Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D1705	A. BUILDING: _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF THE SHOALS ALF, THE	2904 S WILSON DAM RD 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 and complaint investigation was conducted for this 40 bed Assisted Living Facility (ALF) with a census of 13. There were two complaints investigated during this survey. LC#20231218005 was investigated and substantiated with deficiencies cited as a result of the complaint investigation. LC#20230123012 was investigated and no deficiences were cited as a result of the complaint investigation.	A 000		
	Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities. The deficiencies cited caused actual harm to one resident and pose a significant risk of harm to all residents of the facility.			
A 301	420-5-4-.03 (1) (a) (b) (c) (d) Administration. The Assisted Living Facility Governing Authority. (a) An 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 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	A 301		

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A 301	Continued From page 2 reviews, the governing authority failed to ensure the facility operated in compliance with the SBOH rules for ALFs. The governing authority's lack of adequate oversight and failure to apply the SBOH rules to the day to day operations of the facility resulted in deficient practices which caused actual harm to one resident and placed all thirteen residents of the facility at significant risk for harm. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.	A 301		
	Findings: The Alabama Department of Public Health received a complaint which alleged a resident of the facility eloped and was found in the road in the middle of a cold night, wearing only a diaper and a shirt. The complaint also alleged the resident suffered from dementia and was not properly assessed by facility staff to ensure the resident was properly placed in an appropriate setting which was safe and secure. Surveyors were able to substantiate this complaint during the onsite survey. Employee Identifier (EI)#12 was the current owner of the facility. Prior to August 2023, EI#13 was co-owner and managing partner of the facility and had been responsible for the day to day operations of the facility. EI#12 ended the partnership with EI#13 in August 2023 and EI#12 became the sole owner. EI#12 contracted with SRI for management of the facility on November 1, 2023. At the time surveyors entered the facility on January 9, 2024, EI#1 had been the administrator only since November 2023. On January 10, 2024,			

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A 301	Continued From page 3 at approximately 12:35 PM, EI#14, President of SRI Management, was present at the facility and stated SRI had taken over management of the facility on November 1, 2023. The Registered Nurse (RN)/Wellness Director, EI#2, had been employed at the facility since September 2023 but initially worked under the previous administrator. During an interview on January 9, 2024, EI#2 stated she (EI#2) took calls for the facility most of the time but had primarily worked in the specialty care assisted living facility on the same campus until EI#1 became administrator. EI#2 stated she (EI#2) received very little training in RN duties while working under the previous administrator. EI#2 also reported she (EI#2) had not received any training in RN duties from the current management company since they began management of the facility in November 2023. Resident Identifier (RI)#4's facility record was reviewed by surveyors on January 9, 2024. Multiple staff members were interviewed regarding RI#4 during the onsite survey. Refer to deficiency 621 for additional information on RI#4 and events that occurred with RI#4 while RI#4 resided at the facility. RI#4 was admitted to the facility on January 19, 2023 during the time that the previous administrator was employed and the facility was under the management of EI#13. Diagnoses of dementia, major depressive disorder, anxiety, insomnia and suicidal ideations were documented on RI#4's Initial Medical Examination, dated January 10, 2023, prior to RI#4's admission to the facility. In addition, RI#4's Resident Information/Emergency Contact Sheet documented a Health History of dementia. There were numerous times that RI#4 was described in the facility record as having dementia which was	A 301		

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A 301	Continued From page 4 declining, voiced suicidal ideations, had moderate cognitive impairment and had altered mental status as well as increased confusion and anxiety. In addition to this documentation, five staff members (EI#4, EI#7, EI#9, EI#10 and EI#11) reported RI#4 had confusion while residing at the facility. A Mini-Mental State Examination, dated September 19, 2023 and completed by the facility Registered Nurse (RN), documented a total score of 16/30 which indicates "Moderate: 10-20" under "suggested guideline for determining the severity of cognitive impairment".	A 301		
	RI#4 was retained at the facility for almost eleven months with repeated evidence of declining dementia and the need for a more secure environment. On the morning of December 11, 2023, RI#4 was found by police crawling across a road near the facility dressed in only a shirt and a diaper with an outside temperature around 30 degrees Fahrenheit. RI#4 was found near an extremely busy six lane road. RI#4 was taken to a local hospital where a History and Physical, dated December 11, 2023, read "...unable to give any ROS (Review of Systems)/PMH (Past Medical History) due to (his/her) dementia...bilateral knee abrasions...". The History and Physical also documented, under Review of Systems, "Unable to obtain due to patient's advanced dementia." An Assessment/Impression documented a diagnosis of "acute encephalopathy with underlying dementia...". RI#4 was later transferred from the hospital to a skilled nursing facility. During an interview on January 9, 2024, at approximately 9:00 AM, EI#1, current Administrator, reported she (EI#1) had assessed all ALF residents since becoming administrator on November 20, 2023 and had transferred three residents of the ALF to the specialty care assisted			

