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A 000	Initial Comments On December 11, 2025, an unannounced licensure survey and complaint investigation were conducted for this 16 bed Specialty Care Assisted Living Facility (SCALF) with a census of 14. There was one (1) complaint investigated during this survey. Complaint #20230606012 was investigated and unsubstantiated. No citations were cited due to the complaint. 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 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practices resulted in the potential for harm to all residents and require a plan of correction.	A 000		
A 301	420-5-20-.03 (1) (a) (b) (c) (d) Administration. (1) The Specialty Care Assisted Living Facility Governing Authority. (a) A specialty care assisted living facility shall have an identified sole proprietorship, corporation, partnership, limited partnership, or other business entity that is its governing authority, or it shall have a designated individual or group of designated individuals who serve as its governing authority. A facility must give complete information to the Department identifying: 1. Each person who has an ownership interest of 10 percent or more of the governing authority.	A 301		

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A 301	Continued From page 1 2. Each person or entity who has an ownership interest of 10 percent or more in the real property or building used by the specialty care assisted living facility to offer its services. 3. Each officer and each director of the corporation if the governing authority is a corporation. 4. Each partner, including any limited partners, if the governing authority is a partnership. (b) The governing authority shall submit any changes to the information listed above to the Department within 15 days of the change. (c) Responsibility of Staff to Governing Authority. The administrator, medical staff, facility personnel, and all auxiliary organizations shall be directly or indirectly responsible to the governing authority. For the purposes of these rules, auxiliary organizations include but are not limited to licensed or certified outside providers, consultants, management companies that are not the facility license holder. (d) The governing authority is responsible for appointing and supervising the administrator who is responsible for overall management and the day-to-day operation of the facility. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the governing authority failed to ensure	A 301		

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A 301	Continued From page 2	A 301		

the facility operated in compliance with the SBOH rules for Speciality Care Assisted Living Facilities. The governing authority's lack of adequate oversight resulted in widespread deficient practices. These deficient practices placed all fourteen residents of the facility at risk for harm due to the failure of the governing authority to apply the SBOH rules for the day to day operations of the facility.

Findings:

Employee Identifier (EI)#15, the owner, was in meetings and not available, even by telephone, when the surveyor requested an interview. EI#15 did not contact the surveyor at his convenience during the on-site survey that lasted from December 9, 2025, through December 11, 2025.

The following deficient practices were cited due to the lack of management and oversight of the facility by the governing authority.

302 - The facility failed to establish and implement its own policies and procedures.

303 - The administrator failed to perform her day to day duties to ensure the facility operated according to the SBOH rules for Specialty Care Assisted Living Facilities (SCALF).

405 - The facility failed to provide Registered Nurse (RN) oversight of resident care.

406 - The facility failed to provide staff with appropriate special needs training for diabetes, hospice and continuous glucose monitoring.

604 - The facility failed to provide monthly resident assessments.

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A 301	Continued From page 3 611 - The facility failed to provide accurate and timely RN evaluation of the implementation of interventions and responses to interventions of resident care plans. 619 - The facility failed to maintain first aid supplies to ensure their usability. 702 - The facility failed to prevent contamination of ice and ice scoop. The facility failed to have thermometers in all refrigerators and freezers. 703 - The facility failed to have non-perishable food and potable water to serve three meals a day to all residents for 3 days in an emergency. 901 - Clean lint traps were not maintained for all dryers. 1101 -The facility failed to conduct fire drills and semi-annual inspections of the fire sprinkler system. 1203 - The facility failed to maintain the building in good repair and inspect fire extinguishers monthly. 1206 -The facility failed to provide a control panel with capability to remotely unlock all exit doors simultaneously.	A 301		
A 302	420-5-20-.03 (e) Administration. (e) Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and	A 302		

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A 302	Continued From page 4	A 302		

shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). All residents shall be informed of new policies or changes in existing policies that may have bearing on the resident. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies shall cover the following:

(i) Facility responsibility to protect all residents from abuse, neglect, and exploitation.

(ii) How allegations of abuse, neglect, and exploitation will be handled by the facility.

(iii) Resident confidentiality.

(iv) Admission and continued stay criteria.

(v) Discharge criteria and notification procedures for residents and sponsors.

(vi) Facility responsibility when a resident's personal belongings are lost.

(vii) What services the facility is capable and not capable of providing.

(viii) Medication management.

(ix) Infection control.

(x) Meal service, timing, menus and food preparation, storage, and handling.

