STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015015	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plantation Manor Nursing Home	6450 Old Tuscaloosa Highway MC Calla, AL 35111

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews and review of a facility policy titled, CALL LIGHT, the facility failed to ensure Resident Identifier (RI) #69's call light was in reach for RI #69 to summon staff as needed. This deficient practice was observed on three of three days of the survey and affected RI #69, one of 22 sampled residents. Findings Include: Review of an undated facility policy titled, CALL LIGHT, revealed the following: Purpose: To respond to resident's request and needs. RI #69 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Dementia and Adjustment Disorder with Mixed Anxiety and Depressed Mood. Review of RI #69's at risk for falls care plan, with an initiated date of 06/26/2024, had an intervention to keep RI #69's call light in reach and encourage resident to use for assistance. On 02/18/2026 at 8:00 AM, RI #69 was observed lying in bed with the call light on the floor beneath the bed. On 02/19/2026 at 7:56 AM, RI #69 was again observed lying in bed. RI #69's call light was on the floor beneath the bed. On 02/20/2026 at 9:03 AM, RI #69 was observed lying in bed. The call light was observed on the floor at the head of RI #69's bed. On 02/20/2026 at 2:28 PM, the surveyor conducted an interview with RI #69's assigned Certified Nursing Assistant (CNA) for the 7-3 shift, CNA #8. When asked where a resident's call light should be positioned, CNA #8 said within the resident's reach. CNA #8 said RI #69's call light was on the floor. CNA #8 said RI #69 used his/her call light and it would be important to ensure a resident's call light was within their reach so they could call for help when they needed help. On 02/20/2026 at 4:31 PM, the surveyor conducted an interview with the Director of Nursing (DON). When asked where a resident's call light should be positioned, the DON said within the resident's reach. The DON said it would be important to ensure a resident's call light was within the resident's reach so they could tell staff if they needed anything.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review and a review of a facility policy titled, Activities of Daily Living (ADL) CARE POLICY PROCEDURE, the facility failed to ensure Resident Identifier (RI) #11 a resident dependent on staff for bathing was provided a shower as scheduled for January and February of 2026. This deficient practice affected RI #11; one of two residents sampled for ADL Care. This deficient practice was cited as a result of the investigation of complaint/report number 2742518.Findings Include:A review a facility policy titled, ADL CARE POLICY AND PROCEDURE, with no effective date, documented: PURPOSE: Good hygiene and grooming help prevent the spread of infection and promote the resident's feelings of self-worth and dignity.STANDARD: Guidelines for the provision of hygiene and grooming services are: . shower, tub, complete bed bath.PROCESS: II. Essential Pointsa. Resident preferences for time of day, type of bath and frequency of bath should be honored, .RI #11 was admitted to the facility on [DATE] with a diagnosis of Displaced Fracture of Fifth Metatarsal Bone, Left Foot, Initial Encounter for Closed Fracture. RI #11 was discharged on 02/04/2026. On 01/28/2026 an anonymous complainant alleged that RI #11 had been at the facility for two weeks and only received two baths.RI #11's MDS (Minimal Data Set) with an ARD (Assessment Reference Data) of 01/19/2026 revealed on section GG that resident required substantial/maximal assistance with shower/bathe self. RI #11's Care Plan Report revealed: . Requires limited to total assistance with all ADL's . date initiated 01/04/2026. Interventions. Assist with bath per scheduled and prn. A review of RI #11's Documentation Survey Report for the months of January and February of 2026 revealed no documentation that resident received a shower or bathed self while a resident at the facility. On 02/20/2026 at 9:05 AM an interview was conducted with the Director of Nursing (DON). The DON said that RI #11's shower days were Tuesdays, Thursdays, and Saturdays during the 3PM to 11PM, shift. The DON said staff documented showers provided on the resident's ADL sheet. The DON was asked to review the ADL sheet and she said there was no documented evidence that RI #11 received his/her shower as scheduled during her admission, from 01/13/2026 to 02/04/2026.