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A 301	Continued From page 5 living facility. EI#1 further stated she (EI#1) had talked with RI#4 on several occasions and did not find RI#4 to be confused other than a brief period when RI#4 was treated for a urinary tract infection, which had resolved. During an interview on January 9, 2024, at approximately 9:30 AM, EI#2, current Wellness Director, reported it was a shock to her (EI#2) that RI#4 eloped from the facility because she (EI#2) only knew of one time previously when RI#4 was confused while being treated for a urinary tract infection, which had resolved. RI#4 was admitted to the facility with diagnoses of dementia and suicidal ideations and was retained at the facility when RI#4's symptoms indicated a need for transfer to a secure unit or higher level of care. The failure of the governing authority to ensure RI#4 was properly assessed for admission and for retention in the assisted living facility resulted in actual harm to RI#4 and placed all 13 residents of the facility at significant risk of harm. On January 25, 2024, EI#14, President of SRI Management, was asked if clinical staff from the management company had been in the building to assess residents since taking over management of the facility on November 1, 2023. EI#14 stated there had been no clinical staff in the building but added that the Corporate Nurse would be coming to the facility the following week.	A 301		
A 302	420-5-4-.03 (1) (e) Administration. Policies. The governing authority shall be responsible for	A 302		

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A 302	Continued From page 6 establishing and implementing written policies for the management and operation of the facility and 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 residents. 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	A 302		

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A 302	Continued From page 7 preparation, storage, and handling. (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	A 302		

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A 302	Continued From page 8 dietary plan is implemented for any resident with a therapeutic diet or special dietary needs. (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 observations, interviews and record reviews, the facility failed to follow its own policies and procedures. Findings: On January 10, 2024, at approximately 4:00 PM, surveyors reviewed the facility's policies and procedures and found the following deficient practices. Initial Physical Examination According to the facility's Initial Physical Examination Policy and Procedure, "...Not more	A 302		

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A 302	Continued From page 9 than thirty days prior to admission of any resident to an assisted living facility...the resident or prospective resident shall be examined by a physician, who shall report his or her findings in writing to the facility...". At least one resident's Initial Physical Examination was not completed by the physician within 30 days prior to admission. Refer to deficiency 602 for additional information. Plan of Care According to the facility's Assisted Living Facility Assessments and Plan of Care Policy and Procedure, "...The plan of care shall be developed and updated in cooperation with the resident and, if appropriate, the sponsor...This plan shall be kept current, reviewed and updated when there is any significant change in the resident's condition...". The facility failed to maintain current Plans of Care for all residents. Refer to deficiency 611 for additional information. Retention of Residents According to the facility's Assisted Living Admission and Retention of Residents Policy and Procedure, "...An assisted living facility shall not admit a resident, nor shall it retain any resident, if such resident, because of dementia, cannot safely reside in the facility unless his or her egress from the facility is restricted...". The facility retained a resident who was cognitively impaired resulting in elopement of the resident. Refer to deficiency 621 for additional information. Resident Assessments According to the facility's Resident Assessment and Service Plan Policy and Procedure, "...Residents who reside in Assisted Living will be	A 302		

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A 302	Continued From page 10 reassessed: Monthly...Whenever there is significant change in resident condition...The facility shall on a monthly basis weigh and record the weight of each resident. The facility shall assess residents on a monthly basis and more often when necessary to identify significant changes in health status or behavior to include awareness of medication...". The facility failed to properly assess residents resulting in the elopement of a resident. Refer to deficiency 604 for additional information. During an interview on January 10, 2024, at approximately 5:00 PM, EI#1 and EI#2 agreed the facility's policies and procedures had not been followed.	A 302		
A 602	420-5-4-.06 (2) (a) (b) (c) Care of Residents. (2) Medical Examination Record. (a) Initial Physical Examination. Not more than 30 days prior to admission of any resident to an assisted living facility, the resident or prospective resident shall be examined by a physician. For purposes of the initial physical examination only, a currently licensed physician in good standing with the Medical Licensure Commission of any state may complete this physical assessment. The physician shall report his or her findings in writing to the facility. In addition to any information otherwise required by the facility's policies and procedures, and in addition to any other information the physician recommends or believes is pertinent, the initial physical examination record shall contain the following: 1. All of the physician's diagnoses, and	A 602		

