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
	P4515	A. BUILDING: ______ B. WING ______	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THRIVE AT JONES FARM SCALF	2238 CECIL ASHBURN DR SE HUNTSVILLE, AL 35802

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A 000	Initial Comments This is a 26 bed Specialty Care Assisted Living Facility (SCALF) with a census of 26 on July 11, 2019. There was one (1) complaint investigated during this survey. Complaint LC#007-2018 was investigated and no deficiencies were cited. 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 requires a plan of correction.	A 000		
A 303	420-5-20-.03 (2) (a) Administration. (2) The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the specialty care assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an administrator shall meet all applicable statutory requirements. 4. There must be an individual with	A 303		

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A 303	Continued From page 1 experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days. 5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age. 6. The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character. 7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week. 8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment and adequate care actually being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement. 9. The facility administrator is responsible for ensuring that required training is provided to all staff. 10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting.	A 303		

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A 303	Continued From page 2 11. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when needed. 12. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan. 13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained. This Rule is not met as evidenced by: Based on interviews and record reviews, the Administrator failed to failed to ensure Plans of Care for all residents were current and appropriate. In addition, the Administrator failed to ensure the screening assessments were completed as required. Findings: On July 9, 2019, the surveyor requested to review the most current Care Plans. The Care Plans for Resident Identifier (RI)#2, RI#3, RI#4 and RI#5 were not current or based on the resident's needs and problems. Refer to deficiencies 604 and 611 for additional information.	A 303		
A 402	420-5-20-.04 (3) Personnel. (3) Employee Screening.	A 402		

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A 402	Continued From page 3 (a) Prior to any resident contact, such as but not limited to assistance with activities of daily living, newly employed personnel shall have a physical examination certifying that the employee is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to residents through normal staff to resident contact. Employees who develop signs or symptoms of infectious skin lesions or diseases that would be capable of transmission to residents through normal staff to resident contact shall not be permitted to have resident contact until free from such signs and symptoms. (b) Not more than 30 days prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis. (c) Vaccines. Specialty care assisted living facilities shall immunize employees in accordance with current recommended Centers for Disease Control and Prevention (CDC) guidelines (www.cdc.gov/vaccines). Any particular vaccination requirement may be waived or delayed by the State Health Officer in the event of a vaccine shortage. (d) A specialty care assisted living facility shall not hire an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure newly employed personnel had a physical examination certifying they were free of signs and symptoms of infectious diseases prior to resident contact.	A 402		

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A 402	Continued From page 4 Findings: Review of employee personnel files revealed five (5) employees did not have a statement certifying they were free of infectious diseases. Employee Identifier (EI)#2, EI#9, EI#10, EI#11, and EI#12 all had daily contact with residents. The physician provided the following statement, "Physically Qualified" but did not address infectious skin lesions or diseases. On July 11, 2019, EI#1, Administrator, informed the surveyor a form would be devised to include the appropriate employee screening information.	A 402		
A 601	420-5-20-.06 (1) Care of Residents. (1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician. (a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her choice. If the resident is unable to designate an attending physician, or does not wish to designate an attending physician, the facility shall assist the resident in identifying an attending physician who will serve the resident. A resident shall be permitted to change the designation of his or her attending physician at any time. Whenever a resident requires medical attention, an attempt shall first be made to contact the resident's attending physician, except in medical emergencies requiring activation of the local EMS system (911 or other emergency call). (b) Back-up Physician Support. Each specialty care assisted living facility shall have an agreement with one or more duly licensed	A 601		

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physicians to serve in those instances when a resident's own attending physician cannot be reached, and to provide temporary medical attention to any resident whose attending physician is temporarily not available. A nurse practitioner or physician's assistant shall not serve as the back-up physician in a specialty care assisted living facility.

(c) All physician orders shall be written in accordance with community standards. If verbal orders are used, they are to be used infrequently. A physician verbal order shall only be accepted by an RN or LPN employed by the facility and authorized to do so by facility policy and procedures and state law. All verbal orders shall be reduced to writing on the physicians' order sheet by a licensed facility nurse and shall be dated and signed by the nurse receiving the order. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, or another practitioner who is responsible for the care of the resident and authorized to write orders by facility policy. All verbal orders must be authenticated within such time period as provided by facility policy, but in no case shall exceed 30 days following entry of the order.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure physician's orders were followed as written.

