NAME OF FACILITY	FACILITY ADDRESS	DATE OF SURVEY
THE HEARTLAND ALF	639 AVE "H" POWELL, WY 82435	02/26/08 TO 02/28/08

SUMMARY STATEMENT OF DEFICIENCY	FACILITY PLAN OF CORRECTION	FACILITY COMPLETION DATE
A Health and Life Safety Code survey was conducted at your facility on February 26 through 28, 2008 by the Office of HealthCare Licensing and Surveys (OHLS) **Chapter 4. Rules and Regulations for Licensure of Assisted Living Facilities. Section 10. Life Safety and Electrical Safety.** The requirements in the Department of Health Chapter III, Construction Rules for Health Facilities apply. (ii) Assisted Living Facilities operating prior to the effective date of these rules, shall meet the Life Safety Code of the National Fire Protection Association that was in effect at the time the facility was licensed as an Assisted Living Facility. This regulation was NOT MET as evidence by: Based upon observation and staff interview, the facility failed to maintain the fire alarm system as prescribed by NFPA 72. The finding was: On 2/27/08 at 2:15 PM, observation revealed a fire alarm notification appliance mounted on the back wall in the kitchen was obstructed from view by a large two door freezer. The facility maintenance director confirmed	Chapter 4: Section 10. III NFPA 72 The facility shall maintain the fire alarm system as prescribed by NFPA 72. A) The Engineering department technician has removed the large freezer that was obstructing the fire alarm notification appliance. B) All residents have the potential to be affected by failing to maintain the fire alarm system notification appliances as prescribed in NFPA 72. C) The Engineering department technician has removed the obstruction of the fire alarm strobe. Additionally the Engineering technician has provided written documentation to the Director of Plant Operations that the situation has been corrected.	

Provider Representative's Signature/Title CEO

3-24-08
Date

MAR 24 2008

Wyoming Department of Health

Approved POC on 4/4/08 @ 3:00 PM - SL

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the obstruction. Reference: NFPA 101 Life Safety Code, 1994 Edition "22-3.3.4.1 General. A fire alarm system in accordance with Section 7-6 shall be provided." 7-6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code. NFPA 72, National Fire Alarm Code 2002 edition. Table 10.4.3 19. Alarm Notification appliances (a) Audible Devices (c) Visible Devices	D) The Director of Plant Operations shall provide an aggregated report to the Safety Committee on a quarterly basis.	February 29, 2008
Based on record review and staff interview, the facility failed to test 1 (#10) of 13 emergency exit lights in accordance with NFPA 101. The findings were: Review of maintenance record on 2/27/08 at 9:48 AM revealed the emergency exit light #10 had not received an annual 90 minute test in the past 12 months. Maintenance staff verified the testing had not been completed. Reference: NFPA 101 Life Safety Code, 1994 Edition A5-10.3.6...The level of illumination of the exit sign shall be at the level provided in accordance with 5-10.3.2	NFPA 101 The facility shall provide and maintain emergency lighting to meet the 90 minute emergency battery light test to meet NFPA 101 requirements. A) The Engineering department technician has performed the required 90 minute emergency battery light test to meet NFPA 101 requirements.	

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or 5-10.3.3 for the required emergency lighting time duration as specified in 5-9.2.1....@	B) All residents have the potential to be affected by failing to conduct adequate lighting testing procedures. C) The Engineering department technician has provided written documentation of completed 90 minute testing of the (#10) emergency battery light equipment. Additionally the annual test of the emergency battery lighting equipment has been added to the Engineering department test procedure documentation. D) The Director of Plant Operations shall provide an aggregated report to the Safety Committee on a quarterly basis.	
3 Based on record review and staff interview the facility failed to test the installed fire alarm system in accordance with NFPA 72. The findings were: Review of maintenance records on 2/27/08 at 2:48 PM revealed that a smoke detector sensitivity test had not been conducted on any of the 89 detectors in the past year. Maintenance staff verified that the smoke detector sensitivity test had not been conducted. Reference: NFPA 101 Life Safety Code, 1994 Edition ANFPA 101, Chapter 32 Referenced Publications@ ANFPA 72, National Fire Alarm Code, 1993 edition@ ATable 7-3.2" A14. Initiating Devices@ h. Smoke Detectors, Functional, tested annually i. Smoke Detectors, Sensitivity, See 7-3.2.1" A7-3.2.1 Detector sensitivity shall be checked within 1 year after the installation and every alternate year thereafter....@	NFPA 72 The facility shall provide and maintain the fire alarm system in accordance with NFPA 72.	February 29, 2008

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Based on observation and staff interview, the facility failed to ensure complete closure of the double entry doors into the dining room in accordance with NFPA 101. The findings were:

Observation during a fire alarm drill on 2/27/08 at 9:00 AM revealed the magnetically secured double doors leading into the dining room released upon activation of the fire alarm but the doors did not fully close. Closer observation revealed a locking mechanism on the upper edge of one door was stuck in the open position preventing the doors from fully closing. Upon completion of the fire drill, maintenance staff verified the two doors did not fully close.

Reference NFPA 101 Life Safety Code, 1994 Edition
A 1-7.2 Existing life safety features such as, but not limited to automatic sprinklers, fire alarm systems, standpipes, and horizontal exits, if not required by the Code, either shall be maintained or removed.