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A 602	Continued From page 11 the resident's baseline weight and vital signs. 2. Medication presently prescribed (name, dosage, and strength of drug, frequency, and route of administration). 3. A statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact. 4. Documentation of evaluation for tuberculosis within the previous 12 months. (b) Annual Physical Examination. In addition to the admission physical examination, each resident shall be examined annually by a physician, and findings from the annual physical examination shall be documented with a copy placed in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent, or recommended by the resident's attending physician, the annual physical examination shall contain the following: 1. The resident's weight and vital signs. 2. Changes in diagnoses. 3. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration). 4. Changes in treatment. (c) Change of Condition Physician	A 602		

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A 602	Continued From page 12 Examinations. Changes in the resident's condition that require a physician examination and result in a change in diagnoses, medications, or treatments shall be reported to the facility and documented in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent, or recommended by the resident's treating physician, this physical examination shall contain a listing of the following:	A 602		
	1. New diagnoses. 2. Changes in condition. 3. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration). 4. Changes in treatment. This Rule is not met as evidenced by: Based on record review and interview, a resident's Initial Physical Examination was not completed within 30 days prior to the resident's admission to the assisted living facility. Findings: RI#2 was admitted to the facility on January 6, 2023 and had diagnoses which included hypertension, osteoporosis, diabetes mellitus type 2, chronic kidney disease, chronic anemia, lower extremity edema, congestive heart failure, vitamin D deficiency and mitral valve regurgitation.			

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A 602	Continued From page 13 Review of RI#2's facility record on January 10, 2024 revealed the following information. RI#2's Initial Physical Examination read "Date of Physician/HCP Visit 11/08/2022". The Initial Physical Examination was signed by RI#2's physician on December 30, 2022. The date that RI#2's Initial Physical Examination was completed was greater than 30 days from RI#2's date of admission to the facility. On January 10, 2024, at approximately 5:00 PM, EI#1 agreed the examination date was greater than 30 days.	A 602		
A 604	420-5-4-.06 (3) (a) (b) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility shall assess prospective residents for facility eligibility. This assessment shall document identified care needs and serve as a baseline for future assessments. (b) Monthly Assessments. The facility shall assess each resident monthly and more often when necessary to identify changes in resident's status. In addition to other items that may be required by the facility's own policies and procedures, the monthly assessment shall: 1. Assess the resident's ability to safely self-manage medications or safely self-administer medications with assistance. 2. Accurately weigh and record the weight of each resident. 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 or greater weight loss in a period of three	A 604		

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A 604	Continued From page 14 months or less, or a ten 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. 3. Document identified changes in resident status. 4. Assess the appropriateness of each resident's plan of care. Any decline in resident status requires immediate implementation and documentation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on record reviews and interviews, residents' assessments were not completed as required. Findings: Review of residents' facility records on January 10, 2024 revealed the following information. RI#1 was admitted to the facility on August 18, 2018 and had diagnoses which included movement disorder, major depressive disorder, hypertension, hyperlipidemia, anemia, Bell's palsy, curvature of the spine and Parkinson's disease. Monthly assessments, including medication awareness testing and weights, were not documented for RI#1 in April, May, June, July,	A 604		

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A 604	Continued From page 15 August, September and October 2023. RI#2 had resided at the facility since January 6, 2023. Refer to deficiency 602 for additional information on RI#2. Monthly assessments, including medication awareness testing and weights, were not documented for RI#2 in June, July and August 2023. RI#3 was admitted to the facility on October 21, 2020 and had diagnoses which included diabetes mellitus type 2, hypertension, hyperlipidemia, neuropathy, back pain and chronic pain. Monthly assessments, including medication awareness testing and weights, were not documented for RI#3 in August, September, October, November and December 2022 and in January, February, March, April, May, June, July and August 2023. RI#4 was admitted to the facility on January 19, 2023 and had diagnoses which included cerebral infarction, heart disease, hypertension, atrial fibrillation, diabetes mellitus type 2, chronic kidney disease stage 3, chronic obstructive pulmonary disease, hyperlipidemia, dementia, major depressive disorder, anxiety, restless leg syndrome, insomnia, suicidal ideations and frequent falls. RI#4 was discharged from the facility on December 11, 2023. Refer to deficiencies 611 and 621 for additional information on RI#4. Monthly assessments, including medication awareness testing, had not been documented for RI#4 since April 2023. During an interview on January 9, 2024, at approximately 7:30 AM, EI#2, RN, stated she (EI#2) had been employed at the facility since September 2023 but did not take over responsibility for assessments of assisted living residents until around December 2023 when the	A 604		

