Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943102	A. BUILDING: _____ B. WING _____	05/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL ASSISTED LIVING AT PALM BEACH LLC	2090 N. CONGRESS AVENUE WEST PALM BEACH, FL 33401

(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 An unannounced Complaint survey (#2022006962) was conducted on . . . . . through at Colonial Assisted Living At Palm Beach LLC. The facility had deficiencies identified at the time of the survey.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of . . . . . or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , ... The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making . , , ... for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

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A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate supervision, oversight and assessment for 1 of 1 sampled residents, Resident #1. As evidenced by Resident #1 was readmitted to the facility after a 4-month extended rehabilitation stay; was not appropriately assessed for any [illegible] status changes post readmission; and subsequently had access to matches which he used to start a fatal fire in his room. As a result, Resident #1 succumbed to smoke inhalation and [illegible]. This failure had the potential to affect the other 93 residents residing in the facility who could have been affected by the fire and smoke.	A 025		

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A 025	Continued From page 2 The findings included: Review of the incident report filed by the facility with the Agency on . . . . . revealed the following: a. On at approximately 5:54 AM Staff B was on rounds and heard an alarm going off near . , she smelled smoke called 911 and for help from coworkers. b. The facility staff alerted their supervisors and evacuated all residents by 6:10 AM. c. The apartment 215 could not be evacuated as the door was hot and the smoke was overpowering. d. At 6:07 AM Management arrived at the community. e. The source of the fire was . . . . ., the room of Resident #1. f. The fire department arrived along with paramedics and pronounced resident . The fire was extinguished. g. The Fire officials informed us that Resident #1 had expired due to smoke inhalation. The fire inspector found matches and candles in the residents room. Review of the law enforcement Incident/Investigation Report dated revealed that "the resident (Resident #1) in 215 was found at approximately 0611 hrs. (Resident #1) was found in the restroom sitting on the toilet with a box of matches that was scattered throughout the bathroom ...Once the fire was put out and the area made safe by Fire Rescue, the crime scene was secured and crime scene tape was put up. Upon checking the room, I observed a burnt mattress in the living room and numerous matches scattered through out the	A 025		

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A 025	Continued From page 3 floor. There were more matches and a box of matches on the floor of the bathroom. The damage was contained to apt 215". Review of Resident #1's record on revealed the resident moved into the facility in 2018. His health assessments (AHCA Form 1823) noted the following: a. assessment: Diagnosis of "'s" with or Behavioral Status is "alert, disoriented, but can follow si (simple instructions)". b. assessment: Diagnoses of "'s" and "ETOH ( )" with or Behavioral Status as "alert with some level of orientation but also ". c. assessment: Diagnoses of " related, , 's , , (cerbral /), and lack of coordination" with or Behavioral Status as "alert and oriented but forgetful due to ". Additionally, the resident was noted to have an "unsteady gait", required "supervision with ambulation and transfers" and was receiving "hospice" nursing care. A facility Case Note indicates Resident #1 had an unwitnessed on and was transferred to the hospital. A nursing home Minimum Data Set (MDS) note dated shows he was admitted to the nursing home on . He did not return to the facility until as indicated in a facility Case Note. Hospice notes show that the resident was referred to hospice on and admitted on with a diagnosis of " " with a secondary diagnosis of "	A 025		

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A 025	Continued From page 4 without behavioral disturbance". A Nursing Home Medication Review Report dated notes additional diagnoses of "Major , , Single Episode, Unspecified; due to of unspecified , ; other symptoms and signs involving functions and awareness; and, communication ". Further review of the MDS report dated completed by the Nursing Home for Resident #1 revealed the following. Section C Patterns, the resident was assessed for the ( ) to have a score of 3 out of 15 indicating he had severe . During interview with the Director Of Nursing (DON)/Licensed Practical Nurse (LPN) at the facility on at 10:00 AM, she confirmed that Resident #1 returned to the same room that he occupied before transferring out on . She stated he had matches in the room when he was found on but that the facility staff did not know of the resident's possession of the matches prior to the fire being lit. She stated that the resident did go on shopping outings in the community prior to his admission and stay at the nursing home from through . It was possible that the resident had obtained the matches while shopping. The resident's room and belongings were not assessed for safety prior to the resident's return to the facility on . During a telephone interview conducted with the Fire Inspector on at 11:49 AM, he stated that the facility's sprinkler system on the second floor of the building was , since . He stated that the sprinkler that had been disengaged in and the rest of the	A 025		

