STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P1701	A. BUILDING: _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF THE SHOALS SCALF, THE	2904 SOUTH WILSON DAM ROAD MUSCLE SHOALS, AL 35661

(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 January 25, 2024, an unannounced licensure survey was conducted for this 13 bed Specialty Care Assisted Living Facility (SCALF) with a census of 10. There were five (5) complaints investigated during this survey. LC#20220426013, LC#20221108018, LC#20230123012, LC#20230214012 and LC#20230404009 were investigated. There were no deficiencies written as a result of the complaint investigations. 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 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	A 406		

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A 406	Continued From page 1 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 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.	A 406		

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A 406	Continued From page 2 (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 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.	A 406		

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A 406	Continued From page 3 (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 record reviews and interview, licensed staff at the facility failed to complete required training. Findings: On January 10, 2024, at approximately 7:00 AM, and on January 24, 2024, at approximately 1:35 PM, surveyors reviewed the facility's employee files for the following licensed staff: - Employee Identifier (EI)#1, Registered Nurse (RN), Administrator - EI#2, RN, Wellness Director - EI#6, Licensed Practical Nurse (LPN) - EI#7, LPN - EI#15, RN, former employee There was no documentation of training in The Pharmacological Management of Dementia and the Dementia Assessment Series for these five licensed staff members. On January 10, 2024, at approximately 9:00 AM, EI#1 acknowledged this training had not been completed for licensed staff.	A 406		
A 604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents.	A 604		

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A 604	Continued From page 4 (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 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	A 604		

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A 604	Continued From page 5 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. 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).	A 604		

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A 604	Continued From page 6 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, a required assessment was not completed for a newly admitted resident. Findings: Review of facility resident records on January 24, 2024, at approximately 9:40 AM, revealed the following information. Resident Identifier (RI)#1 was admitted to the facility on January 22, 2024 and had diagnoses which included anxiety, hypertension and dementia. RI#1's pre-admission assessment was completed by EI#2, RN. No comprehensive assessment of RI#1 had been completed. When interviewed on January 25, 2024, at approximately 9:00 AM, EI#2 stated RI#1's comprehensive assessment had not been completed prior to admission as required to determine facility eligibility. EI#2 added she (EI#2) had been hired by the previous administrator who was not a nurse and did not provide needed RN training. In addition, EI#2 stated the current management company, which took over	A 604		

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A 604	Continued From page 7 operation of the facility on November 1, 2023, had not provided any training in RN duties.	A 604		
A1001	420-5-20-.10 (1) Sanitation and Housekeeping. (1) Sanitation. (a) Water Supply. 1. If at all possible, all water shall be obtained from a public water supply. If it is impossible to connect to a public water system, the private water supply shall meet the approval of the local County Health Department. 2. Water under pressure of not less than 15 pounds per square inch shall be piped within the building to all sinks, toilets, lavatories, tubs, showers, and other fixtures requiring water. Tubs, showers, sinks, lavatories, and other fixtures used by residents shall have hot water supplied. Hot water accessible to residents shall in no case exceed 110 degrees Fahrenheit. (b) Disposal of Liquid and Human Wastes. 1. There shall be installed within the building a properly designed waste disposal system, connecting to all fixtures to which water under pressure is piped. 2. All liquid and human waste, including floor wash water and liquid waste from refrigerators, shall be disposed through trapped drains into a public sewer in localities where such system is available. 3. In localities where a public sanitary	A1001		

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A1001	Continued From page 8	A1001		

sewer is not available, liquid and human waste shall be disposed through trapped drains into a sewage disposal system approved by the local County Health Department. The sewage disposal system shall be of a size and capacity based on the number of residents and personnel housed and employed in the institution. Where the sewage disposal system is installed at an existing facility prior to granting of a license, it shall be inspected and approved by the local County Health Department.

(c) Premises. The premises shall be kept neat and clean. The property shall be free of rubbish, weeds, ponded water, or other conditions, which may create a health, safety, or sanitation hazard.

(d) Control of Insects, Rodents, and other Pests. Each facility shall be kept free of ants, flies, roaches, rodents, and other pests. Proper and lawful methods for their eradication or control shall be used. Droppings shall be evidence of infestation by pests.

(e) Toilet Room Cleanliness. Floors, walls, ceilings, and fixtures of all toilet rooms shall be kept clean and free of objectionable odors. These rooms shall be kept free of an accumulation of rubbish, cleaning supplies, toiletry articles. The use of a common towel and common bar soap is prohibited.