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A 604	Continued From page 16 previous administrator left. Prior to that time, EI#2 reported she mainly assessed residents in the specialty care assisted living unit. EI#2 stated she (EI#2) had been unable to locate assessments of residents prior to that time and was unsure if the assessments had been completed.	A 604		
A 611	420-5-4-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards.	A 611		
	(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. (b) Plan of Care. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall be based on the initial medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be reviewed and updated based on the annual examination, and all other physician examinations, diagnoses, and recommendations of the resident's treating physician, and the resident's monthly assessments. The plan of care shall be developed and updated in cooperation with the resident and, if appropriate, the sponsor. All entries on the plan of care shall be accurately dated. 1. The plan shall at all times reflect the current condition of the resident and document the personal care and services required from the facility by the resident. In addition to other items			

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A 611	Continued From page 17 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 assisted living facilities shall be assisted and encouraged to maintain a clean, 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. Resident's hair shall be kept clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails	A 611		

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A 611	Continued From page 18 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 record reviews and interviews, residents' facility care plans were not updated to address the resident's diagnoses with appropriate interventions to meet the resident's care needs. Findings: Review of residents' facility records on January 10, 2024 revealed the following information. RI#1 had resided at the facility since August 18, 2018. Refer to deficiency 604 for additional information on RI#1. RI#1's current facility care plan was dated December 15, 2023 and did not include a diagnosis of dementia. However, hospital records, dated May 18, 2023, documented RI#1 was seen in the emergency department due to dementia and was given instructions on dementia. RI#4 resided at the facility from January 19, 2023	A 611		

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A 611	Continued From page 19 until December 11, 2023. Refer to deficiencies 604 and 621 for additional information on RI#4. RI#4 had repeated documentation of a diagnosis of dementia in the facility record. In addition, there was repeated documentation of RI#4 reporting suicidal thoughts and ideations as well as a diagnosis of suicidal ideation. The dementia and suicidal ideations were not addressed on RI#4's current facility care plan dated December 8, 2023. During an interview on January 9, 2024, at approximately 9:30 AM, EI#2, Registered Nurse, reported that she (EI#2) had been employed at the facility since September 2023 but was primarily working in the memory care facility in the same building until December 2023 after the previous administrator left. EI#2 was unsure who had been responsible for residents' care plans prior to that time.	A 611		
A 621	420-5-4-.06 (11) (b) Care of Residents. (b) Retention 1. An assisted living facility shall not allow any resident to return to the assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the facility is licensed to provide or the facility is capable of providing. 2. An assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility. 3. Residents who have unmanageable behaviors or behaviors that may be dangerous to	A 621		

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A 621	Continued From page 20 themselves or others shall not be retained in an assisted living facility. 4. An assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless: (i) The individual is capable of performing and does perform all tasks related to his or her own care; OR (ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity BUT the individual has sufficient cognitive ability to direct his or her own care AND the individual is able to direct others and does direct others to provide the physical assistance needed to complete such tasks, AND the facility staff is capable of providing such assistance and does provide such assistance. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. 5. If a resident of an assisted living facility is diagnosed with a terminal illness other than dementia and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90 days. If the facility is unable or becomes unable to meet the needs of a resident receiving hospice care, or if a resident receiving hospice care requires care beyond what the facility may lawfully provide pursuant to this section, then the facility shall promptly make arrangements to discharge or transfer the	A 621		