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A 025	Continued From page 5 second floor did not activate to extinguish the fire on due to the water being turned off. Review of the Fire Incident report dated notes that the alarm at the facility was activated at 5:49 AM for a "water or stream leak". A note on the report dated at 8:57 AM narrates that the fire department "arrived to the above location (facility) to find a broken fire sprinkler in apartment 215; (units) were requested to assist with water removal until maintenance showed up. Scene was turned over to building manager." Another Fire Incident report dated notes that the alarm was activated at 8:22 AM for "sprinkler activation" with all units cleared at 8:33 AM. During an interview conducted with Staff D (Executive Director) at 12:00 PM on , he stated that there were repairs made to the fire sprinkler system on and the sprinkler company returned to turn the water on, but that "corporate had taken over" with the arrangement of the repairs. He stated he was aware of the water being turned off to the sprinkler system, but was not aware if it had been turned on. A single invoice from a sprinkler company made to the attention of two ALF representatives was presented and noted "On , (the sprinkler company) responded to an urgent call of a broken " fire sprinkler drop at the above referenced location (ALF address). We arrived ( ) the following day to turn on water after 24 hour dry time for glue to restore system." Staff D stated during the interview at this time that the water was turned on after the initial repair on , but "another sprinkler broke and the water had to be turned off".	A 025		

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A 025	Continued From page 6 An email received by Staff C (Owner) on . . . . at 5:57 PM notes " a sprinkler line burst on the second floor...Fire Safety company came out and restored the sprinkler system along with fire panel... . . . . sprinkler pipe burst in adjacent area...Fire panel was reset...the sprinkler lines seemed faulty and may have to be replaced...Faced with significant potential costs for replacement and more so, a very long "down time" for replacing piping etc. the landlord sought out a professional diagnostics company that specializes specifically in this area. (A company) out of Michigan finally replied . . . that they would be willing to inspect the piping and report findings in weeks...final results were only reported in early ...(A company name) was awarded the contract on 4.4.22". A copy of the work proposal submitted to the ALF's Plant Operations Manager with the new fire sprinkler repair company was signed on by the ALF's Vice President Of Operations. Caregiver Staff A who worked the 11:00 PM through 7:00 AM shift on stated during an interview conducted on . . . . . at 10:30 AM that she heard "light beeping in room across Resident #1's room" which was the smoke detector, and "after looking around identified . . . . . as the room with smoke". Staff A "saw silhouette of Resident #1 on floor in the bathroom but could not get to him... . . . her . . . on the door knob trying to open it four times". Caregiver Staff B who worked the 11:00 PM through 7:00 AM shift on stated during an interview conducted on . . . . . at 2:35 PM that she heard "beeping from room across (smoke detector)" and was with Staff A when Staff A attempted to open the door of to get to the resident but the smoke was too heavy. Both staff stated there was no smoke alarm beeping	A 025		