Findings:

RI#3 had a fall on June 3, 2019 and was sent to the emergency department for evaluation. The certified registered nurse practioner (CRNP) was

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A 601	Continued From page 6 notified and orders were written on June 5, 2019. The CRNP ordered a urinalysis and a comprehensive metabolic panel (CMP). However, the record did not include the CMP laboratory report. EI#4, Licensed practical Nurse (LPN), confirmed the blood test had not been completed as ordered.	A 601		
A 604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility RN or care coordinator shall screen prospective residents for eligibility for admission into the specialty care assisted living facility. The screening shall include a clinical history, a mental status examination to include aphasia screening, a geriatric depression screen, a physical self-maintenance screen, and a behavior screen. Appendix A herein, contains the Physical Self Maintenance Scale (PSMS) form and the Behavior Screening form. These forms shall be completed to screen physical functioning and behaviors. The PSMS and Behavior Screen assessments shall be completed by the RN or care coordinator upon admission, annually, and when there is a change in the resident's status. The facility RN shall perform a comprehensive assessment of each prospective resident for facility eligibility. This assessment shall document identified care needs and serve as a baseline for the RN plan of care and future assessments.	A 604		

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(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 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).

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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).

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 observations, record reviews and interviews, the facility's Registered Nurse (RN) failed to complete initial assessments less than 30 days prior to admission and failed to complete a comprehensive assessment for every prospective resident. In addition, the RN failed to perform comprehensive assessments, Physical Self Maintenance Scales (PSMS), and behavior screenings after residents experienced health status changes.

Findings:

Initial Assessment No More Than 30 days Prior to Admission:

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RI#1 was admitted to the facility on October 30, 2017. The initial mental status examination and aphasia screening were dated September 6, 2017. The geriatric screening was not dated.

Comprehensive Assessment of Each Prospective Resident for Eligibility:

RI#3 was admitted to the facility on April 23, 2019, however, the file did not contain the initial comprehensive assessment. EI#2, RN, said it had been done at the time of admission but the supporting documentation could not be found.

Comprehensive Assessment, PSMS and Behavior Screen:

The RN did not complete the required screenings listed above when there were changes in the following resident's health status:

RI#1 was sent out of the facility on November 27, 2018 due to "respiratory issues" (coughing and wheezing). RI#1 remained out of the facility for three (3) weeks and returned December 20, 2018 with two (2) new diagnoses of cardiac arrhythmia and urinary tract infection.

RI#2 had pressure ulcers to "re-open" on the right hip and right buttocks. On April 26, 2019, the CRNP ordered skilled nursing to treat the pressure ulcers.

RI#3 exhibited aggressive (hitting) and inappropriate behaviors (exposing self) toward the staff. On April 28, 2019, RI#3 was transferred to a geriatric psychiatric unit for five (5) days of treatment .

RI#4 experienced a decrease in mental status,

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A 604	Continued From page 10 increased weakness, hypertension (167/100) and tachycardia (pulse 113) on June 11, 2019. RI#4 was sent to the emergency department for evaluation and treated for an acute urinary tract infection. RI#5 was admitted to hospice services on May 7, 2019 with a terminal diagnosis of Alzheimer's disease. RI#5 had numerous falls in the months of May 2019 and June 2019 which were within 30 days.	A 604		
A 611	420-5-20-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. The RN shall develop written plans of care for each resident prior to or at the time of admission. The plans of care shall be based on resident's assessments, diagnoses, and recommendations of the resident's physician. The plan of care shall be developed in cooperation with the resident, if appropriate, and the sponsor. The RN shall identify resident care problem areas and formulate written interventions to address those problems. The RN shall evaluate the implementation of the interventions and the resident's response to the interventions and modify the plan of care as necessary. 1. The plan shall at all times reflect the	A 611		

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current condition of the resident. All entries on the plan of care shall be accurately dated. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following:

2. A listing of the resident's individual needs or problems that require intervention by the facility.

3. A listing of interventions provided by the facility to address the resident's identified needs or problems.

4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider.

5. Activities of Daily Living. Residents of a specialty care assisted living facility shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident.

(i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested.

(ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips.

(iii) Hair. Residents' hair shall be kept clean, neat, and well groomed.

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(iv) Manicure. Fingernails and toenails shall be kept clean and trimmed.

(v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed.

(vi) Personal Safety. Residents shall be provided assistance with personal safety.

