POC accepted 6/5/2025

GRAND SOUTH
SENIOR LIVING

Plan of Correction

Facility Name: Grand South Senior Living
Facility License Number: P3503
Survey Completion Date: 05/22/2025

Administrator: Jamie Summers, II-1681

Plan of Correction

Facility Name: Grand South Senior Living
Facility License Number: P3503
Survey Completion Date: 05/22/2025
Deficiency Cited: A – 406, Failure to ensure all employees had CPR training within 90 days of employment

1. Deficiency Cited:

The facility failed to ensure that all employees obtained Cardiopulmonary Resuscitation (CPR) certification within 90 days of their employment start date. This failure is noncompliant with state regulations and compromises the emergency readiness of the staff.

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2. Corrective Action for Affected Employees:

All employees who had not received CPR training within the required timeframe were immediately identified and scheduled for certification or suspended until completion. As of 6/5/2025, all employees exceeding 90 day of employment are now current with their CPR certifications. Verification records are filed in each employee's personnel file.

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3. Identification of Other Potentially Affected Employees:

A full audit of employee training records was conducted to identify any additional staff members who were noncompliant or nearing the 90-day deadline. Except for the one identified employee, no additional discrepancies were discovered, and all employees are now current.

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4. Systemic Changes to Prevent Recurrence:

- A CPR Training Tracking Log has been implemented to monitor employee compliance within the 90-day window.
- The Wellness Director and Care Coordinator's are responsible for tracking and scheduling CPR training for all new hires.
- New employees are now pre-scheduled for CPR training during onboarding to ensure compliance well before the 90-day deadline.
- A CPR compliance section is on the New Hire Checklist and is verified during the 30-, 60-, and 90-day reviews.

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5. Staff Training and Accountability:

Management staff will be retrained on June 25, 2025, regarding the importance of timely CPR certification and the updated tracking process. Policies were updated and distributed.

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6. Monitoring:

- The Administrator and Wellness Director will conduct a monthly review of CPR compliance reports.
- Any employee approaching the deadline will receive an automated reminder and be scheduled immediately.
- Results will be reviewed at the **Survey Assurance Committee**.

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7. Date of Full Compliance:

- Full implementation of this corrective action plan will be completed 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
Title: Administrator, Grand South Senior Living
Date: 06/05/2025

Plan of Correction

Facility Name: Grand South Senior Living
Facility License Number: P3503
Survey Completion Date: 05/22/2025
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.

Plan of Correction Components:

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.

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.

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** 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.

4. Staff Training:

- A staff training has been schedule for 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.

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.

6. 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
Title: Administrator, Grand South Senior Living
Date: 06/05/2025

Plan of Correction

Facility Name: Grand South Senior Living
Facility License Number: P3503
Survey Completion Date: 05/22/2025
Deficiency Cited: **A-601,** Failure to follow the physician's orders for administration of a resident's medication

1. Deficiency Cited:

The facility failed to follow the physician's orders for the administration of medication to a resident, resulting in noncompliance with state regulations and potential risk to resident health and safety.

2. Plan of Correction:

A. Corrective Action for the Affected Resident:

- The identified medication error was immediately corrected upon discovery.
- The resident's physician and responsible party were notified.
- The resident was monitored for any adverse effects; no negative outcomes were noted.

B. Systemic Changes:

- A full audit of all resident medication administration records (MARs) was conducted to ensure compliance with current physician orders.
- Medication administration policies and procedures were reviewed and updated to reinforce adherence to physician orders.
- Medication aides and nurses received re-education on proper medication administration protocols and the importance of following physician orders without deviation.

C. Staff Training:

- All licensed staff and medication aides will complete a mandatory in-service training by 6/15/2025 on:
    - Interpreting and implementing physician orders.
    - Documenting medication administration accurately.
    - Reporting and addressing any discrepancies or unclear orders.

D. Monitoring and Quality Assurance:

- The Wellness Director or Care Coordinator will conduct weekly random audits of medication records and administration for the next 90 days.

- Any deviation from physician orders will be immediately addressed with staff retraining and documentation.
- Results of audits will be reviewed in the **monthly Survey Assurance Committee.**

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
Title: Administrator, Grand South Senior Living
Date: 06/05/2025

Plan of Correction

Facility Name: Grand South Senior Living
Facility License Number: P3503
Survey Completion Date: 05/22/2025
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.

