ACCEPTED - 09/15/2022

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FORM APPROVED

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D4601	A. BUILDING: _____ B. WING _____	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD TOWN HOME	203 WEST CAHABA AVENUE LINDEN, AL 36748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments On August 24, 2022, an unannounced licensure survey was conducted for this 12 bed Assisted Living Facility with a census of seven (7). There were no complaints investigated during this survey. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities (ALF). The deficiencies cited pose a potential risk of significant harm to the residents and require a plan of correction.	A 000		
A 505	420-5-4-.05 (3) (e) Records and Reports. (e) Financial Agreement. 1. Prior to, or at the time of admission, the administrator and the resident or the resident's sponsor shall execute a written financial agreement. This agreement shall be prepared and signed in two or more copies with at least one copy given to the resident, or sponsor, if the resident did not sign the agreement, and one copy retained in the assisted living facility. This document shall be made readily accessible to personnel from the State Board of Health during inspections. 2. In addition to any information otherwise required by the facility's policies and procedures this agreement shall contain the following: (i) A complete list of the facility's basic charges (room, board, laundry and personal care	A 505	Financial Agreements between the administrator and the resident shall be written , prepared and signed by both the resident/sponsor and the administrator. Basic charges will be included in the agreement. 1. The financial agreement between Old Town Home and RI #1 was updated to include the monthly room charge and the daily charge amount. 2. All agreements were checked by the administrator with no other problems. 3. A new reminder was placed on the outside of the admission pack folder that said, "make sure the monthly charge and daily charge are filled in before signing"	

Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/9/22

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A 505	Continued From page 1 and services). (ii) The period covered by the financial agreement. (iii) A list of services not covered under basic charges and for which additional charges will be billed. (iv) The policy and procedures for refunds of any payments made in advance. (v) The provisions governing termination of the agreement by either party. (vi) The facility's bed-hold policy, procedures, and charges. (vii) Documentation that the resident and sponsor understand that the facility is not staffed and not authorized to perform skilled nursing services nor to care for residents with severe cognitive impairment and that the resident and sponsor agree that if the resident should need skilled nursing services or care for a severe cognitive impairment as a result of a condition that is expected to last for more than 90 days, that the resident will be discharged by the facility after prior written notice. (viii) A reminder to the resident or sponsor that the local ombudsman may be able to provide assistance if the facility and the resident or family member are unable to resolve a dispute about payment of fees or monies owed. (ix) Signatures of both parties or authorized representatives.	A 505	4. The administrator will initial each new admission agreement after checking for accuracy and completion.	9/24/22

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A 505	Continued From page 2 3. Prior to execution of the financial agreement the facility shall ensure that the resident or sponsor fully understands its provisions. In the event that a resident is unable to read the agreement due to illiteracy or infirmity, the administrator shall take special steps to ensure communication of its contents to the resident (for example, by having the administrator or sponsor read the agreement to a vision-impaired or illiterate applicant). This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the financial agreement was completed upon admission for each resident. This deficient practice placed at least one resident at significant risk for harm. Findings: On August 24, 2022, the surveyor reviewed RI#1's record with EI#2. RI#1 was admitted to the facility on July 08, 2022. RI#1's financial agreement signed by RI#1's sponsor, did not document the amount of money that RI#1 was responsible to pay monthly. EI#2 agreed that RI#1's financial agreement was incomplete.	A 505		
A 601	420-5-4-.06 (1) Care of Residents. (1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician.	A 601	Care of Residents 1. RI#1's chart was reviewed and updated by by the RN Supervisor. Changes made including adding an order for O2 and the settings required.	