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A 621	Continued From page 21 resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for assisted living facilities. The facility would in all cases remain responsible for ensuring the appropriate delivery of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident. 6. All skilled services provided in the facility, such as but not limited to wound care or insertion of a urinary catheter, shall be provided by the staff of properly licensed or certified agencies. Skilled services shall not be delegated to facility staff. 7. Residents that develop acute infectious pulmonary disease, such as active tuberculosis, or other diseases capable of transmission to other individuals through normal person-to-person contact shall be immediately transferred to an appropriate level of care until certified by a physician to be free of a contagious condition. 8. No assisted living facility shall be operated in whole or in part in a manner that prevents free and unhindered egress from the facility by any of its residents. 9. An assisted living facility shall not retain any resident who cannot safely reside in the facility unless his or her egress from the facility is restricted. This Rule is not met as evidenced by: Based on record reviews and interviews, the	A 621		

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A 621	Continued From page 22 facility retained a resident who demonstrated and verbalized behaviors which could be dangerous to themselves or to others. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged a resident of the facility who had a diagnosis of dementia was not properly assessed, resulting in elopement of the resident from the facility. The surveyors were able to substantiate this complaint during the onsite survey. RI#4 resided at the facility from January 19, 2023 until December 11, 2023. Refer to deficiencies 604 and 611 for additional information on RI#4. Review of RI#4's facility record on January 9, 2024 revealed the following information. - Initial Medical Examination, dated January 10, 2023, documented Primary Diagnoses of dementia, major depressive disorder, anxiety, insomnia and suicidal ideations. - Resident Information/Emergency Contact Sheet documented Health History of dementia. - On June 1, 2023, the Certified Registered Nurse Practitioner (CRNP) wrote "...Staff report (he/she) has experienced weight loss. Will continue to monitor, may be due to depression/poor appetite...". - A physician's visit note, dated August 25, 2023, read, "...Dementia has a steady decline and will likely continue to worsen...Care Plan...Vascular dementia: Continues to decline. Not a candidate for medical therapy due to age and prognosis...". - On September 1, 2023, the CRNP note read,	A 621		

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A 621	Continued From page 23 "(He/she) tells me (he/she) doesn't want to live anymore and wants to roll (his/her) wheelchair out into the road...". On that date, RI#4 was sent to the psychiatric hospital for evaluation and treatment. - The following statement was signed by the physician and dated "9-18-23" on a Physician/Healthcare Provider Plan of Care: "I have examined this person and find no evidence to support the need for continuous skilled nursing care at this time. The person's needs can be met in the Specialty Care Assisted Living Facility setting". When interviewed on January 10, 2024, at approximately 5:00 PM, EI#1 stated the specialty care assisted living medical examination form was likely used instead of the assisted living medical examination form, causing this to possibly be an incorrect statement. - A Mini-Mental State Examination, dated September 19, 2023 and completed by the facility RN, documented a total score of 16/30 which indicates "Moderate: 10-20" under "suggested guideline for determining the severity of cognitive impairment". - A Physician's Order for lab, dated October 6, 2023, documented a diagnosis of altered mental status. - A Shift Report form for 10:00 PM until 6:00 AM on November 6, 2023 documented RI#4 "has come up thinking it's breakfast several times throughout the night". - A hospital Emergency Room note, dated November 17, 2023, documented the reason for the visit was "dementia" and instructions were given on dementia. - A Shift Report form for 10:00 PM until 6:00 AM on November 21, 2023 documented RI#4 had "been up all night". - On November 22, 2023, the Certified Medical Assistant documented, "...increased confusion	A 621		

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A 621	Continued From page 24 and agitation since last seen. Caregivers report (his/her) behaviors are worse in the afternoons... (He/she) was sent to the hospital recently to evaluate potential medical cause for increased confusion. (His/her) workup was negative and (he/she) was returned to the facility. (He/she) is confused but cooperative for exam. Memory impairment is evident with associated signs and symptoms of memory loss, difficulty reasoning/problem solving, difficulty handling complex tasks, difficulty with planning and confusion...". - A Shift Report form for 6:00 AM until 2:00 PM on December 3, 2023 documented RI#4 was "having some confusion today". During individual interviews with staff on January 9, 2024 and on January 23, 2024, five staff members (EI#4, EI#7, EI#9, EI#10 and EI#11) reported RI#4 had periods of confusion. An incident report was submitted by the facility to the Alabama Department of Public Health on December 11, 2023 at 12:45 PM. The facility reported that RI#4 was found by police outside the facility crossing a street on December 11, 2023 at 12:15 AM. The facility was notified by a 911 call. Paramedics were called by the police and RI#4 was taken to the hospital after being identified by facility staff. A police report from December 11, 2023 at 12:10 AM documented that RI#4 was found in his/her underwear crawling on the crosswalk of the two-lane street beside the facility. A paramedic report from December 11, 2023 at 12:20 AM documented that RI#4 was found sitting in the back seat of the police vehicle in a T-shirt and underwear. The report stated RI#4	A 621		