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A 302	Continued From page 5 (xi) Fire safety and emergency plan, fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness. (xii) Staffing and conduct of staff while on duty. (xiii) Oxygen administration and storage if used in the facility. (xiv) Dietary Policies. The dietitian, with the approval of the administrator, shall develop written policies and procedures for the guidance of all personnel handling food as outlined by the most current Food and Drug Administration Food Code published by the U.S. Department of Health and Human Services. The facility shall develop and implement dietary policies and procedures to meet the needs of the residents in the facility. In addition to other matters deemed necessary by the facility, dietary policies shall address: (I) Sanitation of dishes, utensils, and service equipment, and sanitary food preparation and handling. (II) The attire and cleanliness of staff members who prepare, handle, or serve food. (III) A schedule of meals, which shall include between-meal nourishment or snacks, and fluids. (IV) Food substitutions or alternatives. (V) Method to ensure an adequate dietary plan is implemented for any resident with a therapeutic diet or special dietary needs.	A 302		

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A 302	Continued From page 6 (VI) Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food. (VII) Provision of necessary services to any resident requiring adaptive devices to eat. (VIII) Procedure for the handling of potentially hazardous foods such as meat, milk, ice, and eggs. (IX) Storage of food. (X) Procedure for food service in the event of a disaster. Disaster menus shall be developed. The policy shall address how food will be obtained and maintained at safe temperatures if electricity is not available. This Rule is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow its own policies and procedures for operation of the facility. Findings: Review of the facility policy titled, "Health Supervision " revealed, "13. Assessment ...and when the monthly assessments identifies a problem in any of the following areas... a. Weight loss..." "14. Resident Care Problem Areas"...An RN shall perform a monthly assessment of each resident of the Specialty Care Assisted Living Facility"...Refer to deficiency 604 Review of the facility policy titled, "Fire and Disaster Drills" revealed, "It is the policy of this	A 302		

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A 302	Continued From page 7 facility that fire and disaster drills be conducted periodically to ensure that all personnel have a working knowledge of our fire safety and disaster preparedness plans. Procedure 1. The following drills will be conducted by this facility to assist personnel in preparing for emergency or disaster situations that could occur or affect our routine operations: a. Fire exit drills monthly (one per shift per quarter) ..." Refer to deficiency 1101	A 302		
A 303	420-5-20-.03 (2) (a) Administration. (2) The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the specialty care assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an administrator shall meet all applicable statutory requirements. 4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days. 5. The administrator and any individual authorized to act as a substitute shall be at least	A 303		

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A 303	Continued From page 8 19 years of age. 6. The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character. 7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week. 8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment and adequate care actually being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement. 9. The facility administrator is responsible for ensuring that required training is provided to all staff. 10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting. 11. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when needed. 12. The administrator shall ensure that	A 303		

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A 303	Continued From page 9	A 303		

plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan.

13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, EI#1, the Administrator, failed to perform her administrative duties to ensure the care needs of all residents were met. EI#1 failed to ensure the facility was in compliance with the Rules of the Alabama State Board of Health.

Findings:

A registered nurse was not available for oversite and coordination of resident care. Refer to deficiency 405 for additional information.

Special needs training was not provided for the staff to help meet the needs of the residents. EI#1 admitted and retained residents with special needs such as diabetes, hospice and continuous glucose monitoring but did not ensure (the RN is responsible for training in the SCALF) appropriate training for staff. Refer to deficiency 406 for additional information.

One resident had significant weight loss that was not addressed. Monthly assessments were not completed to identify changes in residents' status. Refer to deficiency 604 for additional information.

The plans of care were not current based on

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A 303	Continued From page 10 residents' needs and problems. Refer to deficiency 611 for additional information. First aid supplies were not inspected for usability. Refer to deficiency 619 for additional information. The dish cleaning water temperatures and chemical concentrations had not been monitored. Refer to deficiency 702 for additional information. There was no emergency three day supply of non-perishable food. Refer to deficiency 703 for additional information. Laundry dryer lint traps were not clean. Refer to deficiency 901 for additional information. Fire drills were not conducted monthly and quarterly on each shift, the fire sprinkler system was not inspected semi-annually. Refer to deficiency 1101 for additional information. The building structure was not maintained. Refer to deficiency 1203 for additional information. A central control panel was not provided to unlock all doors in an emergency. Refer to deficiency 1206 for additional information. On December 11, 2025 at approximately 11:30 AM EI#1, the Administrator reviewed the findings with surveyor and acknowledged the deficient practices.	A 303		
A 405	420-5-20-.04 (6) (7) (8) Personnel. (6) Medical Director. Each specialty care assisted living facility shall have a medical director who is a physician currently licensed to	A 405		

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A 405	Continued From page 11	A 405		

practice medicine in Alabama. The medical director is responsible for implementation of resident care policies, and the coordination of medical care in the facility. The medical director shall participate in quality assurance activities in the facility. A nurse practitioner or physician's assistant shall not serve as the medical director of a specialty care assisted living facility.

(7) Registered Professional Nurse. Each facility shall have at least one RN. An RN may also serve as the administrator or as the care coordinator, but not as both. In all instances where the facility's RN is assigned other duties as an administrator or care coordinator the facility must assure that the RN devotes sufficient time and effort to all clinical duties.

(a) Responsibility. The RN shall be responsible for oversite and coordination of resident care.