6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility's Registered Nurse (RN) failed to develop appropriate written Care Plans (CP). The RN also failed to identify problem areas and formulate written interventions. In addition, a copy of the outside provider's plan of care was not available for all residents.

Findings:

Care Plans:

RI#2 had been a resident at the facility since October 31, 2017. The CP on file was dated October 31, 2017. RI#2's most recent Medical Examination and Plan of Care was completed the physician on October 1, 2018 (annual). The diagnoses included, displaced femur fracture, history of falling, adjustment disorder with depressed mood, right hip pain, dementia without behavioral disturbance, Parkinson's disease,

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A 611	Continued From page 13 chronic obstructive pulmonary disease (COPD), and anxiety. On January 22, 2019, RI#2 began receiving wound care (skilled nursing) to pressure ulcers on the right hip (Stage 2) and right buttock. The pressure ulcers healed but "re-opened" on April 25, 2019. RI#2 was referred to a local wound clinic on June 5, 2019 and daily dressing changes were ordered on June 18, 2019. During the survey RI#2 was observed to be sitting in a wing back chair in the common area for 2-3 hours at a time. On July 9, 2019 at 4:25 PM, the surveyor observed the home health nurse perform wound care on the right lateral trochanter (hip). The nurse informed the surveyor, EI#2, RN, and EI#4, LPN the wound had not improved since the last dressing change. The CP did not include interventions (off-loading) such as re-positioning every 2 hours while sitting or lying to reduce the pressure on the ulcers. RI#3 was admitted to the facility on April 23, 2019, with diagnoses to include osteoarthritis, gastroesophageal reflux disease (GERD), hypertension, dementia, hyperlipidemia, allergic rhinitis, and benign prostatic hyperplasia (BPH). The CP presented to the surveyor was dated April 24, 2019. RI#3 began experiencing aggressive and inappropriate behaviors with staff on the day of arrival but the CP did not mention these two (2) types of behaviors as problems. RI#3 continued to have behaviors and was transferred to a geriatric psychiatric unit on April 28, 2019 and returned the facility on June 4, 2019. However, the CP was not updated with appropriate interventions to address these behaviors should they reoccur. RI#4's admission date was October 23, 2017. There were numerous admitting diagnoses listed on the Physician Evaluation Form dated October	A 611		

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9, 2017. However, the diagnosis of anxiety was not listed as a problem on the CP. The staff described RI#4 to have agitation, attention seeking behaviors, and pacing the hallways. The surveyor was frequently approached by RI#4 throughout the survey anxiously asking the surveyor for help. RI#4 was being treated with alprazolam (Xanax) 0.25 mg daily for anxiety. The CP did not reflect any of these types of behaviors.

RI#5 was admitted to the facility on October 17, 2017. The Physician Evaluation Form listed dementia, hypertension, hypothyroidism, and osteoarthritis as diagnoses. On April 14, 2019, RI#5 was sent to the emergency department for a decreased level of consciousness and abnormal vital signs. RI#5 returned to the facility four (4) days later with a new diagnosis of seizures, however, the CP was not updated with any seizure precaution measures. RI#5 had numerous falls listed on the CP. However, the interventions that were in place did not prevent falls from being repeated.

Home Health and Hospice Services Certification and Plan of Care:

RI#2 had been receiving skilled nursing services for wound care since June 23, 2019. However, there was not a provider's plan of care in RI#4's record. EI#3, LPN, contacted the provider and a faxed copy of the certification and plan of care was received by the facility on July 9, 2019 at 1:33 PM.

RI#5 was admitted to hospice services on May 7, 2019. The hospice plan of care had not been received by the facility. On July 9, 2019 at 3:45 PM, a copy of the plan of care was faxed from the hospice provider.

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THRIVE AT JONES FARM SCALF	2238 CECIL ASHBURN DR SE HUNTSVILLE, AL 35802

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A1101	420-5-20-.11 (1) Fire and Safety	A1101		

420-5-20-.11 (1) Fire and Safety

(1) General.

(a) Fire Safety and Emergency Plan. All specialty care assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place.

(b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years.

(c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs.

(d) Roller latches are prohibited on doors separating corridors from adjacent spaces.

