POC accepted 6/24/2025

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GRAND SOUTH
SENIOR LIVING

Plan of Correction

Facility Name: Grand South Senior Living
Facility License Number: D3519
Survey Completion Date: 06/04/2025

Administrator: Jamie Summers, II-1681

Plan of Correction

Facility Name: Grand South Senior Living
Facility License Number: D3519
Survey Completion Date: 06/04/2025
Deficiency Cited: **A-504,** Failure to ensure resident medical records were kept confidential—computer screen on medication cart was left open and unattended.

Citation Summary:

The facility failed to maintain the confidentiality and security of resident medical records as required. A computer screen containing protected health information (PHI) was observed on a medication cart left unattended and visible to others.

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1. Corrective Action Taken for Resident(s) Affected

The computer screen was immediately closed upon discovery, and the medication cart was secured. No evidence has been found that PHI was viewed by unauthorized individuals. A review was conducted to identify any additional incidents, and none were found.

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2. Measures to Prevent Recurrence

- All licensed nurses and medication aides received re-education on HIPAA regulations, with an emphasis on safeguarding electronic PHI on 06/25/2025.
- A policy reminder was issued requiring all staff to **lock or log off** computer systems immediately when stepping away from medication carts or terminals.
- A visual prompt ("Lock Screen Before Leaving") was added to all medication carts and workstations.

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3. Monitoring Compliance

- The Director of Nursing or designee will conduct **daily random audits** of medication carts for 14 days, then **weekly for 8 weeks**, to ensure screens are locked when unattended.
- Audit results will be documented and reviewed during the facility's monthly **Survey Assurance Committee.**
- Any violation observed will result in immediate retraining and disciplinary action if warranted.

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4. Date of Completion:

- This Plan of Correction will be fully by implemented by: 6/25/2025.
- This Plan of Correction will remain in place for one calendar year until 6/25/2026 unless otherwise deemed necessary.

Administrator Signature:

Name: Jamie Summers, ALA II-1681
Title: Administrator, Grand South Senior Living
Date: 06/19/2025

Plan of Correction

Facility Name: Grand South Senior Living
Facility License Number: D3519
Survey Completion Date: 06/04/2025
Deficiency Cited: **A-506,** Failure to report incidents to the Department's Online Incident Reporting System (ORIS) within twenty-four (24) hours of occurrence.

Citation Summary:

During a recent compliance review, it was determined that Grand South Senior Living failed to report one or more qualifying incidents to the ADPH Online Incident Reporting System within the required 24-hour timeframe, as mandated for licensed Assisted Living Facilities.

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1. Corrective Action Taken for Residents Affected:

- All incidents identified as reported late have been entered into the ADPH Online Reporting System as of 6/05/2025.
- Facility leadership conducted follow-up with affected residents and their families to acknowledge the delay and provide reassurance of corrective actions.
- Documentation was updated in the residents' records to reflect accurate incident details and reporting status.

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2. Steps to Identify Other Residents Who May Be Affected:

- A retrospective audit of incident records from the past 60 days was completed to identify any other incidents that were not reported or were reported late.
- No additional incidents were identified and subsequently reported as required.
- No other residents were found to be affected by delayed reporting.

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3. Systemic Changes to Ensure Compliance:

- Grand South Senior Living has revised its **Incident Reporting Policy** to emphasize mandatory 24-hour online reporting to ADPH.
- A new **Incident Tracking Log** has been implemented to monitor reporting deadlines and submission confirmations.
- Responsibility for report follow-up has been reassigned to the **Administrator and the Wellness Director** to ensure backup coverage at all times.

- ADPH Online Reporting access information and procedures have been prominently posted in FYI book in the nurses' station.

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4. Staff Training:

- A staff training 6/11/2025, for all relevant staff including administration, nurses, and department heads to receive in-service training on:
    - Reportable incidents as defined by ADPH,
    - Use of the ADPH Online Reporting System,
    - Facility policy updates regarding reporting timelines.
- All trained staff signed acknowledgments of completion and passed a post-training assessment to confirm understanding.

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5. Monitoring and Quality Assurance:

- The Administrator or Wellness Director will conduct **reviews of all incident logs** at daily stand-up to ensure timely reporting.
- A **monthly audit** of incident reporting practices will be reviewed by the facility's **Survey Assurance Committee**, with documentation maintained.
- Staff non-compliance with reporting policy will result in immediate corrective counseling or further disciplinary action as warranted.

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6. Date of Completion:

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Administrator Signature:

Name: Jamie Summers, ALA II-1681
Title: Administrator, Grand South Senior Living
Date: 06/19/202

Plan of Correction

Facility Name: Grand South Senior Living
Facility License Number: D3519
Survey Completion Date: 06/04/2025
Deficiency Cited: **A-613**, Failure to obtain physician's orders authorizing residents to retain personal custody of OTC or prescription medications.

Citation Summary:

During the facility review, it was found that one or more residents were permitted to keep OTC or prescription medications in their possession without documented physician orders authorizing such custody. This practice does not comply with ADPH regulatory standards, which require a physician's written order for residents to self-administer or maintain possession of medications.