1. The RN shall assess the residents in the specialty care assisted living facility.

2. The RN shall develop, document, and evaluate resident plans of care.

3. The RN shall consult with the administrator on all issues of resident safety, health, and wellbeing.

4. The RN shall communicate significant resident changes to the resident's physician and sponsor or responsible family member.

5. The RN shall identify staff training needs and ensure needed training is

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A 405	Continued From page 12 appropriately provided. 6. The RN shall direct the practice of any licensed practical nurse. (8) Care Coordinator. There shall be a care coordinator who will manage the daily routine delivery of resident care. This person shall be an LPN or RN. An LPN care coordinator shall work under the supervision of the RN in the management and delivery of resident care. This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to employ a Registered Nurse (RN) to provide oversite and coordination of resident care. Findings: On the morning of December 9, 2025 during a tour of the community it was revealed that the facility did not have an RN. During an Interview with EI#2, the Care Coordinator/Licensed Practical Nurse (LPN), EI#2 was asked how did an RN provide oversight. EI#2 stated the facility has not had an RN since the middle of October 2025, therefore there was no oversite. On the morning of December 11, 2025 the Interim Regional Director of Operations EI#3 was asked how oversite was provided to EI#2, LPN, since there was not an RN available at the facility. EI#3 stated she was informed there was no RN at the facility for the first time on December 5, 2025. EI#3 stated an RN should have been contracted to provide oversite.	A 405		

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A 406	Continued From page 13	A 406		
A 406	420-5-20-.04 (9) Personnel. (9) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. An RN shall identify staff training needs and shall provide or arrange for needed training. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that, prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on specialty care assisted living facilities. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire. 5. Identifying and reporting abuse, neglect, and exploitation. 6. Basic first aid. 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environmental	A 406		

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A 406	Continued From page 14 safety. (b) Prior to providing any resident care, all staff shall complete The Dementia Education and Training Act (DETA) Care Series Training developed by the Alabama Department of Mental Health or equivalent training approved by the State Health Officer. All licensed staff shall complete DETA Brain Series Training, The Pharmacological Management of Dementia, and the Dementia Assessment Series provided by the DETA Program or equivalent training approved by the State Health Officer prior to resident contact. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained. (c) All staff who have resident contact shall be able to demonstrate diversional methods and redirection. All staff shall be able to demonstrate an understanding of the implications of caring for residents with agnosia, amnesia, aphasia, and apraxia. All staff shall be able to demonstrate an understanding of the facility's fire and evacuation plan and all other policies regarding safety, including policies for preventing elopements, responding to elopements, and fall prevention. (d) Cardiopulmonary Resuscitation. A specialty care assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of a specialty care assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within	A 406		

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A 406	Continued From page 15 90 days of hire. A specialty care assisted living facility equipped with an automated external defibrillator (AED) shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or the American Red Cross in CPR or AED utilization. (e) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training. (f) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff received required training. Findings: Special Needs Training At the time of the survey, one resident was receiving hospice services and multiple residents had a diagnosis of diabetes mellitus. There was no documentation of staff training for these special needs of the residents, specifically training on hospice, diabetes, and continuous	A 406		

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A 406	Continued From page 16 glucose monitoring devices. On December 10, 2025 at approximately 10:16 AM EI#1, the Administrator stated that she did not know that training had not been completed.	A 406		
A 604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility RN or care coordinator shall screen prospective residents for eligibility for admission into the specialty care assisted living facility. The screening shall include a clinical history, a mental status examination to include aphasia screening, a geriatric depression screen, a physical self-maintenance screen, and a behavior screen. Appendix A herein, contains the Physical Self Maintenance Scale (PSMS) form and the Behavior Screening form. These forms shall be completed to screen physical functioning and behaviors. The PSMS and Behavior Screen assessments shall be completed by the RN or care coordinator upon admission, annually, and when there is a change in the resident's status. The facility RN shall perform a comprehensive assessment of each prospective resident for facility eligibility. This assessment shall document identified care needs and serve as a baseline for the RN plan of care and future assessments. (b) Monthly Assessments. The RN shall assess each resident monthly and more often when necessary to identify changes in the	A 604		

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A 604	Continued From page 17 resident's health status. The monthly assessment shall include a review of monthly weights, falls, incidents, elopements, behavioral symptoms, medications, changes in resident status, and appropriateness of the resident's plan of care. (c) Comprehensive Assessment. The facility RN shall perform a comprehensive assessment and communicate with the resident's attending physician and with the resident's sponsor or responsible family member when a decline in health status or behavior occurs, or if the resident develops any of the following problems: 1. Weight loss: (i) Each month, the facility shall accurately weigh and record the weight of each resident. (ii) A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half percent or greater weight loss in a period of 3 months or less, or a 10 percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician. 2. Falls (two or more falls within a 30 day period). 3. Elopement.	A 604		