(e) If alcohol-based hand rub dispensers

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A1101	Continued From page 16 are used in the facility, the dispensers must be installed in a manner that: 1. Minimizes leaks and spills. 2. Adequately protects against inappropriate access. 3. Complies with the requirements of the currently adopted Life Safety Code. (f) Fire Alarm and Sprinkler System. 1. Fire Alarm System. Where fire alarm systems are required, a corridor smoke detection system shall be installed on each floor, including areas open to the exit access corridor, to comply with NFPA 72, connected to the facility's fire alarm system. In lieu of corridor smoke detection, smoke detectors connected to the building fire alarm system may be installed in each resident's room, open areas, and at smoke doors (except that corridor smoke detection shall not be deleted when its use is dictated by other requirements). 2. Fire alarm and sprinkler system outages of more than 4 hours require evacuation of the facility or the establishment of a continuous fire watch. The fire watch procedure must be coordinated with the Department and the local Fire Marshal. Outages and fire watch documentation shall be reported to the Department within 12 hours or no later than the next duty day, and shall be corrected expeditiously. 3. The fire alarm system and the sprinkler system shall be inspected by licensed, trained, and qualified personnel at least	A1101		

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A1101	Continued From page 17 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, the facility failed to conduct fire drills every month.. Findings: On July 9, 2019, the surveyor reviewed the facility's monthly fire drill reports for 2017, 2018 and 2019. The facility had not conducted fire drills for the following months; 3rd quarter 2017 (December), 4th quarter 2018 (November), and 1st quarter 2019 (March). EI#1 acknowledged the fire drills had not been done monthly. EI#1 also said the facility had hired a new Physical Plant Manager (EI#6) in April 2019 to correct the problem.	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.	A1203		

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(c) Lighting. Each resident's room shall have artificial light adequate for reading and other uses as needed. All entrances, hallways, stairways, inclines, ramps, cellars, attics, storerooms, kitchens, laundries, and service units shall have sufficient artificial lighting to prevent accidents and promote efficiency of service. Night lights shall be provided in all hallways, stairways, and bathrooms.

(d) Screens. All screen doors and operable windows shall be equipped with tight-fitting, full-length 16 mesh screens. Screen doors shall be equipped with self-closing devices.

(e) Emergency Lighting.

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.

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A1203	Continued From page 19 2. Any differences in floor levels shall not prevent a resident from navigating safely throughout the facility. (g) Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface and shall be kept clean and in good repair. (h) Windows. Operable windows shall be so constructed and maintained so that they fit snugly, and are capable of being opened and closed easily. Windows in specialty care facilities may have devices which prevent full opening of the window. (i) Ceiling Height. Each room occupied by residents shall have a ceiling height of eight 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	A1203		

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A1203	Continued From page 20 connected to resident bedroom shall swing into the bedroom. 2. Bedroom and bathroom doors may be equipped with hardware that will permit a resident to lock himself within the room, provided a master key is readily accessible for the staff at a central location. 3. Resident bedroom and other exit access doors in specialty care assisted living facility shall be at least three feet wide. 4. Exterior egress doors except the main entry/exit door, may be equipped with a delayed egress locking system installed in accordance with NFPA 101. Other exterior egress doors may be arranged to prevent free and 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	A1203		

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A1203	Continued From page 21 extinguishers shall be provided for each hall, kitchen, and laundry, of type and capacity appropriate to the need. 1. Each fire extinguisher shall receive an annual inspection with maintenance, and recharging when necessary, by a fire equipment servicing representative. An annual servicing tag shall be attached to the extinguisher reflecting the name of the servicing company, representative, day, month, and year of maintenance. 2. A visual inspection of each fire extinguisher shall be conducted monthly by a designated staff of the facility and documented on the attached extinguisher tag by the designated staff person. (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	A1203		

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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 specialty care assisted living facilities. This does not apply to a fire place with gas logs protected as noted elsewhere in these rules.

3. Lighting shall be restricted to electricity. Electric wiring, motors, and other electrical equipment in all specialty care assisted living facilities shall be in accordance with local electrical codes and the NFPA National Electrical Code.

This Rule is not met as evidenced by:
Based on observation and interview the facility failed to maintain the courtyard exit door in good and safe repair.

Findings:

On July 8, 2019 at 12:40 PM, the surveyor exited

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A1203	Continued From page 23 the building through the courtyard door. The surveyor and EI#7, LPN, observed a twisted piece of wire approximately 8 inches long that was exposed at the bottom of the door. EI#7 told the surveyor the door would be repaired immediately. DEBRA FREEMAN, REGISTERED NURSE	A1203		