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A 601	Continued From page 3 (a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her choice. If the resident is unable to designate an attending physician, or does not wish to designate an attending physician, the facility shall assist the resident in identifying an attending physician who will serve the resident. A resident shall be permitted to change the designation of his or her attending physician at any time. Whenever a resident requires medical attention, an attempt shall first be made to contact the resident's attending physician, except in medical emergencies requiring activation of the local EMS system (911 or another emergency call). (b) Back-up Physician Support. Each assisted living facility shall have an agreement with one or more duly licensed physicians to serve in those instances when a resident's own attending physician cannot be reached, and to provide temporary medical attention to any resident whose attending physician is temporarily not available. A nurse practitioner or physician's assistant shall not serve as the back-up physician in an assisted living facility. (c) All physician orders shall be written in accordance with community standards. If verbal orders are used, they are to be used infrequently. A physician verbal order shall only be accepted by an RN or LPN employed by the facility and authorized to do so by facility policy and procedures and state law. All verbal orders shall be reduced to writing on the physicians' order sheet by a licensed facility nurse and shall be dated and signed by the nurse receiving the order. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the	A 601	RI#1 went to her attending Physcian on 9/1/2022. The Xarelto was re-started on that date. The RN checked to make sure the order was on the MAR and being give correctly. The HCTZ order was clarified and updated on the chart on 8/25/22. A new blood pressure was done by the RN supervisor (with a new cuff) on 8/24/2022. RI# 2 RI#2's orders were verified for Vitamin B Complex routinely/daily and Vitamin B6 PRN. RI#2 has not requested Vitamin B6 for greater that 6 months. RN talked with RI#2 and she voiced she no longer needed the Vitamin B6 so the order for Vitamin B6 PRN was discontinued. RI#3 The order for the time for morning medications were reviewed by the RN and discussed with the resident. The order remained for morning medications and the resident agreed to allow staff to wake her to take her morning medications Staff is giving morning medications at appropriate time and the resident is accepting to this schedule. #2. The RN Supervisor reviewed all charts for errors in medication orders and reviewed to ensure orders, MAR and medications given were correct.	

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A 601	Continued From page 4 ordering practitioner, or another practitioner who is responsible for the care of the resident and authorized to write orders by facility policy. All verbal orders must be authenticated within such time period as provided by facility policy, but in no case shall exceed 30 days following entry of the order. This Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure that all resident care was provided under the supervision of a physician. This deficient practice placed all seven (7) residents at significant risk for harm. Findings: On August 24, 2022, the surveyor reviewed the resident records for RI#1, RI#2, and RI#3, with EI#1 and EI#2. 1. RI#1 was admitted to the facility on July 08, 2022, with diagnoses which included chronic obstructive pulmonary disease and hypertension. RI#1 returned to the facility from the hospital after treatment for Covid symptoms on approximately August 12, 2022. On August 24, 2022, the surveyor observed RI#1 at the dining room table with oxygen at two (2) liters per nasal cannula. EI#3 checked RI#1's blood pressure after RI#1 had received RI#1's morning medications. EI#3 told the surveyor that RI#1's blood pressure measured 64/55. EI#3 reported RI#1's low blood pressure which was double checked by a nurse from the local nursing home.	A 601	3.New physcian order sheets and new PRN sheets were intiated. RN supervisor listed all PRN medications on new sheets. A new Blood Pressure Cuff was purchased as well as a backup. All staff was inserviced on the requirment that medications given must match physican's orders. 4.The RN Supervisor will check physicians orders, MAR's and medications for "matching' and accuracy once a week for 4 weeks and then monthly and at new admissions.	9/24/22

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A 601	Continued From page 5 RI#1 had an order for Xarelto which was to be given twice a day for 21 days then every day. According to RI#1's July and August 2022 MAR's, RI#1 only received the Xarelto twice a day for 10 days. The Xarelto order was erroneously transcribed onto the August MAR as once a day, then discontinued. There was no physician's order to discontinue RI#1's Xarelto medication in RI#1's record. There was no documentation notifying RI#1's physician of the medication error. EI#2 could not find a physician's order documented in RI#1's record for the use of oxygen or an order to add Hydrochlorothyazide (HCTZ) to RI#1's medication regimen. The HCTZ was started on August 21, 2022, according to RI#1's medication administration record (MAR). EI#2 could not show the surveyor the specific documented discharge medication orders from RI#1's recent hospital stay. EI#2 told the surveyor that EI#2 had not had a resident to return from the hospital before, and EI#2 did not know what hospital discharge orders were. 2. RI#2 was admitted to the facility on May 12, 2021. RI#2's MAR documented Vitamin B6 to be given as needed. EI#2 was unable to find a documented physician's order to change the Vitamin B6 from a scheduled daily dose to as needed. 3. RI#3 was admitted to the facility on November 28, 2018, with diagnoses which included: hypertension and depression. On August 24, 2022, at approximately 12:00 PM, EI#3 was observed to give RI#3 their medications	A 601		