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A 604	Continued From page 18 4. Any sign and symptom of adverse drug reaction, interaction or over sedation, or circumstances which contraindicate medications that have been prescribed for the resident. 5. Unmanageable, combative, or potentially harmful behavior(s). 6. Any accident with injury. (d) Focused Assessments. The RN or LPN shall conduct focused assessments when necessary to identify changes in resident status. (e) Any change in resident status requires immediate documentation and implementation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide adequate health supervision of a resident with significant weight loss and failed to perform monthly assessments. Findings: No monthly assessment Resident Identifier (RI)#1 had resided at the facility since December 6, 2021. RI#1 was admitted with diagnoses chronic arterial disease, dementia, hypertension and hypomagnesemia. The facility record revealed no RN monthly assessments for the months of April 2025, May 2025, and November 2025.	A 604		

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A 604	Continued From page 19 RI#3 had resided at the facility since October 10, 2025. RI#3 was admitted with diagnoses of chronic kidney disease, stage 3B, cardiac artery disease, cardiac pacemaker, B12 deficiency, hallucinations, hyperlipidemia and glaucoma. The facility record for RI#3 revealed no RN monthly assessment had been conducted for the month of November 2025. RI#4 had resided at the facility since April 7, 2023. RI#4 was admitted with diagnoses of coronary arterial disease, aortic valve replacement, dementia, atrial fibrillation, hypothyroidism and cardiomyopathy. In November 2025 the resident weighed 104.2 pounds. One month later, in December 2025, RI#4 weighed 97.4 pounds. RI#4 lost 6.8 pounds which is 6.5 percent of his/her total body weight in one month. The facility record for RI#4 revealed there was no RN monthly assessment conducted for the month of November 2025. On the afternoon of December 10, 2025 during an Interview with EI#2, Care Coordinator/LPN EI#2 stated the facility did not have an RN to perform assessments and EI#2 has been performing assessments.	A 604		
A 611	420-5-20-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times.	A 611		

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A 611	Continued From page 20 (b) Plan of Care. The RN shall develop written plans of care for each resident prior to or at the time of admission. The plans of care shall be based on resident's assessments, diagnoses, and recommendations of the resident's physician. The plan of care shall be developed in cooperation with the resident, if appropriate, and the sponsor. The RN shall identify resident care problem areas and formulate written interventions to address those problems. The RN shall evaluate the implementation of the interventions and the resident's response to the interventions and modify the plan of care as necessary. 1. The plan shall at all times reflect the current condition of the resident. All entries on the plan of care shall be accurately dated. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following: 2. A listing of the resident's individual needs or problems that require intervention by the facility. 3. A listing of interventions provided by the facility to address the resident's identified needs or problems. 4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider. 5. Activities of Daily Living. Residents of a specialty care assisted living facility shall be assisted and encouraged to maintain a clean,	A 611		

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A 611	Continued From page 21 well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident. (i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested. (ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips. (iii) Hair. Residents' hair shall be kept clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be provided assistance with personal safety. 6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility RN failed to develop and evaluate written plans of care that adequately addressed residents' care needs with appropriate	A 611		

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A 611	Continued From page 22 interventions. Findings: RI#1 RI#1 was admitted to the facility on December 6, 2021, and had diagnoses which included coronary artery disease, dementia, hypertension and hypomagnesia. RI#1 sustained falls at the facility on June 12, 2025 and December 2, 2025. There were no current interventions on RI#1's facility care plan to prevent a recurrence of falls. RI#4 RI#4 was admitted to the facility April 7, 2023, and had diagnoses which included coronary artery disease, aortic valve replacement, dementia, atrial fibrillation, hypothyroidism and cardiomyopathy. RI#4 sustained a significant weight loss of 6.5% of his/her total body weight in the last thirty days. Though weight loss was listed on the care plan, no interventions were documented to address the weight loss and prevent further decline. On the afternoon of December 10, 2025 during record review, EI#1, the Administrator and EI#2, the Care Coordinator/LPN agreed interventions were not documented and implemented to prevent recurrence of falls and further weight loss for the residents.	A 611		
A 619	420-5-20-.06 (8) Care of Residents. (8) Storage of Medical Supplies. (a) First Aid Supplies. First aid supplies	A 619		

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A 619	Continued From page 23 shall be maintained in a place readily accessible to persons providing personal care and services in the specialty care assisted living facility. These supplies will be inspected at least annually to ensure their usability. This Rule is not met as evidenced by: Based on observation and interview the facility failed to annually inspect and maintain usability of first aid supplies. Findings: On the afternoon of December 9, 2025, during tour of community it was observed by the surveyor that the first aid kit had not been inspected annually as required. No inspection date was noted on the first aid kit to ensure usability. EI#2 the Care Coordinator/LPN was asked who was responsible for the first aid kit. EI#2 stated that the nurse on duty is normally responsible and when items are needed they request them from EI#1. EI#2 stated she was not aware that the kit is supposed to be checked annually for usability.	A 619		
A 702	420-5-20-.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	A 702		

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A 702	Continued From page 24 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 the manufacturers' instructions. Utensils and dishes shall be completely immersed for a period of not less than 10 seconds in a clean solution containing not less than 50 ppm, and not more than 200 ppm, of available chlorine bleach or its equivalent or 30 seconds 12.5 ppm of iodine or the amount of time specified 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	A 702		

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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 shall be stored in a holder inside 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.

