Plan of Correction Accepted 8/27/26

Connie Cherry

ROSE MANOR OF HALEYVILLE
FACILITY IDENTIFICATION #: P6701
ADMINISTRATOR: ELIZABETH LAY
SURVEY COMPLETE: 05/12/2026

PLAN OF CORRECTION

1) **A604 420-5-20-.06 (3)(a)(b)(c)(d)(e) Care of Residents**

2) **Corrective Action for each resident or example listed in the deficiency:**

On 5/14/2026, Administrator in-serviced unit coordinator on regulations pertaining to completing comprehensive assessments.

3) **Steps taken to identify other residents or concerns not identified by the survey team:**

On 5/14/2026, all current resident charts were audited to ensure comprehensive assessments were completed by R.N.

4) **Measures, systems, or changes put into place to ensure this deficiency does not reoccur:**

To maintain compliance the Administrator will implement routine audits to ensure ongoing compliance, verifying all comprehensive assessments are completed and signed by the R.N.

5) **Monitoring of the proposed corrective actions:**

The Administrator will conduct weekly compliance audits for a duration of 4 weeks. Followed by an additional monthly audit for 4 months.

The POC binder will be kept in the Administrators office.

ROSE MANOR OF HALEYVILLE
FACILITY IDENTIFICATION #: P6701
ADMINISTRATOR: ELIZABETH LAY
SURVEY COMPLETE: 05/12/2026

PLAN OF CORRECTION

1) A620 420-5-20-.06 (9) (a) Care of Residents:

2) Corrective Action for each resident or example listed in the deficiency:

Resident discharged to a higher level of care on 05/18/2026. Director of Operations in-serviced Administrator and Unit Coordinator on resident admission criteria.

3) Steps taken to identify other residents or concerns not identified by the survey team:

On 05/14/2026, the Administrator and Unit Coordinator did an audit to ensure all current residents PSMS meet retention criteria and regulations.

4) Measures, systems, or changes put into place to ensure deficiency does not Reoccur:

To ensure all future residents meet criteria for admission the Unit Coordinator will submit a copy of the pre-admit forms to Administrator for review prior to admission.

5) Monitoring of the proposed corrective actions:

Administrator will audit all new residents pre-admit forms weekly for 4 weeks. Followed by 4-monthly checks to verify we are in full compliance of state regulations.

The POC binder will be kept in the Administrators office.

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SURVEY COMPLETE: 05/12/2026

PLAN OF CORRECTION

1) A621 420-5-20-.06 (9)(b) Care of Residents

2) Corrective Action for each resident or example listed in the deficiency:

RI#3 was discharged on 05/18/2026 to a long-term care facility. On, 05/14/2026 the Unit Coordinator spoke with RI#2 family and hospice nurse regarding dietary requirements. It was stated that this was a family choice due to the diagnosis of "potential aspiration pneumonia" in 2023 not a medical necessity. The physician verified that she was to be on a regular diet.

3) Steps taken to identify other residents or concerns not identified by the survey team:

All current resident charts were audited by the administrator to ensure all residents meet retention requirements.

4) Measures, systems, or changes put into place to ensure deficiency does not reoccur:

To maintain systemic compliance with resident retention the administrator in-serviced nurses on resident retention guidelines. The unit coordinator will present any change of conditions to administrator to ensure we are complying with regulations.

5) Monitoring of the proposed corrective action:

Administrator will review all resident change of condition forms, to ensure compliance, weekly for 4 weeks. Followed by monthly checks for an additional 4 months.

The POC binder will be kept in the Administrators office.

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SURVEY COMPLETE: 05/12/2026

PLAN OF CORRECTION

1) A 702 402-5-20-.07 (2) Food Service

2) Corrective Action for each resident or example listed in the deficiency:

On 05/12/2026, the Maintenance Director installed an internal thermometer to the dishwasher.

3) Steps taken to identify other residents or concerns not identified by the survey team:

Administrator and Maintenance Director did a thorough audit of the kitchen to ensure there were no other regulatory issues.

4) Measures, systems, or changes put into place to ensure deficiency does not reoccur:

Administrator in-serviced the dietary staff of the state regulations regarding monitoring the dishwasher temperature to ensure the appropriate temperature and time span for heat sanitization.

5) Monitoring of the proposed corrective actions:

The Administrator will monitor the dishwasher thermometer and ongoing temperature log once weekly for 4 weeks followed by monthly checks for 4 months to ensure ongoing compliance.

The POC binder will be kept in the Administrators office.

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PLAN OF CORRECTIONS

1) A 1203 420-5-20-.12 (5) Physical Environment

2) Corrective Action for each resident or example listed in the deficiency:

On 05/14/2026, Maintenance Director cleared all debris from gutters.

3) Steps taken to identify other residents or concerns not identified by the survey team:

Administrator and Maintenance Director performed a thorough audit of the facility grounds to ensure the facility was in regulatory compliance.

4) Measures, systems, or changes put into place to ensure deficiency does not reoccur:

The facility implemented a routine maintenance schedule to ensure the facility and grounds were in regulatory compliance. The Administrator will provide oversight to ensure the facility and grounds are properly maintained.

5) Monitoring of the proposed corrective actions:

The Administrator will do a monthly audit for 4 months to ensure the maintenance schedule is upheld and he facility remains in regulatory compliance.

The POC binder will be kept in the Administrators office.

***A copy of the in-service forms / education will be kept in the POC / Compliance binder. ***

ALA
Rose Manor Administrator Signature

8-18-26
Date