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A 601	Continued From page 6 that were scheduled for 8:00 AM on RI#3's MAR. EI#3 told the surveyor that RI#3 did not get up until noon, so EI#3 gave RI#3 their morning medications at lunch. RI#3's morning medications included: Magnesium Oxide 400 milligrams (mg) one tablet and Amlodipine 10 mg (half tablet). Both of these medications were scheduled to be given again at 5:00 PM. EI#2 could not find documentation in RI#3's record that RI#3's physician had been notified of the morning medication time change, and there was no documentation that RI#3's physician had approved for RI#3's medications to be scheduled so close together.	A 601		9/24/22
A 616	420-5-4-.06 (7) (k) (l) (m) (n) (o) Care of Residents. (k) Medications kept under the control or custody of an assisted living facility shall be packaged by the pharmacy and shall be maintained by the facility in unit dose packaging. Medications kept under the control or custody of an assisted living facility that are not available in unit dose packaging must be packaged by the pharmacy and administered by a physician, RN, or LPN or self-administered with assistance under the total control and direction of the resident. (l) Unless a resident can and does self-manage his or her own medications, an assisted living facility shall require each resident to use a single pharmacy. This does not apply to emergency pharmacy services. All residents need not use the same pharmacy that is used by other residents unless express policy of the assisted living facility provides otherwise and all	A 616	Medications will be kept under the control or custody of the facility. A. Medicine Cart unlocked. 1. The Cart was locked after the surveyor noted the deficiency. EI#3 was counseled about the requirement to keep medicine cart locked. She stated understanding. 2. The administrator made rounds on August 24th at 4:00 P.M. to ensure that all medicines were under the custody of the facility. No other problems were noted. 3. A note was put on the cart stating that the cart must remain locked. All staff was inserviced on the importance of keeping the cart locked. 4. The administrator/supervisor will make rounds weekly to ensure compliance.	

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A 616	Continued From page 7 residents are informed of such policy and provided a copy of such policy prior to or at the time of admission. The assisted living facility shall require pharmacies used for medication supply for residents not self-managing their medications to review all ordered medication regimens for possible errors or adverse drug interactions and to advise the facility and the prescribing health care provider when these are detected. (m) If controlled substances prescribed for residents of any assisted living facility are kept in the custody of the assisted living facility, they shall be stored in a manner that is compliant with state and federal laws, the requirements of the Alabama State Board of Pharmacy, and any requirements prescribed by the State Board of Health. At a minimum, controlled substances in the custody of the facility shall be stored using a double lock system, under proper temperature and humidity controls and permit only authorized personnel access. The facility shall maintain a system to account for all controlled substances in its possession. All other medications in the custody of the facility shall be stored using at least a single lock, under proper temperature and humidity controls and permit only authorized personnel access. This shall include medications stored in a resident's room when the staff and not the resident have access to the medications. Medications may be kept in the custody of an individual resident who can safely manage his or her medications. Such medications may be stored in a locked container accessible only to the resident and staff, or may be stored and secured in the resident's living quarters, if the room is single occupancy and has a locking entrance. (n) Medication administration or	A 616	B. Medicines in the food refrigerator 1. The insulin stored in the refrigerator was removed immediately 2. The refrigerator was checked for any other medications and none were noted. 3. A new refrigerator dedicated for medicines was purchased. A sign was posted on the food refrigerator that states "Do not put Medicines in this refrigerator" All staff was inserviced that medicines are to be stored in new refrigerator and not in the food refrigerator. 4. The administrator/supervisor will make rounds weekly to ensure compliance.	9/24/22