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1. Corrective Action Taken for Residents Affected:

- All residents currently in possession of OTC or prescription medications were immediately reviewed.
- Physician orders were obtained on 6/9/2025 @ 9:00am, for all residents identified as retaining medications without authorization.
- Medications were temporarily secured by staff until proper physician orders were documented, where applicable.
- Resident care plans were updated to reflect medication management status.

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2. Steps to Identify Other Residents Who May Be Affected:

- A comprehensive audit of all resident medication records was conducted to identify additional instances of non-compliance.
- The audit included medication administration records (MARs), physician orders, and resident self-administration assessments.
- There were no additional cases were identified.

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3. Systemic Changes to Ensure Compliance:

- A revised **Medication Management Policy** has been implemented, explicitly requiring written physician orders for any resident maintaining custody of OTC or prescription medications.
- A **Resident Self-Administration Authorization** has been added to the admission and care plan process.

- Admission and periodic reviews will now include a specific checkpoint to verify medication custody status and physician approval.

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4. Staff Training:

- A training has been scheduled for 06/25/2025, all nursing, administrative, and caregiving staff will be retrained on:
    - ADPH regulations regarding medication management,
    - Proper procedures for resident self-administration,
    - Documentation and physician order requirements.
- Staff signed acknowledgments of training completion and passed a policy knowledge check.

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5. Monitoring and Quality Assurance:

- The Care Coordinator or Assistant Care Coordinator will perform **weekly medication custody audits** to ensure all residents in possession of medications have documented physician orders.
- Findings will be discussed in **monthly Survey Assurance Committee** meetings.
- Any instances of non-compliance will trigger immediate review and corrective action, including possible retraining or disciplinary measures.

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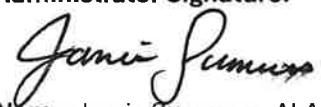
6. Date of Completion:

- Full implementation of this corrective action plan will be completed by:

  This Plan of Correction will be fully by implemented on: 6/25/2025.
- This Plan of Correction will remain in place for one calendar year until 6/25/2026 unless otherwise deemed necessary.

Administrator Signature:



Name: Jamie Summers, ALA II-1681
Title: Administrator, Grand South Senior Living
Date: 06/19/2025

Plan of Correction

Facility Name: Grand South Senior Living
Facility License Number: D3519
Survey Completion Date: 06/04/2025

Deficiency: A-618, 1. Oxygen administration not recorded on the Medication Administration Record (MAR). 2. Oxygen bottle not safely or properly stored.

Citation Summary:

The facility failed to accurately record oxygen therapy on the resident's MAR and failed to ensure safe storage of the portable oxygen bottle, which could pose safety and compliance risks.

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1. Corrective Action Taken for Resident(s) Affected

- The resident's MAR was immediately (06/04/2025) updated to reflect the physician-ordered oxygen use.
- The improperly stored oxygen tank was promptly (06/03/2025) secured in an approved upright oxygen storage rack, away from heat or potential sources of ignition.
- The resident involved was assessed with no adverse outcomes identified.

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2. Measures to Prevent Recurrence

- All licensed nurses and medication aides were re-educated on 06/25/2025:
    - The requirement to document oxygen therapy on the MAR in accordance with physician orders.
    - Proper procedures for the storage and handling of oxygen tanks as per facility policy and fire safety regulations.
- The MAR template was reviewed and updated to include a clearly labeled section for oxygen therapy documentation.

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3. Monitoring Compliance

- The Director of Nursing or designee will conduct **weekly audits** of MARs to ensure oxygen therapy is properly documented for all applicable residents for 8 weeks.
- The Director of Community Relations (RN) and clinical team will perform **weekly oxygen storage inspections** to verify safe storage protocols are followed.

- Any discrepancies will result in immediate correction and staff retraining.
- Audit results will be reported at the **monthly Survey Assurance Committee**.

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4. Date of Compliance:

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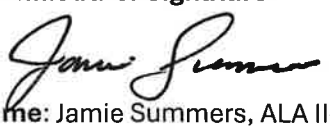

Name: Jamie Summers, ALA II-1681
Title: Administrator, Grand South Senior Living
Date: 06/19/2025

Plan of Correction

Facility Name: Grand South Senior Living
Facility License Number: D3519
Survey Completion Date: 06/04/2025

Deficiency: A-702, The facility failed to provide thermometers in refrigerators located in resident apartments, preventing proper temperature monitoring for safe food storage.

Citation Summary:

The facility failed to provide thermometers in refrigerators located in resident apartments, preventing proper temperature monitoring for safe food storage.

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1. Corrective Action Taken for Resident(s) Affected

- Thermometers were immediately (06/06/2025) placed in all resident refrigerators that previously did not have one.
- Maintenance and nursing staff verified that each thermometer was functional and placed correctly.
- No residents were found to have consumed improperly stored food, and no adverse outcomes were reported.