(f) Garbage Disposal.

1. Garbage must be kept in water-tight suitable containers with tight-fitting covers. Garbage containers must be emptied at frequent intervals and shall be thoroughly cleaned and

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A1001	Continued From page 9 aired before using again. 2. Garbage and waste shall be disposed of in accordance with local and state regulations. (g) Control of Odors. The facility shall be free of objectionable odors. This Rule is not met as evidenced by: Based on observations and interviews, the premises of the facility was not maintained in a healthy, safe and sanitary manner. Findings: On the morning of January 11, 2024, at approximately 8:30 AM, the surveyors and EI#1 observed the premises of the facility. The following deficient practices were observed and discussed with EI#1. - Trash was noted on the ground and in the bushes in front of the building. - The vinyl on the exterior walls of the building was in need of pressure washing. - The shrubbery on the sides and back of the building was overgrown. - Multiple items were stored in the yard beside the storage building including toilets, furniture, fire extinguishers, cabinets and a washing machine. - The dryer vent in the outside storage room was covered with filters, creating a fire hazard. The filters were immediately removed by EI#3. EI#1 agreed the premises of the facility had not been properly maintained. EI#1 added that there had been no fulltime maintenance personnel at	A1001		

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A1001	Continued From page 10 the facility for several months.	A1001		
A1002	420-5-20-.10 (2) Sanitation and Housekeeping. (2) Housekeeping and Physical Plant Maintenance. The facility must provide a safe, functional, decent, sanitary, and comfortable environment for residents, staff, and the public. (a) Equipment and Supplies. The home shall maintain an adequate quantity of housekeeping and maintenance equipment and supplies. (b) Bathtubs and Lavatories. Bathtubs and lavatories shall be kept clean and in proper working order, and shall not be used for laundering. (c) Resident Bedrooms. Resident bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance. (d) General Storage. 1. Broken beds, extra mattresses, mop buckets, and dust rags shall not be kept in hallways, closets, corners, or occupied resident rooms. Such items must be stored neatly and orderly in designated storage rooms. 2. The use of attics for storage of combustible materials shall be prohibited unless protected by an automatic sprinkler system and then only in small quantities so as not to create a hazardous condition. 3. Basements used for storage shall	A1002		

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A1002	Continued From page 11 meet acceptable standards for storage and shall be designed and constructed in a manner that protects against fire hazards. 4. Flammable materials such as gasoline, motor fuels, lighter fluid, turpentine, acetone, and oil based paint shall not be stored in the facility. Unless prohibited by a facility's own policies, however, a cognitively intact resident who uses lighter fluid to fill a personal cigarette lighter, or one who uses flammable materials such as paint or glue in connection with a personal hobby, may store small quantities of those materials in a safe and secure manner within his or her own room. 5. Poisonous or External Use Substances. Facility cleaning supplies and poisons shall be attended at all times or shall be kept in a secure area. This Rule is not met as evidenced by: Based on observations and interview, the facility failed to provide a safe and sanitary environment for residents and staff in the Laundry Room. Findings: On the morning of January 9, 2024, at approximately 7:10 AM, surveyors observed the Laundry Room, which was located in the assisted living portion of the building. Trash, lint, dust and clothing articles were found behind the washers and behind the dryers. A heavy coating of lint and dust was on the electrical cords leading from the washers and dryers to the electrical outlet, creating a fire hazard.	A1002		

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A1002	Continued From page 12 On January 9, 2024, at approximately 9:00 AM, surveyors discussed this finding with EI#1 who agreed the Laundry Room was unsafe.	A1002		
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	A1101		

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A1101	Continued From page 13 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. 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	A1101		

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A1101	Continued From page 14 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. This Rule is not met as evidenced by: Based on record reviews and interviews, fire drills were not conducted monthly and quarterly on each shift. In addition, the fire alarm system and sprinkler system had not been inspected as required. Findings: On the afternoon of January 10, 2024, around 2:00 PM, surveyors reviewed fire drill reports and fire alarm/sprinkler inspection reports provided by EI#3. The following deficient practices were identified from review of these reports. - No fire drills were documented in October and December of 2023. Fire drills were not conducted on each shift for the fourth quarter of 2023. - No sprinkler inspections were documented for 2023. Two sprinkler inspections were documented in 2022 but the inspections were only three months apart in March 2022 and June 2022. - Only one fire alarm inspection was documented for 2023 on December 4, 2023. - An inspection of the facility's fire alarm system by the local fire department, on January 3, 2024,	A1101		