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A 616	Continued From page 8 medication assistance records and written physician orders for all over-the-counter drugs, legend drugs, and controlled substances shall be retained for a period of not less than three years. They shall be made available for inspection at reasonable times by residents, anyone authorized by the resident, and by the sponsors of residents. (o) Labeling of Drugs and Medicines. All containers of prescribed medicines and drugs shall be labeled in accordance with the rules of the Alabama State Board of Pharmacy and shall include appropriate cautionary labels, such as, "Shake Well," or "For External Use Only." This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the medications in the custody of the facility were properly stored. This deficient practice placed all seven (7) residents at a potential risk for harm. Findings: 1. On August 24, 2022, at approximately 09:15 AM, EI#3 greeted the surveyor on the front porch. Upon entering the facility the medication cart located in the kitchen area next to the dining room was observed unlocked and unsupervised. The surveyor observed two residents in the dining room eating breakfast. 2. On August 24, 2022, at approximately 10:47 AM, the surveyor and EI#2 observed a bottle of insulin stored in the main refrigerator where the residents' cold food was also stored. The main refrigerator could not be locked, making the	A 616		

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A 616	Continued From page 9 insulin medication available to anyone who accessed the refrigerator. The kitchen was not locked when it was unsupervised. There was no refrigerator available that was dedicated to medication storage that could also be secured. EI#1 and EI#2 agreed that the medication cart should have been secured when unsupervised, and also agreed that medications should not be stored with the residents food.	A 616		9/24/22
A 702	420-5-4-.07 (2) Food Service (2) Food Handling Procedures. (a) Dish and Utensils Washing, Disinfection, and Storage. 1. Wash water shall be changed with sufficient frequency to avoid gross contamination, and final rinse water shall be kept clean and clear. 2. Hand washed repeated service and multi-service utensils and dishes, after washing and rinsing, shall be sanitized by either of the following methods: (i) Utensils and dishes shall be completely immersed for a period of not less than 30 seconds in water that is at least 171 degrees Fahrenheit (pouring scalding water over utensils and dishes does not meet this requirement); or (ii) A cold water sanitizer. A sanitizing solution shall be used in accordance with manufacturer's instructions. Utensils and dishes shall be completely immersed for a period of not less than 10 seconds in a clean solution	A 702	A. Insulin in the Refrigerator 1. The Insulin was immediately removed from the refrigerator. . 2. The refrigerator was checked for any other medicines. No other problems was noted. 3. A note was put on the refrigerator as a reminder that no medicines are to be stored in that refrigerator. All staff was inserviced on the importance of not storing medicines in the refrigerator. The refrigerator will be cleaned and sanitized by the night staff every Sunday. 4. The administrator/supervisor will make rounds weekly to ensure that the refrigerator is clean and has no medicines stored inside.	

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A 702	Continued From page 10 containing not less than 50 ppm, and not more than 200 ppm, of available chlorine bleach, or 30 seconds in 12.5 ppm of iodine or the amount of time set by the manufacturer in a 200 ppm quaternary ammonium solution. Water temperature must be at least 75 degrees Fahrenheit. Water temperatures and chemical concentrations shall be monitored and documented prior to dishwashing. A record of each test shall be maintained for at least three months. 3. Dishes and utensils shall be allowed to air dry. 4. After washing, rinsing, sanitizing, and air-drying, all repeated use service ware (utensils and dishes) shall be stored in a clean, dry place that is protected from pests, dust, splash, and other contaminants. Utensils shall be handled in such a way as to prevent contamination from hands and clothing. 5. The results from the use of dishwashing machines shall be equivalent to those obtained from the method outlined above, as documented in material provided from the manufacturer and kept on file at the facility. (b) Ice. Crushed or chipped ice shall be protected from splash, drip, and hand contamination during storage and service. The ice scoop may be stored in the ice bin in a manner to prevent ice from coming into contact with the handle, or it may be stored in an airtight container outside the ice bin. (c) Protection of Food from Contamination.	A 702	B. Sanitizing the dishes. 1. Residents will be served on paper plates until a new dishwasher is installed and a new policy and process is started. A new dishwasher was ordered and will be delivered on 9/9/22 2. The administrator made rounds on 8/25/2022. No other sanitary defficiencies were noted. A new dishwasher will be purchased and installed. The faciility dietary consultant was notified of the deficient practice. A new policy was initiated utilizing sanitizing tablets, testing and recording. All staff will be inserviced on the correct usage of the sanitizing tablets, testing and recording. 4. The administrator/supervisor will make rounds weekly to ensure the new procedure is being followed.	9/24/22