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of the facility policy titled Catheter Care the facility failed to ensure that Resident Identifier (RI) #77's urinary drainage bag from his/her catheter was maintained in accordance with professional standards of practice and in a manner to prevent infection and maintain dignity. Specifically RI #77's urinary drainage bag observed on a floor mat and without a privacy cover. This placed the drainage system at risk for contamination and resident at risk of urinary tract infection. This deficient practice affected one of three residents observed for urinary catheter maintenance and incontinent care.Findings Include:A review of a facility policy titled, Catheter Care with no effective date revealed:Catheter Care Policy: It is the policy of this facility to ensure residents . receive appropriate catheter care and maintain their dignity .2. catheter drainage bags will be covered at all times.9. Ensure drainage is located below the level of the bladder to discourage backflow of urine.RI #77 was admitted to the facility on [DATE].RI #77's diagnoses to include: Protein-Calorie Malnutrition, Chronic Systolic Congestive Heart Failure, and Muscle Weakness (Generalized). On 02/18/2026 at 9:26 AM during on an observation of RI #77, it was observed that RI #77's urinary drainage bag was on a blue mat on the floor and uncovered. On 02/20/2026, at 11:01 AM an interview with Licensed Practical Nurse (LPN) #15. She stated the catheter bag was not covered. When asked about the facility's protocol for hanging a Foley catheter drainage bag, LPN #15 stated the bag should be hooked to the bed frame. She further acknowledged that placing the catheter bag on the floor could cause infection.On 02/20/2026 at 12:25 PM an interview was conducted with RN #3, Assistant Director of Nursing (ADON) who said she had worked as ADON and Infection Control Nurse for 23 years. RN #3 said staff should use a clamp to hook foley catheter bags to the resident's bed frame.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and the facility policy titled, Weight Monitoring, the facility failed to ensure Resident Identifier (RI) #23, a resident with a history of weight loss, received his/her frozen treat and Ensure as recommended by the Registered Dietitian (RD). At the lunch meal on 02/18/2026, RI #23 did not receive his/her frozen treat and Ensure, and at the lunch meal on 02/20/2026, RI #23 did not receive his/her Ensure. This deficient practice affected RI #23, one of five residents sampled for nutrition.Findings Include: Review of a facility policy titled, Weight Monitoring, with a Copyright date of 2025, revealed the following: . Compliance Guidelines: . The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: . c. Developing and consistently implementing approaches. 3. Information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns. The care plan should address the following, to the extent possible: c. Identify resident-specific interventions. 4. Interventions will be. implemented, . consistent with the resident's assessed needs, . RI #23 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Type II Diabetes Mellitus with Hyperglycemia, Generalized Anxiety Disorder and Gastro-Esophageal Reflux Disease with Esophagitis. A review of the RD's Nutritional Recommendations, dated 12/12/2025, revealed RI #23 had a readmission weight loss and a frozen treat was recommended to be given every day due to weight loss. RI #23's at risk nutritional decline and weight change care plan, with an initiated date of 09/25/2025 revealed the intervention to add a supplement was initiated on 12/13/2025. RI #23's Nutrition/Dietary Note, dated 01/02/2026 revealed RI #23 was currently receiving oral nutrition and a frozen treat due to his/her history of weight loss. The note included the following weights for RI #23:12/05/2025-157 pounds11/18/2025- 166 pounds A review of the RD's Nutritional Recommendations, dated 01/02/2025, revealed the RD recommended to continue RI #23's Plan of Care. On 02/18/2026 at 1:13 PM an observation was conducted of RI #23's lunch meal being served. The served meal did not include either supplement. RI #23's frozen nutritional treat and strawberry Ensure was not served during the lunch meal. On 02/20/2026 at 9:07AM an interview was conducted with Licensed Practical Nurse (LPN) #4. The LPN said the kitchen was responsible for providing RI #23 with his/her daily supplements. A