 1:1 meeting. The ED will audit the report to validate documentation is complete and contains the date and time of the fire drill, staff attending and outcome of the drill.

The ED will report the audit of the fire drills monthly to the QA Committee monthly x 3 for review and further recommendations.

Date of Compliance: 12/01/2025

A1201

420-5-4-.12 (1) Physical Environment

With Respect to the specific deficiency cited:

On July 28, 2025 electrical room door was locked immediately upon finding unlocked.

With Respect to how the community will identify other concern:

On July 28, 2025, the ED checked all electrical rooms to ensure that they were locked.

With Respect to Systemic Measures that have been put into place to address the stated concern:

DPO will make daily rounds Monday – Friday checking all electrical room doors to ensure they are locked.

With Respect to How the Plan of Corrective Measures will be Monitored:

The DPO and/or the ED will check all electrical room doors to ensure they are locked on a daily basis Monday through Friday.

Date of Compliance: 09/01/2025

A1205

420-5-4-.12 (7) Physical Environment

With Respect to the specific deficiency cited:

No negative outcomes were reported in relations to the fire doors on the 100 hall not fully closing.

With Respect to how the community will identify other concern:

NA

With Respect to Systemic Measures that have been put into place to address the stated concern:

On July 29, 2025 the DPO had the doors serviced and repaired by Piedmont Door Solutions.

With Respect to How the Plan of Corrective Measures will be Monitored:

The DPO and/or the ED will monitor the fire doors for proper closing during fire drills.

Date of Compliance: 12/01/2025

Susan L Melvin, MPH ALA

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09/03/2025