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A 702	Continued From page 11 1. Food and food ingredients shall be stored, handled, and served so as to be protected from pests, dust, rodents, droplet infection, unsanitary handling, overhead leakage, sewage back flow, and any other contamination. Sugar, syrup, and condiment receptacles shall be provided with lids and shall be kept covered when not in use. 2. Medications, biologicals, poisons, detergents, and cleaning supplies shall not be kept in the refrigerator or in other areas used for storage of food. 3. Food shall not be stored on the floor. All food and food ingredients stored on shelving must be placed on shelving that is at least six inches above the floor. 4. Refrigerators shall maintain a maximum temperature of 41 degrees Fahrenheit. Freezers shall be maintained at a maximum temperature of 0 degrees Fahrenheit. Thermometers shall remain in refrigerators and freezers at all times. 5. All leftover foods shall be labeled and dated with a "use by date", so that it may be consumed or discarded by that date, which is no more than 3 days from the date it was prepared. 6. All food products shall be used by the manufacturer's indicated date or discarded. 7. Food shall be prepared either in the licensed facility or another location even when that location is not part of the licensed facility. All food preparation areas used by the facility shall	A 702		

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A 702	Continued From page 12 be subject to the same inspections as though part of the licensed facility. The licensed facility is responsible to ensure adequate equipment and measures are used to ensure that food is not contaminated in transport and that foods that are transported are held and served at the appropriate temperatures at all times. 8. Hot food shall be maintained at a minimum of 135 degrees Fahrenheit and cold foods at a maximum 41 degrees Fahrenheit. 9. Frozen food items (raw and cooked) shall be thawed under refrigeration or under running water prior to preparation. Frozen food may also be thawed as part of the cooking process when indicated by package directions. Raw meats shall be stored below and away from vegetables, fruits, and other foods to prevent contamination (meat juices dripping on other foods). 10. Laundry shall not be brought through the food preparation or service area. (d) Storage and Service of Milk and Ice Cream. 1. Milk and fluid milk products shall be served only from the original containers in which they were received from the distributor. This shall not apply to cream for coffee, cereals, and milk for milk drinks which may be dispensed from a readily cleanable container approved for such use. 2. Milk and fluid milk products shall be stored in such a manner that bottles or containers, from which the milk or milk product is	A 702		

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	D4601	A. BUILDING: _____ B. WING _____	08/24/2022

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A 702	Continued From page 13 to be poured or drunk, will not become contaminated from drip or contact with foods. Milk shall be maintained and stored at a maximum temperature of 41 degrees Fahrenheit and shall not be served at a temperature warmer than 45 degrees Fahrenheit unless specifically requested to be served at a warmer temperature by a resident. 3. Contaminating substances shall not be stored with or over open containers of ice cream. Ice cream dippers, spatulas, and other serving utensils shall be cleaned between uses. (e) Kitchen Garbage and Trash Handling. 1. Kitchen garbage and trash shall be placed in suitable containers with tight-fitting lids and properly stored pending removal. Kitchen garbage and trash shall not be allowed to accumulate in the kitchen and shall be removed from the premises at frequent intervals. 2. After being emptied, all garbage cans and trash cans shall be washed and dried before reuse. (f) Employees' Cleanliness. 1. Employees engaged in the handling, preparation, and serving of food shall wear clean clothing at all times. Employees shall wear hair restraints, for example, hairnets, headbands, caps, or other adequate means to prevent contamination of food from hair. Employees whose duties include contact with residents shall change clothing or wear a clean covering over clothing before handling, preparing, or serving	A 702		

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A 702	Continued From page 14 food. 2. Employees handling food shall wash their hands thoroughly before starting work each day, immediately after contact with any soiled matter, and before returning to work after each visit to the rest room. 3. Street clothing not worn by the employee shall be stored in lockers, dressing rooms, or closets designated for staff use. (g) Live Fowl or Animals. Live fowl or animals shall not be allowed in the food service area. (h) Smoking and Spitting. Smoking, other use of tobacco products, and spitting within the food service area shall be prohibited for all staff, residents, and visitors. (i) Dining in Kitchen. Dining in the kitchen shall not be permitted in congregate assisted living facilities. (j) Paper for Food Wrapping. Only new paper, foil, or plastic wrap shall be used for wrapping of foods. (k) Laundering of clothing shall not be permitted in food preparation or service areas. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that employees properly sanitized the dishes for each meal, failed to have the appropriate chemical testing strips available, and also failed to document the dish sanitation test	A 702		