Plan of Correction Components:

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 5/19/2025 @ 7:00pm, prior to the survey's conclusion, 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.

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.

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.

4. Staff Training:

- A training has been schedule for 06/11/2025 and 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.

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.

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:

Jamie Summers

Name: Jamie Summers
Title: Administrator, Grand South Senior Living
Date: 06/05/2025

Plan of Correction

Facility Name: Grand South Senior Living
Facility License Number: P3503
Survey Completion Date: 05/22/2025
Deficiency Cited: A-702, Failure to label prepared food with a "use by date" not exceeding three (3) days from the date prepared.

Plan of Correction

1. Deficiency:
Prepared foods stored in the kitchen were not labeled with a "use by date" that is no more than three (3) days from the date the food was prepared, as required by state regulation.

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2. Corrective Action for the Resident(s) Affected:

- All improperly labeled or unlabeled prepared food items were immediately discarded upon identification.
- A complete inventory check was conducted to ensure no other food items were out of compliance.

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3. Corrective Action to Prevent Recurrence:

- All dietary and kitchen staff were retrained on proper food labeling procedures, including:
    - Dating all prepared foods with the date of preparation and a "use by" date that is no more than three (3) days later.
    - Using approved labels or stickers that clearly display this information.
- A new **Daily Kitchen Food Safety Checklist** was implemented, which includes a verification step for proper food labeling.
- The Executive Chef or Dining Services Coordinator will conduct **daily spot-checks** to ensure ongoing compliance with food labeling requirements.

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4. Monitoring and Quality Assurance:

- The **Executive Chef** or **Dining Services Coordinator** will review the labeling practices weekly for four (4) weeks, and then monthly for the next six (6) months.
- Results of these audits will be reported to the facility's **Survey Assurance Committee** for evaluation and further recommendations, if necessary.

- Continued non-compliance will result in progressive disciplinary action for responsible staff, in accordance with the facility policy.

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5. Completion Date:

- Full implementation of this corrective action plan will be completed by: 6/15/2025
- This Plan of Correction will remain in place for one calendar year until 6/15/2026 unless otherwise deemed necessary.

Administrator Signature:

Name: Jamie Summers
Title: Administrator, Grand South Senior Living
Date: 06/05/2025

Plan of Correction

Facility Name: Grand South Senior Living
Facility License Number: P3503
Survey Completion Date: 05/22/2025
Deficiency Cited: A-703, Failure to provide a sufficient amount of potable water on hand for three (3) days

1. Deficiency Cited:
The facility did not have an adequate supply of potable water stored to sustain residents and staff for a minimum of three (3) days, as required for emergency preparedness and safety compliance.

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2. Corrective Action Taken for Residents Affected:
Upon notification of the deficiency, the facility immediately secured and stored an adequate amount of bottled potable water to meet the needs of all residents and staff for a minimum of three days. Water was calculated at one gallon per person per day for hydration and sanitation needs.

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3. Identification of Other Residents Potentially Affected:
A review of emergency preparedness supplies was conducted to confirm that all residents in the facility were potentially affected by the water shortage. No adverse outcomes occurred as a result of the deficiency.

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4. Systemic Changes to Prevent Recurrence:

- A written Emergency Water Supply Policy has been created and implemented.
- Inventory checks will be conducted monthly to verify that a three-day supply of potable water is maintained at all times.
- The Emergency Preparedness Plan has been updated to include water supply monitoring and storage protocols.
- The Executive Chef and Director of Dining Services will oversee compliance with water storage requirements.

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5. Training:
All staff involved in emergency preparedness, including maintenance and administrative personnel, will be retrained on June 25, 2025, regarding emergency water supply requirements and documentation procedures.

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6. Monitoring:

- The Executive Chef and Director of Dining Services will oversee compliance with water storage requirements.
- Results of these audits will be reported to the facility's **Survey Assurance Committee** for evaluation and further recommendations, if necessary.

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7. Date of Compliance:

- Full implementation of this corrective action plan will be completed by: 6/25/2025
- This Plan of Correction will remain in place for one calendar year until 6/25/2026 unless otherwise deemed necessary.