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A 025	Continued From page 7 from . . . . . During an interview conducted on . . . . . at 10:00 AM with the Maintenance Technician, he stated that the last time the smoke detectors were checked were in 2021 but he had no documentation showing that any checks on the detectors were made. He stated that he assisted the Maintenance Director with checking the smoke detectors when he was employed by the facility, but the facility does not currently have a Maintenance Director. The Maintenance Director who was employed by the facility from . . . . through . . . . . stated during a telephone interview conducted on . . . . . at 11:00 AM that while he was employed he conducted monthly checks on the smoke detectors located in each resident's room. He stated that he documented the checks and need for repair or replacement but that he did not know where the documentation was at this time. During an interview conducted with the Executive Director on at 1:30 PM, he was asked for documentation showing the smoke detectors were checked and the policy and procedure for these checks. On . . . . . at 9:45 AM, a list of resident rooms was presented, indicating checks were done on each smoke detector. The Executive Director stated at this time that the Maintenance Director conducted these checks on and . The list documented by a check mark under "fail" or a notation of "replacing" that seven smoke detectors were currently . , ... , including the one in Resident #1's . During a telephone interview conducted with Resident #1's representative on . . . . . at 10:16 AM, she stated that the resident was a	A 025		

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A 025	Continued From page 8 non-smoker and there was no reason for matches or two candles to be in the room as he never used either of them that she was aware of. She stated that she was "in the resident's room in around Christmas time" last, and that the resident was "neat and tidy" with "no matches or candles" observed. Review of the facility's census and 2nd floor roster revealed at the time of the fire incident regarding Resident #1 approximately 47 residents resided on the second floor. Resident #1 having access to matches and not being supervised placed all of the remaining residents at risk that resided on that floor. Based on the above findings, the facility failed to thoroughly assess Resident #1's status and safety of his environment upon return to the facility after an extensive leave of absence from through . The facility failed to provide adequate supervision of this resident, neglecting his safety, by allowing the resident to return to where the fire sprinkler system and smoke detector were and fire producing items were accessible. Class I	A 025		
A 077	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational	A 077		

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A 077	Continued From page 9 requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.;	A 077		

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A 077	Continued From page 10 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , , , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each	A 077		

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A 077	Continued From page 11 other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure there was a designated Administrator who was responsible for the operation, maintenance and oversight of the facility and staff to ensure a safe living environment and appropriate provision of care directly affecting 94 of 94 residents currently residing in the facility (Resident #1 through Resident #94).	A 077		

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A 077	Continued From page 12 The findings included: On [redacted] at 10:00 AM, Staff D (Executive Director) stated that he was "not the Administrator of the ALF", and that he was the "Executive Director" of the ALF. During another interview conducted with Staff D at 12:00 PM on [redacted], he stated that there were repairs made to the fire sprinkler system on [redacted] and the sprinkler company returned to turn the water on, but that "corporate had taken over" with the arrangement of the repairs. Staff D stated that he is not responsible for the financial components of operating the building (including making building repairs) and that Staff C (Owner of the facility) is responsible for this. He stated he was aware of the water being turned off to the sprinkler system, but was not aware if it had been turned on. A single invoice from a sprinkler company made to the attention of two ALF representatives, not the ED, was presented and noted "On [redacted], (the sprinkler company) responded to an urgent call of a broken [redacted]" fire sprinkler drop at the above referenced location (ALF address). We arrived ([redacted]) the following day to turn on water after 24 hour dry time for glue to restore system." Staff D stated during the interview at this time that the water was turned on after the initial repair on [redacted], but "another sprinkler broke and the water had to be turned [redacted] off". Review of the Executive Director's Job Description revealed the following position duties: a. The primary purpose of this position is to develop, coordinate, direct and administer policies and procedures appropriate to an assisted living facility in accordance with current federal, state and local standards, guidelines and	A 077		

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A 077	Continued From page 13 regulations that govern the protection of the rights of the residents and employees. b. Ensure that all facility personnel, residents, visitors, and guests follow established safety regulations, including fire safety, department of health guidelines, control and sanitary conditions throughout facility. c. Ensure that the building and grounds are maintained in good repair. The facility failed to thoroughly assess Resident #1's status and safety of his environment upon return to the facility after an extensive leave of absence from through . The facility failed to provide adequate supervision of this resident, neglecting his safety, by allowing the resident to return to where the fire sprinkler system and smoke detector were , and fire producing items were accessible, resulting in the of Resident #1. The facility failed to ensure the water was on for the fire sprinkler system (on the 2nd floor) to work since which could have prevented Resident #1's mattress from and causing smoke that caused the resident's . Additionally, the smoke detector in Resident #1's room was not checked for operation regularly and upon the resident's return after him being absent from through . These failures of adequate assessment of a resident and the environment, the maintenance of the fire sprinkler system and smoke detectors and lack of supervision of a resident with , lead to Resident #1's in a fire at the facility in the resident's room on . Class I	A 077		