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 backflow, 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 nor 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

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maximum temperature of 41 degrees Fahrenheit. Freezers shall maintain 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 three days from the date is 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 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 so that food is not contaminated in transport and foods that are transported are held and served at the appropriate temperature at all times.

8. Hot food shall be maintained at a minimum temperature of 135 degrees Fahrenheit and cold foods at a maximum temperature of 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

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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 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

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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 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

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A 702	Continued From page 29 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 observations, interview, and record reviews the facility failed to monitor and document dish water temperatures and chlorine concentrations to ensure dishes had been properly sanitized. The facility failed to have working thermometers in all refrigerators and freezers. The kitchen staff also failed to store the ice scoop properly so that it was protected from contamination. In addition, the garbage can was without tightly fitting lid. Findings: Food Storage During the kitchen tour on the morning of December 9, 2025, the surveyor observed that two of the three freezers did not have functioning thermometers. One freezer exceeded the maximum temperature of 0 Fahrenheit and was indicating 3 degrees Fahrenheit on the integral thermometer in the freezer door. EI#6, the Cook, was asked if she checked temperatures daily. EI#6 stated she did not check it every day. One	A 702		

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A 702	Continued From page 30	A 702		

refrigerator had a broken thermometer that indicated off the range of the scale. EI#6 was asked if she was aware that the thermometer was not functional. EI#6 stated no she did not and that she (EI#6) would notify the Maintenance Director, EI#5.

Dish Sanitization

On the afternoon of December 9, 2025, the surveyor toured the facility kitchen with EI#6. EI#6 was asked by the surveyor to provide the kitchen water temperature and sanitization logs. EI#6 stated, "I don't have any logs". During observation of dish cleaning, EI#6 was unable to verbalize how to check to ensure dishes were properly sanitized. EI#6 stated, "I run them in the dishwasher with soap". EI#6 stated that she hand washed the dishes and silverware then ran them in the dishwasher. EI#6 stated she (EI#6) had not been shown how to test the water. No strips were available in the facility to check sanitization chemical concentration (ppm). EI#6 was unable to provide the surveyor a log of ppm and water temperature recordings. EI#6 agreed staff had not been properly trained to monitor and ensure dishes were properly sanitized.

Ice Scoop

The surveyor observed that the kitchen ice maker machine had it's ice scoop on top of the ice machine. The ice scoop was not in a container to prevent contamination. EI#6 stated that the ice scoop has been always stored on the top of ice machine. On the afternoon of December 11, 2025 EI#4 the Dietary Manager was asked about storage of the ice scoop and responded that the ice scoop should have been stored in a separate container to prevent contamination.

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A 702	Continued From page 31 Garbage Can Lids The surveyor observed a garbage can in the corner of the kitchen without a tightly fitting lid. EI#6 stated she did not think the container had a lid. On the afternoon of December 11, 2025 EI#4 the Dietary Manager was asked if kitchen garbage cans were supposed to have tightly fitting lids. EI#4 responded that all garbage cans were supposed to have tightly fitting lids on them.	A 702		
A 703	420-5-20-.07 (3) Food Service. (3) Dietary Service. (a) Number of Meals. No fewer than three meals shall be provided each 24 hours. Food service shall be provided in a resident's room during temporary illness if necessary. The diet shall be well-balanced, palatable, properly prepared, and sufficient in quantity and quality to meet the nutritional needs of the residents in accordance with Dietary Reference Intakes of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The food must be adapted in type and preparation to the habits, preferences, and physical abilities of the residents. (b) Timing of Meals. A time schedule for serving meals to residents and personnel shall be established. Meals shall be served approximately five hours apart with no more than 14 hours between the evening meal and breakfast. The time schedule of meals shall be posted with the menu. The facility shall make evening snacks available after service of the evening meal. The	A 703		

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A 703	Continued From page 32	A 703		

facility shall provide fluids throughout the day and shall make between-meal nourishment (snacks) available.

(c) Menu. The menu shall be planned and written at least 1 week in advance. The current week's menu shall be posted in the food service area and shall be kept on file for the following 2 weeks. For any resident with a physician's order for a therapeutic diet, the facility shall have a copy of the diet and the facility shall document the adjustment of its menu to accommodate the resident's needs.

(d) Alternate food selections or substitutes shall be made available to all residents.

(e) A facility shall not obtain food from charitable organizations. A facility shall not avoid serving a meal by sending or transporting residents to missions, soup kitchens, or other charitable facilities for meals.

(f) The amount of food on hand shall be sufficient to serve three meals per day to all residents for 3 days. Non-perishable food and potable water shall be maintained in the facility in sufficient quantity to serve three meals per day to all residents for 3 days.