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A 702	Continued From page 15 results on logs which were maintained for at least three (3) months. These deficient practices placed all seven (7) residents at risk for significant harm. Findings: 1. On August 24, 2022, at approximately 10:47 AM, the surveyor and EI#2 observed a bottle of insulin stored in the main refrigerator where the residents' cold food was also stored. EI#1 and EI#2 agreed that the medications should not be stored with the residents food. 2. On August 24, 2022, at approximately 01:15 PM, the surveyor observed EI#3 washing the lunch dishes and utensils. EI#3 told the surveyor that EI#3 put an unmeasured amount of "Clorox" in the wash water, then rinsed the dishes in plain water, and then put the dishes in the dishwasher. EI#3 told the surveyor that the dishes were put through a complete cycle with only "dawn" dish soap added to the dishwasher. EI#3 told the surveyor that there were no sanitation testing logs available. EI#2 and EI#3 showed the surveyor some test strips hanging above the sink and used the "Quaternary" labeled test strips to test the amount of Clorox in the wash water. The Quaternary test strips were verified with EI#1 and EI#2 as the wrong test strips for testing the levels of Clorox in the wash water.	A 702		9/24/22
A1101	420-5-4-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All assisted living facilities shall maintain a current written fire safety, relocation, and evacuation	A1101		

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A1101	Continued From page 16 plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift of Group and Congregate facilities. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the currently adopted Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs. (d) Roller latches are prohibited on doors separating corridors from adjacent spaces. (e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that: 1. Minimizes leaks and spills.	A1101	Fire and Safety A. Fire drills and testing 1. The Inspections were printed from EI#1's e-mail and taken to Old Town Home. 2. The administrator informed the Environmental supervisor and made rounds with him on 8/25/22. No other defficent practice was noted. 3. A new notebook was made and labeled "Fire Inspection Reports/Sprinkler Reports. This notebook will be kept in the office of Old Town Home. 4. The Enviornmental supervisor will check twice a year to ensure results of the schedule fire inspections have been printed and placed in the new Inspection Book. 9/24/22	

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A1101	Continued From page 17 2. Adequately protects against inappropriate access. 3. Complies with the requirements of the currently adopted Life Safety Code. (f) Fire Alarm and Sprinkler System. 1. Fire Alarm System. Where fire alarm systems are required, a corridor smoke detection system shall be installed on each floor, including areas open to the exit access corridor, to comply with NFPA 72, connected to the facility's fire alarm system. In lieu of corridor smoke detection, smoke detectors connected to the building fire alarm system may be installed in each resident's room, open areas, and at smoke doors (except that corridor smoke detection shall not be deleted when its use is dictated by other requirements). 2. Fire alarm and sprinkler system outages of more than 4 hours require evacuation of the facility or the establishment of a continuous fire watch. The fire watch procedure must be coordinated with the Department and the local Fire Marshal. Outages and fire watch documentation shall be reported to the Department within 12 hours or no later than the next duty day, and shall be corrected expeditiously. 3. The fire alarm system and the sprinkler system shall be inspected by licensed, trained, and qualified personnel at least semiannually for compliance with the respective codes. Inspection and testing reports shall be maintained in the facility for a period of at least 3 years.	A1101		

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A1101	Continued From page 18 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain the fire and sprinkler inspection reports for the past three years in the facility. Findings: On August 24, 2022, EI#1 told the surveyor that he/she was looking for the fire and sprinkler inspections for the past two years, but was only able to locate one facility sprinkler inspection dated for July 2021 and one for July 2022. EI#1 was unable to provide any fire inspection reports for the past two years. EI#1 told the surveyor that EI#1 received the reports via email, but had not printed the fire and sprinkler inspection reports out and could not locate the required inspection reports at the time of the survey.	A1101		
A1205	420-5-4-.12 (7) Physical Environment. (7) Building Requirements - Group Assisted Living Facilities. (a) General. Group assisted living facilities licensed, constructed, or renovated after December 25, 1991, shall be limited to one story buildings and shall comply with the currently adopted building code and National Fire Protection Association, Life Safety Code. Facilities, or portions of facilities, built under the currently adopted codes shall comply with the Life Safety Code Chapter for New Residential Board and Care Occupancies (excluding NFPA 101A Alternative Approaches to Life Safety). Facilities,	A1205		