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A 621	Continued From page 25 was "confused and unable to articulate any details" but the deputy reported to the paramedic that he and his partner spotted RI#4 on the road on hands and knees crawling slowly in the dark. Hospital records were reviewed for RI#4 from December 11, 2023 until December 15, 2023 when RI#4 was discharged to a skilled nursing facility. According to the hospital records, RI#4 was admitted with acute mental status changes and a history of dementia. The Final Diagnosis listed acute encephalopathy with underlying dementia. It was noted that RI#4 had a Foley catheter inserted at the hospital due to urinary retention and RI#4 pulled the catheter out resulting in gross hematuria. An emergency room visit note read, "...(He/she) has dementia which appears to be fairly advanced...". The emergency room "Examination" report documented RI#4 had "bilateral knee abrasions". As noted above, RI#4's facility record contained documentation of repeated episodes of confusion, depression and suicidal thoughts and ideation which began prior to RI#4's admission to the assisted living facility. The only documented assessment of RI#4's mental status by facility staff was in September 2023 when a mini-mental examination was conducted and RI#4 was found to have moderate cognitive impairment. No assessment of RI#4's ability to utilize the unit dose packaging system for medications and to protect himself/herself from a medication error had been completed since April of 2023. RI#4's facility care plan had not been updated to address RI#4's dementia and suicidal ideation with appropriate precautions and interventions for staff to follow in protecting RI#4. RI#4 likely did not meet the criteria for retention in an assisted living facility due to altered mental status and an	A 621		

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A 621	Continued From page 26 unlocked facility as well as history of suicidal thoughts and ideations. RI#4 was found in the middle of the night, crawling across a road which intersected with a six-lane, extremely busy highway. The road where RI#4 was found by police was approximately 60 to 80 feet from the front entrance to the facility. The temperature at the time RI#4 eloped was around 30 degrees Fahrenheit, according to the complainant. RI#4 sustained actual harm in the form of knee abrasions and was at extreme risk of further harm due to failure of the facility to properly assess RI#4 and ensure RI#4 was residing in a safe environment where his/her care needs could be met. During an interview on January 10, 2024, at approximately 5:00 PM, both EI#1 and EI#2 agreed there was documentation and evidence of dementia and confusion in RI#4's facility record which indicated RI#4 should likely have been discharged to an appropriate level of care, preventing RI#4's elopement from the facility.	A 621		
A1001	420-5-4-.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,	A1001		

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A1001	Continued From page 27 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 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 that may create a health, safety, or sanitation hazard.	A1001		

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A1001	Continued From page 28 (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, and 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 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 were not maintained in a healthy, safe and sanitary manner. In addition, water temperatures were not maintained in a safe range.	A1001		

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A1001	Continued From page 29 Findings: Premises Not Properly Maintained 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 the facility for several months. Water Temperature On January 9, 2024, at approximately 4:50 PM, the water temperature was checked by surveyors in the bathroom of Resident Room 110 (vacant) and found to be 120 degrees Fahrenheit. This finding was discussed with EI#3 who agreed the water temperature was not acceptable and stated the temperature would be adjusted. On the morning of January 10, 2024, at approximately 7:00 AM, surveyors rechecked the water temperature in the bathroom of Resident Room	A1001		

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A1001	Continued From page 30 110 and found it to be 108 degrees Fahrenheit. EI#3 stated, when he adjusted the water temperature the previous day, it had been set at 120 degrees. EI#3 added that water temperatures had not been consistently checked until recently when he (EI#3) started working at the facility.	A1001		
A1002	420-5-4-.10 (2) Sanitation and Housekeeping. (2) Housekeeping and Physical Plant Maintenance. The facility must provide a safe, functional, sanitary, decent, 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	A1002		

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A1002	Continued From page 31 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 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 interviews, the facility Laundry Room was not maintained in a safe and sanitary manner. Findings: On the morning of January 9, 2024, at approximately 7:10 AM, surveyors observed the Laundry Room. The door to the Laundry Room was open and no staff attended the room at the time. OdoBan disinfectant, Lysol, lime solvent	A1002		