This Rule is not met as evidenced by:
Based on observations and interview, the facility failed to ensure a sufficient quantity of non-perishable food and potable water was maintained for all the residents for three (3) days.

Findings:

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A 703	Continued From page 33 On the afternoon of December 10, 2025, the surveyor observed that the emergency non-perishable food supply was not sufficient to provide 3 days of meals and water for 14 residents as required. The on hand food supply marked for emergency non-perishable consisted of 3 one pound cans of baked ham, 4 one gallon jars of grape jelly and 4 one gallon containers of water. EI#1 the Administrator stated the dietary manager was supposed to take care of ensuring that there is a sufficient supply of emergency food and water. EI#1 stated she was responsible to ensure it was done. EI#1 stated "it was not done".	A 703		
A 901	420-5-20-.09 (1) (2) Laundry. (1) General. (a) Direction and Supervision. Responsibility for laundry services shall be assigned to an employee. (b) Linen. Linens shall be handled, stored, processed, and transported in a manner consistent with generally accepted infection control practices. (2) Location and Space Requirements. (a) Each specialty care assisted living facility shall have laundering facilities unless commercial laundries are used. An on-site laundry shall be located in a specifically designated area, and there shall be adequate rooms and spaces for sorting, processing, and storage of soiled material. Laundry rooms shall not open directly into resident rooms or food service areas. Domestic washers and dryers	A 901		

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A 901	Continued From page 34 which are for the exclusive use of residents may be provided in resident areas, provided they are installed in such a manner that they do not cause a sanitation problem or offensive odors. (b) Each specialty care assisted living facility shall have a system in place to keep clean linen and dirty linen separated and to prevent the re-use of dirty linen before it is cleaned. Dirty linens and clothing shall not be stored, even temporarily, in the area set aside for clean linen. (c) Ventilation of Laundry. Provisions shall be made for proper mechanical ventilation of the laundry, if located within the specialty care assisted living facility. Provisions shall also be made to prevent the re-circulation of air in commercial equipment laundries into heating and air conditioning systems outside the laundry area. (d) Lint Traps. Adequate, effective, and clean lint traps shall be used in all dryers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain clean lint traps for all dryers. Findings: During a tour of the main laundry room on the afternoon of December 10, 2025, the surveyor, accompanied by EI#13, Resident Care Assistant, observed the lint traps of both laundry dryers were not properly maintained and were full of lint. EI#13 stated normally the lint traps were supposed to be cleaned with every use by the	A 901		

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A 901	Continued From page 35 user. EI#13 stated that the traps were not cleaned as they were supposed to be by the last person to use it.	A 901		
A1101	420-5-20-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All specialty care assisted living facilities shall maintain a current written fire safety, relocation, and evacuation 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. 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 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.	A1101		

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A1101	Continued From page 36 (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. 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	A1101		

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A1101	Continued From page 37 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. This Rule is not met as evidenced by: Based on record review and interview, fire drills were not conducted monthly and quarterly on each shift. The facility failed to ensure the sprinkler system was inspected semi-annually. Findings: Fire drills On the morning of December 10, 2025, record review of fire drills revealed the facility could only produce 3 of 12 fire drill reports for 2023, 3 of 12 fire drill reports for 2024 and none of the 2025 fire drill reports. On the morning of December 10, 2025 EI#1 stated she was aware of the missing reports and did not have a response as to why the fire drills had not been done. On the same morning EI#5, the Maintenance Director stated, "It's on me I should of known about it, but it was not done." Sprinkler system inspection On the morning of December 10, 2025, record review revealed there were no inspections of the fire alarm system in 2023. The sprinkler inspections had not been performed for 2023, 2024, and 2025. EI#5 stated that he would try to	A1101		

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A1101	Continued From page 38 obtain the sprinkler inspection reports from the fire sprinkler inspection company. EI#5 was unable to produce any fire sprinkler inspection reports for the surveyor.	A1101		
A1203	420-5-20-.12 (5) Physical Environment. (5) General Building Requirements - Group and Congregate. (a) Structural Soundness and Repair. The building shall be structurally sound, free from leaks and excessive moisture, in good repair, and painted with sufficient frequency to be reasonably attractive inside and out. The interior and exterior of the building shall be kept clean and orderly. (b) Temperature to be Maintained. The facility shall maintain a comfortable temperature. A comfortable range is between 71-81 degrees Fahrenheit. (c) Lighting. Each resident's room shall have artificial light adequate for reading and other uses as needed. All entrances, hallways, stairways, inclines, ramps, cellars, attics, storerooms, kitchens, laundries, and service units shall have sufficient artificial lighting to prevent accidents and promote efficiency of service. Night lights shall be provided in all hallways, stairways, and bathrooms. (d) Screens. All screen doors and operable windows shall be equipped with tight-fitting, full-length 16 mesh screens. Screen doors shall be equipped with self-closing devices. (e) Emergency Lighting.	A1203		