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	AL11943102	A. BUILDING: _____ B. WING _____	05/16/2022

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A 152	Continued From page 14	A 152		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not	A 152		

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A 152	Continued From page 15 be . . . . . . This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure its residents were provided with a safe living environment for 50 of 50 residents residing on the second floor, to include Resident #1. The facility failed to ensure the fire sprinkler system was functioning on the entire second floor. Additionally, the facility failed to maintain an operable smoke detector in . . , Resident #1's room. As a result of these failures, when a fire was started in Resident #1's living quarters, the , sprinklers and smoke detector were directly related to Resident #1 succumbing to smoke inhalation and subsequently dying. The findings included: Resident #1 returned to the facility on . . . . . after an approximate four month stay receiving rehabilitation at the Nursing Home located on the campus. On , the resident was able to obtain matches and started a fire within his room (located on the 2nd floor), and subsequently perished as a result of the fire. During a telephone interview conducted with the Fire Inspector on at 11:49 AM, he stated that the facility's "sprinkler system on the second floor of the building was , since ". He stated that the "water valve to the 3rd branch or second floor" of the system was turned off due to repairs needed and had not been turned . . . . on since. He stated that the water being turned off was a "critical deficiency" that was required to be reported to the fire department because it occurred for more than 24 hours. This , was "not reported to the fire	A 152		

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A 152	Continued From page 16 department". The sprinkler that had been disengaged in and the rest of the second floor sprinklers did not activate to extinguish the fire on due to the water being turned off. Review of www.safeopedia.com on , titled What is a Sprinkler System, revealed the following. A sprinkler system is a fire fighting device that is installed in buildings as a preventative measure. The sprinkler heads are placed in the ceilings facing toward either the floor or towards any fire hit spots. The other end of the sprinkler system is connected to a number of pipes and a high pressure water supply. Review of the law enforcement Incident/Investigation Report dated revealed that "the resident (Resident #1) in 215 was found at approximately 0611 hrs. (Resident #1) was found in the restroom sitting on the toilet with a box of matches that was scattered throughout the bathroom ...Once the fire was put out and the area made safe by Fire Rescue, the crime scene was secured and crime scene tape was put up. Upon checking the room, I observed a burnt mattress in the living room and numerous matches scattered through out the floor. There were more matches and a box of matches on the floor of the bathroom. The damage was contained to apt 215". Review of the incident report filed by the facility with the Agency on revealed the following: a. On at approximately 5:54AM Staff B was on rounds and heard an alarm going off near ; she smelled smoke, called for 911 and for help from coworkers.	A 152		

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A 152	Continued From page 17 b. The facility staff alerted their supervisors and evacuated all residents by 6:10 AM. c. The apartment 215 could not be evacuated as the door was hot and the smoke was overpowering. d. At 6:07 AM management arrived at the community. e. The source of the fire was , the room of Resident #1. f. The fire department arrived along with paramedics and pronounced resident . The fire was extinguished. g. The Fire officials informed us that Resident #1 had expired due to smoke inhalation. The fire inspector found matches and candles in the resident's room. Review of the Fire Incident report completed by the fire department dated notes that the fire alarm at the facility was activated at 5:49 AM for a "water or stream leak". A note dated at 8:57 AM narrates that the fire department "arrived to the above location (facility) to find a broken fire sprinkler in apartment 215; (units) were requested to assist with water removal until maintenance showed up. Scene was turned over to building manager." Another Fire Incident report dated notes that the alarm was activated at 8:22 AM for "sprinkler activation" with all units cleared at 8:33 AM. Observation of (Resident #1's room) was made on at 11:00 AM. The furniture, carpet and tile in the bathroom, and remaining personal effects were dry. The Executive Director stated during an interview conducted at this time that the sprinkler system did not activate on when the fire was started by Resident #1. A second observation of the room on at 1:00 PM revealed the	A 152		

