POC Accepted 9.5.25

Connie Cherry

The Ridge at Grandeview SCALF

Facility Identification Number: P3733

Administrator: Susan Melvin

Survey Exit Date: 7/17/2025

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.

A508

420-5-20-.05 (3) (h) Records and Reports

With Respect to the specific deficiency cited:

On 8/28/2025 the Executive Director (ED) entered a report through the Alabama Department of Public Health's Online Reporting System (OIRS). The report reflected the missed medications on the 34 SCALF residents that occurred on 6/7/2025. The residents' primary care physician and their responsibly parties were notified at the time of the incident.

With Respect to how the community will identify other concern:

34 SCALF residents were affected.

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

Director of Health and Wellness (DHW) was hired on 6/25/2025 and LPN Director of Memory Support (DMS) was hired on 07/25/2025. These nurses are responsible for the 24/7 clinical operations of the SCALF and are available in the event of a nurse call off.

On 8/27/2025 the Senior Vice President of Quality and Risk Management (SVPQM) re-educated the ED, DHW, and DMS regarding the Alabama Department of Health reporting guidelines.

The DHW, as part of the DHW Morning Routine, will review the medication dashboard on the community electronic health record (HER) system to identify any missed errors. The DHW will complete an investigation and validate if the medication error occurred. The

DHW will report the finding of the DHW audit and the investigation to the ED in clinical stand up. In the event a medication error occurred the incident will be promptly reported to via the Alabama Department of Public Health's Online Reporting System.

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

The ED will complete a review of the EHR medication dashboard weekly x 4 weeks, biweekly x 2 and monthly x 1 month validate compliance with the reporting requirements for identified medication errors. 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: 12/1/2025

A604

429-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents

With Respect to the specific deficiency cited:

Resident #1 has a current monthly assessment and continues to meet residency requirements.

Resident #2 has a current monthly assessment and continues to meet the residency requirements.

Resident #3 has a current monthly assessment and continues to meet the residency requirements.

Resident #5 has a current monthly assessment and continues to meet residency requirements. A comprehensive assessment, PSMS, Behavior was completed on 7/10/2025.

Resident #7 is currently out to the hospital and be re-assessed for continued residency prior to return.

Resident #8 is currently moving out of the community.

Resident #4, 10 and 11 no longer reside in the community.

With Respect to how the community will identify other concern:

On 8/27/2025 DHW conducted an audit to validate current SCALF residents have a valid monthly assessment. Residents identified with a significant change were audited to

validate a comprehensive assessment was completed and the PSMS and behavioral screening was completed. Issues identified were addressed immediately.

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

On 8/27/2025 the ED re-educated the RN, DHW, regarding the Alabama Department of Public Health requirements for resident assessments prior to admission, monthly and with significant change.

The RN, DHW, no more that 30 days prior to admission, will complete a pre-admission comprehensive assessment/ screening to include clinical history, mental status evaluation, aphasia screen, depression screen, physical self-maintenance screen (PSMS), and a behavioral screen. The RN, DHW, will additionally complete a PSMS and Behavior screen annually and with significant change. SCALF residents will have a monthly assessment completed by the RN, DHW. Comprehensive assessments will be completed when a decline in health status or behavior occurs and will be reviewed with the residents' attending physician and responsible party.

The community utilized an electronic health record (EHR) that tracks required assessments. As part of the DHW Morning Routine the DHW will review the EHR "Assessments Report" to identify any assessments due. The DHW will additionally review incident reports, chart notes, medication dashboard and 24 Hr Resident Report sheets to identify any change of condition requiring a comprehensive assessment. The DHW will report to the ED during clinical stand-up the results of the audits and the plan for completing the required assessments.

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

The ED will review the pre-assessments for potential residents prior to moving in x 3 months to validate compliance with the regulation.

The ED will audit the EHR "Assessment Report" for assessments due as well as identified significant change assessments due weekly x 4 weeks, biweekly x 2 and monthly x 1 to validate compliance with required monthly and annual required assessments. 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: 12/1/2025

A611

420-5-20-.06 (4) (a) (b) Care of Residents

With Respect to the specific deficiency cited:

The assessment and service plans for resident #1 and #5 have been reviewed and revised to reflect the appropriate interventions necessary to meet the residents' current needs. Resident #4 no longer resides in the community. Resident #7 is currently in the hospital and will be reassessed for continued residency prior to return. If appropriate 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

A616

420-5-20-.06 (5) (i) (j) (k) (l) (m) Care of Residents

With Respect to the specific deficiency cited:

No identified resident.