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A1203	Continued From page 39 1. All specialty care assisted living facilities shall provide an emergency artificial lighting system to adequately illuminate halls, corridors, and stairwells in case of electrical power failure. As a minimum, dry cell battery-operated lighting shall be provided to light such spaces. 2. Emergency lighting must provide illumination in accordance with the currently adopted Life Safety Code for at least 90 minutes. (f) Floors. 1. All floors shall be level, smooth and free of cracks, and finished so as to be easily kept clean. The basic requirement for floor finishes shall be wall-to-wall with such finishes as paint, stain, sealer, carpet, sheet vinyl, vinyl tile, hard tile, or other appropriate floor finish. 2. Any differences in floor levels shall not prevent a resident from navigating safely throughout the facility. (g) Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface and shall be kept clean and in good repair. (h) Windows. Operable windows shall be so constructed and maintained so that they fit snugly, and are capable of being opened and closed easily. Windows in specialty care facilities may have devices which prevent full opening of the window. (i) Ceiling Height. Each room occupied by residents shall have a ceiling height of eight	A1203		

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A1203	Continued From page 40 feet or more. Existing facilities with ceiling heights less than eight feet shall be acceptable when the height complies with the codes. (j) Handrails. If handrails are installed in halls or corridors, the handrails shall be mounted at 30 - 36 inches above the floor and returned to the wall at each end. (k) Stairways. Stairways shall be well lighted, kept in good repair, and have handrails. Open space under stairs shall not be used for storage purposes. All walls and doors under stairs shall meet the same fire rating as the stairwell. (l) Doors. 1. In each new specialty care assisted living facility, doors of resident bathrooms connected to resident bedroom shall swing into the bedroom. 2. Bedroom and bathroom doors may be equipped with hardware that will permit a resident to lock himself within the room, provided a master key is readily accessible for the staff at a central location. 3. Resident bedroom and other exit access doors in specialty care assisted living facility shall be at least three feet wide. 4. Exterior egress doors except the main entry/exit door, may be equipped with a delayed egress locking system installed in accordance with NFPA 101. Other exterior egress doors may be arranged to prevent free and	A1203		

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unhindered egress from specialty care assisted living facilities, in accordance with the Special Requirements portion of this section.

5. Exit doors swinging outward shall swing out over a landing having a minimum length and width equal to the door's width at the same level as the floor level, except existing doors shall not have more than a four inch step down.

(m) Ventilation. The building shall be well ventilated at all times to prevent accumulation of objectionable odors. Kitchens, laundries, service rooms, toilets, and bathrooms shall be ventilated by windows, gravity vents, or mechanical means as necessary to prevent offensive odors from entering other parts of the facility.

(n) Fire Extinguishers. Fire extinguishers shall be provided for each hall, kitchen, and laundry, of type and capacity appropriate to the need.

1. Each fire extinguisher shall receive an annual inspection with maintenance, and recharging when necessary, by a fire equipment servicing representative. An annual servicing tag shall be attached to the extinguisher reflecting the name of the servicing company, representative, day, month, and year of maintenance.

2. A visual inspection of each fire extinguisher shall be conducted monthly by a designated staff of the facility and documented on the attached extinguisher tag by the designated staff person.

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A1203	Continued From page 42 (o) Call System. A central electric or electronic call system shall be conveniently provided for each resident, usable in bedrooms and bathrooms. The call system shall be certified to meet the applicable Underwriters Laboratories standard. (p) Manufactured homes/mobile homes are not permitted. (q) Fireplaces and inserts shall be inspected and cleaned annually, and shall comply with the currently adopted building code. Openings shall be protected with screens or doors. (r) Exit marking. In all facilities, a sign bearing the word "EXIT" in plain legible block letters shall be placed at each exit. Additional signs shall be placed in corridors and passageways wherever necessary to indicate the direction of exit. Letters of signs shall be at least four inches high. All exit and directional signs shall be kept clearly legible by continuous internal electric illumination and have battery back-up or emergency power. (s) Heating, Lighting, and other Service Equipment. 1. Central or individual room gas heating systems shall be of the enclosed flame type equipped with automatic flame shut-off control and shall be vented directly to the outside. Heating units of any type shall be located to avoid direct contact with any combustible material and shall be maintained in accordance with manufacturer's recommendation.	A1203		

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A1203	Continued From page 43 2. Open flame and portable heaters are prohibited in specialty care assisted living facilities. This does not apply to a fire place with gas logs protected as noted elsewhere in these rules. 3. Lighting shall be restricted to electricity. Electric wiring, motors, and other electrical equipment in all specialty care assisted living facilities shall be in accordance with local electrical codes and the NFPA National Electrical Code. This Rule is not met as evidenced by: Based on observation and interview, the building structure was not free from leaks, not in good repair and not kept clean and orderly. The visual inspections of fire extinguishers were not performed and documented monthly as required. Findings: On the morning of December 10, 2025, it was observed by the surveyor that the building roof edges and soffit areas had multiple holes, damaged areas, and missing structure elements indicating the building was not in good repair. Areas of the roof soffit were missing boards which allowed for weather, rodents, insects, and other wildlife to gain access to the roof area. The damaged areas had various holes ranging in size from small (3 inches or less) to very large (30 inches). EI#1 the Administrator stated that EI#1 was awaiting governing body approval to conduct repairs. EI#5 the Maintenance Director stated he had not been able to repair the areas as approval for funding was pending.	A1203		