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A1101	Continued From page 15 indicated the five year inspection was due and had not been completed since 2018. On January 9, 2024, at approximately 11:00 AM, EI#3, Maintenance, stated he (EI#3) had only worked at the facility since November 1, 2023. EI#3 added that he (EI#3) was also responsible for maintenance at two sister facilities one hour away, which limited the time available for him (EI#3) to complete necessary maintenance duties at the facility. EI#3 confirmed there was no documentation of a five year inspection of the fire alarm system since 2018 and added the five year inspection should have been completed when the system was inspected in December 2023.	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	A1203		

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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.

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

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A1203	Continued From page 17 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 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	A1203		

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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 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

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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.

(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

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A1203	Continued From page 20 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. 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 observations and interviews, the building was not maintained in good repair, inside and out, to provide a safe, functional, sanitary, decent and comfortable environment for residents, staff and visitors. In addition, fire extinguishers were not visually inspected monthly. Findings: Building Not in Good Repair On the morning of January 11, 2024, at	A1203		

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A1203	Continued From page 21 approximately 8:30 AM, the surveyors and EI#1 observed the exterior of the facility. The following deficient practices were observed. - There was rust on the trim around the top of the chimney on the north end of the building. - The wooden steps leading to the storage building were rotten. - The wooden bases of the columns on the back porch of the facility were rotten. - Multiple window screens were torn and some were not properly placed. - The vinyl siding was not properly secured in some areas. - A wooden ramp leading off the sidewalk curb behind the 100 hall was rotten and contained numerous rusty nailheads which extended 1-2 inches above the wood. On January 23, 2024 at approximately 7:00 AM, the surveyors observed the following additional deficient practices in maintenance of the interior building. - In Resident Room 203 the trim around the bottom of the walls in the bathroom was peeling. - The carpet in Resident Room 205 was badly stained. - The linoleum floor in the bathroom of Resident Room 208 was curled upward on the edges. - Multiple resident rooms contained cabinets for small refrigerators. The boards under some of the refrigerators were filthy and worn to the extent that there was sagging of the boards. - In the hallway, near Resident Rooms 205 and 207, was a coat rack. When the coat rack was removed, there was exposed plumbing and electrical wiring in the wall. This area was partially repaired by EI#3 during the onsite survey.	A1203		

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A1203	Continued From page 22 Fire Extinguishers During a tour of the kitchen on January 10, 2024, at approximately 1:35 PM, surveyors noted a fire extinguisher outside the dry storage room. The tag on the fire extinguisher indicated an annual inspection and maintenance of the fire extinguisher had been performed in October 2023. However, no monthly visual inspections of the fire extinguisher had been documented since the annual inspection. During a tour of the facility on January 23, 2024, at approximately 7:00 AM, surveyors noted a fire extinguisher on the wall to the left, just inside the entrance to the facility. Review of the tag on the fire extinguisher revealed no visual inspections had been documented since November 2023. On the morning of January 24, 2024, at approximately 7:00 AM, these maintenance issues were discussed with EI#1. EI#1 acknowledged the building was in need of numerous repairs. EI#1 added that there had been no fulltime maintenance staff at the facility for several months. On January 9, 2024, at approximately 11:00 AM, EI#3 stated he (EI#3) had only worked at the facility since November 1, 2023 and added that he (EI#3) was also the maintenance man for two sister facilities about one hour away from the facility.	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	A1206		

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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 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

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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. 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.

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A1206	Continued From page 25 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 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 observations and interview, the facility's exit door locks failed to release automatically upon activation of the fire alarm system. Findings:	A1206		

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A1206	Continued From page 26 On January 10, 2024, at approximately 1:00 PM, EI#3 activated the facility's fire alarm system at the request of the surveyor. The door locks failed to release on all three exit doors upon activation of the fire alarm system. An immediate plan of action was implemented including a fire watch. Repairs were completed and the door locks released upon activation of the fire alarm system by EI#3 on January 11, 2024 at approximately 9:00 AM. CONNIE CHERRY, REGISTERED NURSE TROY BLACK, REGISTERED NURSE	A1206		