With Respect to how the community will identify other concern:

EI#7 reported she did not provide medication assistance to any other resident.

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

On 08/01/2025 the ED re-educated community care staff of the regulation requiring a licensed nurse only to administer medications to residents of the SCALF.

The SCALF will be staffed with a licensed nurse available for medication administration. In the event that a call out occurs in the SCALF the DHW and/or the DMS will be available to administer medications to the memory care residents.

The DMS will prepare the nursing schedule for a 30 day period and present to the DHW for review to validate licensed nurse is available for medication administration.

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

The ED will audit the SCALF nursing staff schedule weekly x 4 weeks, bi weekly x 2 and monthly x 1 to validate compliance with the regulation. The ED will present the results of the audits to the QA Committee monthly x 3 months for review and further recommendations.

Date of Compliance: 10/01/2025

A617

420-5-20-.06 (6) Care of Residents

With Respect to the specific deficiency cited:

The community was unable to locate the disposition form for resident #11's medications upon discharge. Chart note from 1/29/2025 indicates "Resident has all medications and signed for".

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:

A804

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

With Respect to the specific deficiency cited:

On 7/16/2025 the community Chef cleaned the oven and the basins on the steam table.
On 7/18/2025 the ED validated the cleanliness of the oven and the steam table basins.

With Respect to how the community will identify other concern:

On 7/18/2025 the kitchen 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 07/18/2025 the ED re-educated the Director of Restaurant and Hospitality and the kitchen staff regarding cleanliness of the oven and the steam tables.

Sanitation audits will be completed by the Director of Restaurant and Hospitality (Chef) weekly. Issues identified will be corrected immediately and staff will be re-educated

regarding kitchen sanitation standards. The audits will be reviewed with the ED during the Chef '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 kitchen using the kitchen sanitation audit 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

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

With Respect to the specific deficiency cited:

The toilet in rooms 312, 319, and 325 were cleaned by the housekeeping staff on 7/14/2025. The ED audit the rooms on the evening of 7/14/2025 to validate the cleaning occurred.

With Respect to how the community will identify other concern:

The DHW audited the bathrooms of SCALF resident rooms on 7/14/2025 to validate toilets were clean and free of feces. No other issues were identified.

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

On 08/25/2025 Director of Memory Support held an in-service with care partners and LPN's regarding shift rounds being completed to ensure the cleanliness of residents' bathrooms and toilets.

Care Partners, LPNs and the Director of Memory Support will make rounds throughout shifts evaluating the residents' bathrooms to ensure they are clean. If housekeeping is not available to take care of any cleaning needs at that time, the employee who evaluated that specific bathroom will take care of cleaning that bathroom immediately.

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

The DMS will conduct random rounds of 5 resident bathrooms 3x weekly for 4 weeks , biweekly x 8 weeks to validate the cleanliness or the bathroom. Issues identified will be

addressed immediately. The results of the audit will be reviewed weekly with the ED during the DMS 1:1 meeting.

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

420-5-20-.11 (1) Fire and Safety

With Respect to the specific deficiency cited:

The fire evacuation routes were posted by the ED on 7/14/2025.

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

A1203

420-5-20-.12 (5) Physical Environment

With Respect to the specific deficiency cited:

No negative outcomes were reported in relations to untimely response to resident pendant/pull cords.

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 the ED initiated community staff re-training regarding timely response to pendant/pull cord alerts.

Licensed nurses and care partners working in the SCALF are required to sign out pagers to carry during their assigned shift. The pagers are programmed to alert staff of a pendant/pull cord alert. Staff assigned to that room are to respond to the alert or radio for another staff to assist. The LPN nurse supervisors are assigned to monitor the alerts to validate alerts are answered timely. If alert is not answered the nurse is to page for additional assistance from other staff.

Pendant/pull cord response times are reviewed with newly hired staff during general orientation.

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

The DPO and/or the DPO monitor pendants/pull cord monthly for proper functioning.

The ED and the DHW review the pendant/pull cord report during daily stand-up to validate compliance with call light response. If noted during daily audit that a call-light was not answered in appropriate timeframe, training is held with that care partner assigned to that resident.

The ED will review the pendant/pull cord report with the QA committee monthly x 3 for review and further recommendations.

Date of Compliance: 12/01/2025

Susan L Melvin, MPH ALA

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08/28/2025