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A1203	Continued From page 44 All fire extinguishers contained an annual servicing tag documenting they received an annual inspection in July 2025. However, five (5) fire extinguishers did not show documentation of monthly visual inspections for November 2025. EI#5 agreed the monthly inspections had not been completed as required.	A1203		
A1206	420-5-20-.12 (8) Physical Environment (8) Additional Requirements for Specialty Care Assisted Living Facilities. (a) Facilities shall be certified and licensed for housing residents with dementia, and must comply with these special requirements for the physical plant. Facilities should confirm local code requirements, which may vary from those indicated below. (b) Additional Smoke Detection. Smoke detectors (electrical or system type) shall be provided in the sleeping rooms and any bedroom suite sitting areas, which house dementia residents. These detectors shall initiate at least a local alarm or supervisory signal, through the fire alarm system or call system. (c) Windows in specialty care facilities may have devices which prevent opening of the window. (d) Areas to Wander and Secure Perimeter. 1. Each facility shall have a secure boundary or perimeter to safely accommodate residents in all aspects of its physical plant. Exterior building walls and doors, and walled or	A1206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P0104	A. BUILDING: _____ B. WING _____	C 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSPRINGS I	811 GREENSPRINGS DRIVE PRATTVILLE, AL 36067

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A1206	Continued From page 45 fenced outdoor areas may form this boundary. Such walls or fences shall be at least six feet high. 2. Each walled or fenced area shall have at least one gate, located along the discharge path of travel from the building egress doors to the public way. Gates shall be readily unlockable from either side by the staff or by automatic means. "Automatic means" shall be in the same manner as locked or delayed-egress exit doors. 3. If the facility's emergency plan utilizes fenced or walled outdoor spaces as refuge areas for containment of residents, each refuge area shall be of sufficient size to accommodate all occupants at a distance of not less than 50 feet from the building while providing a net area of 15 square feet per person. A gate shall be located within this refuge area. 4. If the facility's emergency plan uses the fenced or walled outdoor spaces merely as areas that are immediately passed through and exited, not as refuge areas for containment of residents, there is no size or area requirement for the fenced or walled spaces. 5. An outdoor courtyard, which is completely surrounded by the building, must have at least two separate doorways, located remotely from each other, leading into separate smoke compartments of the building. (e) Locking of Exit Doors. Locks on exit doors of each specialty care assisted living facility, if installed, shall be electrical locked or electrical delayed-egress locking devices.	A1206		

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A1206	Continued From page 46 Buildings shall be protected throughout by an approved supervised automatic sprinkler system connected to the fire alarm system. 1. Delayed-egress locks must comply with the requirements for "Special Locking Arrangements" found in NFPA 101 Life Safety Code. 2. Electrically locked doors shall comply with the following: (i) A control panel shall be provided at one or more stations with the capability to remotely unlock all exit doors, simultaneously. Locks may be arranged to unlock in Specialty Care compartments based on a zoning concept, where each zone is a rated fire or smoke compartment and the locks on all egress doors unlock within the alarmed zone or compartment. This zoning concept is permitted to apply to automatic functions required by the Life Safety Code. (ii) A key, code, or card release switch shall be provided inside the facility at each locked door, which shall override the locking system to allow exiting from the compartment or building. (iii) All locks shall release automatically upon activation of the facility fire detection, or fire sprinkler system, or upon disablement of the fire alarm system. (iv) Locks shall release automatically upon loss of electric power controlling the lock. (v) The facility shall provide the residents sponsors with adequate information	A1206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1206	Continued From page 47 about the facility's door locking arrangements. (vi) The facility shall assure, at least monthly, that locked or delayed-egress exit doors function properly, in accordance with required fire safety provisions. This Rule is not met as evidenced by: Based on interviews and observation, the facility failed to provide a functioning central control panel for remotely unlocking all exit doors. Findings: On the morning of December 10, 2025, it was observed by the surveyor that the facility was unable to remotely unlock all exit doors. EI#1, the Administrator, EI#2 the Care Coordinator/LPN, EI#5, The Maintenance Director and Resident Care Assistants, EI#7, EI#8, EI#9, EI#10, EI#11, EI#12 and EI#13 were unable to identify a central unlocking device for exit doors in the event of an emergency. The system was not present to permit unlocking of egress doors in an emergency evacuation. No central control panel was provided at any station to remotely unlock all exit doors simultaneously. EI#1 stated that she would notify the governing body to have a central control panel installed immediately. GREGORY ZEITLIN, REGISTERED NURSE	A1206		