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A1205	Continued From page 19 or portions of facilities, built under previous adopted editions of the codes shall comply with the currently adopted Life Safety Code Chapter for Existing Residential Board and Care Occupancies, Impractical Evacuation Capability (excluding NFPA 101A Alternative Approaches to Life Safety). (b) Required Fire Exits. 1. At least two exits, remote from each other and so located that there will be no dead-end corridors in excess of 20 feet, shall be provided. 2. Exits shall be so located that the distance of travel from the corridor door of any occupied room to an exit shall not exceed 100 feet. 3. Each bedroom or suite shall have at least one doorway opening directly to the outside, or to an exit corridor leading directly to the outside. 4. Exit doors shall swing to the exterior. 5. Panic hardware shall be installed on all exit doors of facilities submitted for plan review. As a minimum, single action hardware is required on all exit doors of existing facilities. (c) Corridors and Passageways. Corridors and passageways used as a means of exit, or part of a means of exit, shall be at least 36 inches wide, shall be unobstructed, and shall not lead through any room or space used for a purpose that may obstruct free passage.	A1205		

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A1205	Continued From page 20 (d) Smoke Barrier Separations. 1. Buildings exceeding 3,000 square feet in area shall be divided into separate areas by smoke barriers so located as to provide ample space on each side for approximately one-half the beds. Smoke barriers shall have a fire-resistive rating of not less than one hour or minimum one-half hour for existing sprinkled facilities. 2. Doors provided in smoke barriers shall be smoke-resistive, so installed that they may normally be kept in the open position, but will close automatically upon fire alarm activation. 3. Duct penetrations in smoke barriers shall be properly protected with smoke dampers. 4. Penetrations of smoke barriers with wiring, conduits, pipes, etc., shall be sealed to maintain the fire and smoke rating. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all designated fire exits were accessible, had single action hardware, and also had a hard path to a public way. This deficient practice placed all seven (7) residents at risk for significant harm due to delayed egress from the facility in the event of a fire or an emergency. Findings: On August 24, 2022, the surveyor with EI#1 observed that the designated EXIT, located next to the shower room and room three, had four	A1205	A. Designated Exit 1. A ramp will be added to the Exit near the shower room. It will go to a a hard path to a public way. 2. On 8/25/22 the Environmental supervisor and the administrator made rounds to identify any other areas of concern. Another ramp will be added to the front porch in place of steps that are going to a sidewalk and a public way. Dill construction and Poppy's gravel were contacted to begin work on the	

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A1205	Continued From page 21 steps which led to a grassy yard. The same EXIT door knob also had a twist lock which would require two steps to open the door when in the locked position. On August 24, 2022, the surveyor with EI#1 observed the designated EXIT door located next to room #2 also had a twist lock door knob which would require two actions to open the door when in the locked position. EI#1 verbalized understanding of the dual action door lock; lack of accessibility for residents with walkers and wheelchairs; and the lack of a hard path to a public way for evacuating the facility in the event of an emergency or a fire. TONYA AVENATTI, REGISTERED NURSE	A1205	ramps and exit areas. 3. All staff were inserviced on the importance of exit to a hard path and a public way. 4. The environmental supervisor or Administrator will make rounds monthly to ensure that all exits lead to a hard path to a public way. B. Twist lock door knobs 1. New latches that do not have twist locks were ordered and will be installed to ensure safe exit during a fire. 2. The environmental supervisor and the administrator made rounds on 8/25/22 to identify any other twist lock doors. No others were noted. 3. All staff were inserviced on the twist lock doors and need for new latches. 4. The environmental supervisor or Administrator will make rounds monthly to ensure that all designated exits jdo not have a twist locking door.	11/30/22