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A 152	Continued From page 18 room had two sprinkler heads in the bedroom area above the mattress (1 to the left and 1 to the right of the bed) that was burnt, another sprinkler in the entryway by the door, 1 in the resident's closet across from his bed, 1 in the linen closet near the bathroom and another in the bathroom (5 total sprinkler heads). During an interview conducted with the Staff D (Executive Director) at 12:00 PM on , he stated that there were repairs made to the fire sprinkler system on and the sprinkler company returned to turn the water on, but that "corporate had taken over" with the arrangement of the repairs. He stated he was aware of the water being turned off to the sprinkler system, but was not aware if it had been turned on. A single invoice from a sprinkler company made to the attention of two ALF representatives was presented and noted "On , (the sprinkler company) responded to an urgent call of a broken " fire sprinkler drop at the above referenced location (ALF address). We arrived ( ) the following day to turn on water after 24-hour dry time for glue to restore system." Staff D stated during interview at this time that the water was turned on after the initial repair on , but "another sprinkler broke and the water had to be turned off". An email received by Staff C (Owner) on at 5:57 PM notes " a sprinkler line burst on the second floor...Fire Safety company came out and restored the sprinkler system along with fire panel... sprinkler pipe burst in adjacent area...Fire panel was reset...the sprinkler lines seemed faulty and may have to be replaced...Faced with significant potential costs for replacement and more so, a very long "down	A 152		

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A 152	Continued From page 19	A 152		

time" for replacing piping etc. the landlord sought out a professional diagnostics company that specializes specifically in this area. (A company) out of Michigan finally replied that they would be willing to inspect the piping and report findings in weeks...final results were only reported in early ...(A company name) was awarded the contract on 4.4.22". A copy of the work proposal submitted to the ALF's Plant Operations Manager with the new fire sprinkler repair company was signed on by the ALF's Vice President of Operations.

During an interview with Caregiver Staff A and Caregiver Staff B, the first responding staff, the following was revealed. Caregiver Staff A who worked the 11:00 PM through 7:00 AM shift on stated during an interview conducted on at 10:30 AM that she heard "light beeping in room across Resident #1's room" which was the smoke detector, and "after looking around identified as the room with smoke". Staff A "saw silhouette of Resident #1 on floor in the bathroom but could not get to him... her on the doorknob trying to open it four times". Caregiver Staff B who worked the 11:00 PM through 7:00 AM shift on stated during an interview conducted on at 2:35 PM that she heard "beeping from room across (smoke detector)" and was with Staff A, when Staff A attempted to open the door of to get to the resident but the smoke was too heavy. Both staff stated there was no smoke alarm beeping from . Both staff confirmed they were not able to reach the resident located in his room.

During an interview conducted on at 10:00 AM with the Maintenance Technician, he

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A 152	Continued From page 20 stated that the last time the smoke detectors were checked were in 2021 but he had no documentation showing that any checks on the detectors were made. The Maintenance Director who was employed by the facility from . . through stated during a telephone interview on . . . . . at 11:00 AM that while he was employed he conducted monthly checks on the smoke detectors located in each resident's room. He stated that he documented the checks and need for repair or replacement but that he did not know where the documentation was at this time. During an interview conducted with the Executive Director on at 1:30 PM, he was asked for documentation showing the smoke detectors were checked and the policy and procedure for these checks. On . . . . . at 9:45 AM, a list of resident rooms was presented, indicating checks were done on each smoke detector. The Executive Director stated at this time that the Maintenance Director conducted these checks on and . The list documented by a check mark under "fail" or a notation of "replacing" that seven smoke detectors were currently . . . . . , including Resident #1's . Class I	A 152		