review of RI #23's meal tray card for 02/20/2026 revealed RI #23 was to receive the supplements, A Frozen Nutritional Treat and a Strawberry Ensure at the lunch meal. On 02/20/2026 at 12:38 PM an observation was conducted of RI #23's lunch meal being served by Certified Nursing Assistant (CNA) #5. The served meal did not include either supplement. CNA #5 went to the lunch meal cart and returned with RI #23's frozen nutrition treat and did not provide the Ensure. On 02/20/2026 at 12:46 PM an interview was conducted with CNA #5 who said most times the supplements were on the resident's tray, or they would send them up on a separate tray and the staff knew who received what supplement. CNA #5 RI #23's ice cream was sent with the lunch cart and RI #23's Ensure was not. On 02/20/2026 at 4:33 PM an interview was conducted with the Director of Nursing (DON) who confirmed that RI #23 was a resident with weight loss. The DON said RI #23 was ordered the frozen treat and Ensure Plus for the weight loss. The DON said according to RI #23's meal tray card he/she should receive the supplements at lunch time. The DON said dietary and nursing would be responsible to ensure RI #23 received his/her supplements. The DON said nursing would be responsible because if staff saw something that was not on the tray staff went and got it. The DON said it was important for RI #23 to receive his/her supplements because RI #23 had loss weight. On 02/20/2026 at 4:40 PM an interview was conducted with the Dietary Manager (DM). When asked if a resident received a supplement would the supplement come from her department, the DM said yes. The DM said according to RI #23's meal tray card, RI #23 was to receive supplements at lunch time. The DM said a resident would receive a frozen nutritional treat and an Ensure for weight loss. The DM (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said it would be important for a resident to receive their supplements as ordered so they would not lose more weight. On 02/20/2026 at 5:04 PM a telephone interview was conducted with the RD who said it would be important for the RD recommendations to be followed because that was what the resident was assessed as needing. The RD said even though RI #23 was over his/her Ideal Body Weight, she (the RD) would still address the weight loss. The RD said the supplements were ordered for RI #23's weight loss.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews the facility failed to ensure infection control practices were implemented when staff stored unlabeled and uncovered bath basins and bed pans in a shared bathroom. These practices demonstrated improper storage of resident care items and created the potential for cross-contamination.This had the potential to affect RI #77, 1 of 22 sampled residents.Findings Include:On 02/19/2026 at 8:16 AM, observation of a bathroom revealed six bath basins and two bedpans stored without resident identification and without protective covering. One bedpan was observed on the windowsill with a roll of tissue placed inside of the bedpan.On 02/20/2026, at 11:19 AM an interview was conducted with LPN #15 who said she did not know if bed pans were single use items. LPN #15 said bath basins should be washed, dried with a paper towel, placed in a plastic bag, and labeled for the appropriate resident. When asked whether unlabeled and improperly stored bedpans and bath basins could increase the risk of cross-contamination, LPN #15 responded, yes and acknowledged a need for a better labeling system. LPN #15 accompanied surveyor to the shared bathroom and LPN #15 confirmed six bath basins and two bedpans were in the shared bathroom of RI #77. LPN #15 confirmed that one bedpan was in the windowsill and contained a roll of toilet tissue.On 02/20/2026, at 12:40 PM, Registered Nurse (RN) #3, Assistant Director of Nursing (ADON)/Infection Control Nurse stated bed pans were single-use and thrown away after use. The ADON said bath basins were to be washed, dried, placed in a clean garbage bag, labeled with resident's name and stored in the resident's drawer. The ADON confirmed that six bath basins and two bedpans were in the shared bathroom and were not labeled with a resident's name, not stored in bags, and that one of the bedpans contained a roll of toilet tissue. this was not facility procedure. When asked about infection control risks, the ADON stated, uncovered and improperly stored items in shared bathrooms create contamination risks and can lead to infection.