Name: Jamie Summers
Title: Administrator, Grand South Senior Living
Date: 06/05/2025

Plan of Correction

Facility Name: Grand South Senior Living
Facility License Number: P3503
Survey Completion Date: 05/22/2025

Deficiency Cited: A-1002, Failure to store cleaning supplies in a secure area

1. Deficiency Cited:

Cleaning supplies, including chemicals and hazardous materials, were observed in an unsecured area accessible to residents, which poses a risk to resident health and safety and is in violation of state safety standards.

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2. Corrective Action for Affected Residents:

The unsecured cleaning supplies were immediately removed and relocated to a locked, staff-only storage area. A full sweep of the building was conducted to identify and secure any other chemical products found in accessible areas. No residents were harmed or exposed.

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3. Identification of Other Potentially Affected Residents:

A facility-wide assessment was conducted to determine all areas where cleaning chemicals are stored. All residents were considered potentially affected due to the risk of access. All unsecured cleaning supplies were relocated to designated locked storage areas.

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4. Systemic Changes to Prevent Recurrence:

- All chemical storage areas are now clearly labeled and secured with functioning locks.
- "Do Not Leave Unattended" signs have been posted on all housekeeping carts.
- A new policy has been implemented requiring all staff to secure cleaning supplies when not in use.
- Family Members were reminded about what products are appropriate in a SCALF.
- A daily safety checklist has been added for housekeeping supervisors to confirm compliance.

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5. Staff Training:

All staff will receive retraining on June 25, 2025, regarding the proper storage and handling of cleaning chemicals in accordance with OSHA and facility safety standards. This training included identifying secure storage areas and how to respond if unsecured chemicals are found.

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6. Ongoing Monitoring:

- The **Maintenance Director** will conduct **weekly audits** of all storage areas and cleaning carts.
- The **Administrator** will perform **monthly spot checks** to ensure compliance.
- Results of these audits will be reported to the facility's **Survey Assurance Committee** for evaluation and further recommendations, if necessary.

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7. Date of Compliance:

- Full implementation of this corrective action plan will be completed by: 6/25/2025
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Name: Jamie Summers
Title: Administrator, Grand South Senior Living
Date: 06/05/2025

Plan of Correction

Facility Name: Grand South Senior Living
Facility License Number: P3503
Survey Completion Date: 05/22/2025

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

1. Deficiency Cited:

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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2. 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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3. 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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4. 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.

5. 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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6. 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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7. Date of Compliance:

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Name: Jamie Summers
Title: Administrator, Grand South Senior Living
Date: 06/05/2025

Plan of Correction

Facility Name: Grand South Senior Living
Facility License Number: P3503
Survey Completion Date: 05/22/2025

Deficiency: A-1203, Failure to perform visual inspection of each fire extinguisher monthly

1. Deficiency Cited:

The facility failed to complete and document the required **monthly visual inspection** of all fire extinguishers, which is necessary to ensure they are present, accessible, and in good working condition. This failure constitutes noncompliance with fire safety regulations.

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2. Corrective Action for Affected Areas:

An immediate facility-wide inspection of all fire extinguishers was conducted. All extinguishers were confirmed to be present, properly charged, unobstructed, and in operable condition. Each was tagged and documented as inspected for the current month.

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3. Identification of Other Potentially Affected Areas:

All resident care areas, common areas, and service areas that contain fire extinguishers were considered potentially affected. A review of historical inspection records was conducted, and single gap in documentation were identified and addressed.

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4. Systemic Changes to Prevent Recurrence:

- A **Monthly Fire Extinguisher Inspection Log** has been implemented to record visual inspections.
- The **Maintenance Director** has been assigned responsibility for conducting and documenting monthly inspections of all extinguishers.

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5. Staff Training:

On **June 25, 2025**, maintenance and supervisory staff will be retrained on how to properly conduct and document fire extinguisher inspections, including checking for:

- Physical damage
- Proper pressure

- Secure mounting
- Updated inspection tag

Training included how to immediately report and replace any extinguisher found to be deficient.

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6. Monitoring:

- The **Administrator** will review the completed inspection logs **monthly** to ensure compliance.
- Any missed inspections or irregularities will be addressed and corrected immediately.
- Compliance will be reviewed at the **Survey Assurance Committee**.

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7. Date of Full Compliance:

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Name: Jamie Summers
Title: Administrator, Grand South Senior Living
Date: 06/05/2025