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2. Measures to Prevent Recurrence

- A facility-wide check was conducted to ensure **all resident refrigerators are equipped with accurate, easy-to-read thermometers**.
- Staff were re-educated on the importance of refrigerator temperature safety and the need to maintain temperatures at or below 41°F.
- Thermometers will now be part of the standard checklist for **move-in inspections**, **room safety checks**, and **annual apartment audits**.

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3. Monitoring Compliance

- The Maintenance Director or designee will perform **monthly audits** to ensure all resident refrigerators have thermometers in working condition.

- Nursing staff will report any issues with refrigerator temperatures or missing thermometers during routine rounds.
- Audit results and any corrective actions will be documented and reviewed during the **monthly Survey Assurance Committee**.

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Survey Completion Date: 06/04/2025

Deficiency: A-1001, The facility failed to control persistent odor in a specific resident room.

Citation Summary:

The facility failed to maintain a clean, odor-free environment in accordance with sanitation and dignity standards. A persistent foul odor was noted in a specific resident's room during the survey.

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1. Corrective Action Taken for Resident(s) Affected

- The identified resident room was immediately (06/05/2025) deep cleaned and sanitized, including all surfaces, flooring, furnishings, and waste containers.
- The resident was assessed for any medical or incontinence-related issues that may have contributed to the odor. The resident was found to have an active UTI. Antibiotics were prescribed.
- The housekeeping supervisor and nursing staff collaborated to ensure follow-up monitoring and hygiene support for the resident.

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2. Measures to Prevent Recurrence

- Housekeeping staff were re-educated on odor control procedures, including proper cleaning of high-risk areas and use of approved deodorizers.
- Nursing staff were reminded to report any signs of persistent odor or hygiene concerns promptly to housekeeping and clinical supervisors.
- A **daily odor check protocol** was implemented for all resident rooms, with immediate intervention if odors are detected.

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3. Monitoring Compliance

- The Housekeeping team-lead will conduct **daily walk-throughs** of all resident rooms for 2 weeks, then **weekly for 2 months**, to monitor for odors.
- Findings will be documented, and any issues will be addressed immediately.

- Results will be reviewed during the facility's **monthly Survey Assurance Committee**.

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Deficiency: A-1101, Failure to perform fire drills on each shift as required

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Citation Summary:

The facility did not conduct fire drills on **all shifts** (day, evening, and night) at the required frequency. This failure compromises resident and staff preparedness in the event of a fire emergency.

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1. Corrective Action for Affected Residents and Staff:

The facility immediately scheduled and completed fire drills for all shifts that were missed during the previous quarter. Staff and residents were debriefed, and emergency response roles were reviewed. No adverse events occurred as a result of the oversight.

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2. Identification of Other Potentially Affected Areas:

A complete review of fire drill records from the past 12 months was conducted. It was determined that one night shift drills had not been performed. All areas and all residents could have been affected by this deficiency.

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3. Systemic Changes to Prevent Recurrence:

- A **Fire Drill Calendar** has been created to ensure drills are scheduled and documented for **each shift every quarter**.
- The **Maintenance Director** or designee is responsible for coordinating and leading drills across all shifts.
- A **Fire Drill Log Form** is currently being used to document drill details, attendance, and any issues identified.

4. Staff Training:

All staff will be retrained on June 25, 2025, on fire safety procedures, the importance of shift-specific drills, and individual responsibilities during fire drills. Training included review of evacuation routes and response expectations for each shift.

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5. Monitoring:

- The Administrator will **review and sign off on all fire drill logs monthly**.
- Drill performance will be reviewed during **Survey Assurance Committee**.
- Any missed or delayed drills will be corrected within 7 days and documented.

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Survey Completion Date: 06/04/2025

Deficiency: A-1203, Failure to prohibit the use of portable heaters in resident rooms, creating a potential fire and safety hazard.

Citation Summary:

The facility failed to enforce its policy prohibiting the use of portable space heaters in resident rooms, compromising safety and violating fire prevention standards.

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1. Corrective Action Taken for Resident(s) Affected

- The portable heater was immediately removed from the resident's room upon discovery.
- The resident and their family were informed of the facility's no-heater policy and alternative temperature comfort measures were offered (e.g., facility-approved heating solutions, extra blankets).
- A full inspection of all resident rooms was completed to ensure no other prohibited heaters were present.

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2. Measures to Prevent Recurrence

- Staff were re-educated on the facility's fire safety policy, specifically the prohibition of personal heating devices in resident rooms.
- Residents and families were reminded in writing of the safety policy, and signage was placed in common areas and on bulletin boards.
- Portable heater prohibition was added to the **move-in checklist** and annual safety re-education materials for residents and families.

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3. Monitoring Compliance

- The Maintenance Director or designee will conduct **monthly safety inspections** of all resident rooms to ensure compliance with heater prohibition.
- Any violations will be addressed immediately, and non-compliant items will be removed.
- Safety inspection findings will be reviewed at the facility's monthly QAPI meetings.

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