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A1002	Continued From page 32 cleaner and Spic-n-Span cleaner were noted in the Laundry Room, unsecured. 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. These findings were discussed with EI#1 on January 9, 2024, at approximately 9:00 AM. EI#1 agreed the Laundry Room had not been properly maintained.	A1002		
A1101	420-5-4-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift of Group and Congregate facilities. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the currently adopted Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be	A1101		

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A1101	Continued From page 33 assessed monthly, filed, and kept for at least three years. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs. (d) Roller latches are prohibited on doors separating corridors from adjacent spaces. (e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that: 1. Minimizes leaks and spills. 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	A1101		

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A1101	Continued From page 34 when its use is dictated by other requirements). 2. Fire alarm and sprinkler system outages of more than 4 hours require evacuation of the facility or the establishment of a continuous fire watch. The fire watch procedure must be coordinated with the Department and the local Fire Marshal. Outages and fire watch documentation shall be reported to the Department within 12 hours or no later than the next duty day, and shall be corrected expeditiously.	A1101		
	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			

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A1101	Continued From page 35 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, 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	420-5-4-.12 (5) Physical Environment. (5) General Building Requirements - Family, 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.	A1203		

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A1203	Continued From page 36 (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 insect screens. Screen doors shall be equipped with self-closing devices. (e) Emergency Lighting. 1. All assisted living facilities shall provide emergency artificial lighting to adequately illuminate halls, corridors, kitchens, dining areas, 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	A1203		

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A1203	Continued From page 37 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.	A1203		
	(h) Windows. Operable windows shall be so constructed and maintained so that they fit snugly, and are capable of being opened and closed easily. (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 purpose. All walls and doors under stairs shall meet the same fire rating as the stairwell. (l) Doors. 1. In each new assisted living facility, doors of resident bathrooms connected to			

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A1203	Continued From page 38 resident bedrooms 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 each assisted living facility shall be at least three feet wide. Bedroom doors in Family assisted living facilities shall not be less than 32 inches 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 special locking arrangements are permitted only in specialty care assisted living facilities. 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. Exit doors of Family facilities may swing inward. (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	A1203		

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A1203	Continued From page 39 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 designated staff of the facility and documented on the attached extinguisher tag by the designated staff person. (o) Call System. Except in Family facilities, 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 Group and Congregate 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	A1203		

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A1203	Continued From page 40 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. 2. Open flame and portable heaters are prohibited in 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 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.	A1203		

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A1203	Continued From page 41 Findings: Building Not in Good Repair On the morning of January 11, 2024, at approximately 8:00 AM, the surveyors and EI#1 observed the interior and 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. - The maintenance room/fire panel room on the 300 hall was cluttered and had large items stored near the fire panel. The room was cleaned by EI#3 during the onsite survey. - The room which housed the water heater (near room 302) was also used for storage of housekeeping carts and cleaning items. These items were stored within 1-2 feet of the water heater. - Resident Room 303 contained no toilet and the wall in the bathroom had been repaired but not repainted. There was debris in the bathroom floor from the wall portion that had been removed. EI#1 stated the wall repair was due to a leak. - The bathroom floor in Resident Room 310 was linoleum which was curled upward on all edges. - Multiple resident rooms contained cabinets for	A1203		

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A1203	Continued From page 42 small refrigerators. The boards under the refrigerators were filthy and worn to the extent that there was sagging of the boards. - The carpet in Resident Room 316 was badly stained. - The flooring in bathrooms of multiple resident rooms was stained and worn. - The staff break room contained multiple large chipped areas in the plaster walls and was in need of painting. - The ceiling in the hallway near Resident Room 101 was sagging. EI#1 reported a leak had recently been repaired in that area. - In Resident Room 115 all walls were in need of paint, plaster on the walls was badly chipped, the bathroom floor was stained and worn and the doors were in need of repair and paint. - There were multiple areas in the ceiling where water leaks had been repaired which had not been repainted. - The Mechanical Room on the 100 hall was cluttered and contained a plastic pipe which led from the ceiling to a bucket on the floor. No one at the facility was able to explain the purpose of this pipe. 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. EI#1 acknowledged the building was in need of numerous repairs. EI#1 added that there had	A1203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D1705	A. BUILDING: _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF THE SHOALS ALF, THE	2904 S WILSON DAM RD MUSCLE SHOALS, AL 35661

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A1203	Continued From page 43 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, limiting the time he (EI#3) was available for maintenance duties at this facility. CONNIE CHERRY, REGISTERED NURSE TROY BLACK, REGISTERED NURSE	A1203		