A) The Engineering department technician has scheduled and completed the sensitivity test procedure on the provided fire alarm system.

B) All residents have the potential to be affected by failing to test the installed fire alarm system in accordance with NFPA 72.

C) The Engineering department technician has provided written documentation of completed sensitivity test procedure of the fire alarm system. Additionally the required sensitivity test procedure has been added to the Engineering department test procedure documentation.

D) The Director of Plant Operations shall provide an aggregated report to the Safety Committee on a quarterly basis.

February 28, 2008

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Chapter 12. Program Administration for Assisted Living Facilities Section 7. Assisted Living Facilities (ALF) Core Services. (b) Resident Assessment and Services. (i) The completion of the ALF 102 (I) The ALF 102 is only valid if completed within forty-five (45) days	NFPA 101 The facility shall provide and maintain magnetically secured doors to function properly as it was originally intended. A) The Engineering department technician has repaired/adjusted the magnetically secured double doors leading into the dining room, to properly close and latch into position. B) All residents have the potential to be affected by failing to test the installed fire alarm system in accordance with NFPA 101. C) The Engineering department technician shall perform monthly door inspections of all magnetically secured doors within the facility. All non-compliant findings and repairs shall be reported to the Director of Plant Operations through written documentation. D) The Director of Plant Operations shall provide an aggregated report to the Safety Committee on a quarterly basis.	March 3, 2008

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prior to admission and there is no change in the resident's condition. This Standard is not met as evidenced by: Based on medical record review and staff interview the facility failed to complete an ALF 102 form prior to admission for one (#5) of 5 sample residents. The findings were: Review of the medical record on 2/28/08 at 10:20 AM revealed the resident was admitted to the facility on 1/4/07. However, the admission ALF 102 was not signed by the nurse until 1/9/07. Interview with the facility nurse on 2/28/08 verified the resident's ALF 102 was signed after admission. Section 7. Assisted Living Facilities (ALF) Core Services. (b) Resident Assessment and Services. (vi) Resident assistance plan. (B) Each facility shall construct its own forms for such plans, which at a minimum shall contain documentation of the following: (VII) Dated signature of the RN, the facility manager, and the resident or the resident's responsible party. This Standard is not met as evidenced by: Based on medical record review and staff interview the facility failed to obtain the necessary dates and	Chapter 12: Section 7 (b) The facility will ensure that the ALF 102 is completed within 45 days prior to admission. A) Resident #5- Resident continues to reside in the facility; unable to correct this record. B) All residents have the potential to be affected by an incomplete ALF-102 prior to admission. C) ALF-102 forms will be flagged for signature during the assessment that is completed prior to admission. D) A random audit will be preformed by the RN quarterly to ensure that the process is being followed. The benchmark will be set at 100%. Aggregate data will be compiled and submitted to the Quality Council. Section 7: (b)(vi)(B) - (VII) The facility shall ensure that the Annual Resident Assessment and Services Form contain the necessary dates and signatures.	April 25, 2008.

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signatures on the annual resident assistance service plans for four (#1, #2, #4, #5) of 5 sampled residents. The findings were:

Review of the medical record on 2/28/08 revealed the following concerns:

Resident #1 was admitted to the facility on 8/2/03. The annual resident assistance service plan was signed and dated by the facility service providers during the months of October and November 2007. However, the plan was neither signed nor dated by either the resident or the facility administrator.
Resident #2 was admitted to the facility on 3/4/05. The annual resident assistance service plan was signed and dated by the facility service providers during the months of August and September 2007. However, the plan was neither signed nor dated by either the resident or the facility administrator.
Resident #4 was admitted to the facility on 7/10/06. The annual resident assistance service plan was signed and dated by the facility service providers during the months of October and November 2007. However, the plan was not neither signed nor dated by either the resident or the facility administrator.
Resident #5 was admitted to the facility on 1/4/07. The annual resident assistance service plan was signed and dated by the facility service providers on 1/10/08. However, the

(A) Resident #1-Due to the age of this document, signatures will not be obtained for this record.
A) Resident # 2- Due to the age of this document, signatures will not be obtained for this record.
A) Resident # 4- Due to the age of this document, signatures will not be obtained for this record.
A) Resident #5- Due to the age of this document, signatures will not be obtained for this record.

B) All residents have the potential to be affected by an assistance service plan that is not signed by the resident and the facility administrator to confirm agreement.

C) Director has created an *Annual Resident Assistance Services Plan* document which includes signature spaces for the resident and the facility administrator.

D) An audit of all *Annual Resident Assistance Service Plans* will be performed quarterly by the RN to ensure that all plans have been signed by the appropriate individuals. The benchmark for this

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plan was neither signed nor dated by either the resident or the facility administrator. Section 7. Assisted Living Facilities (ALF) Core Services. (m) Facility Policies and Procedures. (i) Management shall develop policies and procedures that are available to residents and staff. This Standard is not met as evidenced by: Based on review of the facility's most current policies and procedures and staff interview the facility failed to maintain up-to-date policies and procedures. The findings were: 1. The facility's transfer and discharge policy dated 7/05 stated "The Heartland will not ask residents to leave without 14 days written notice." Current ALF rules and regulation adopted 12/12/07 now allow a 30 day written notice be given. 2. The facility's undated dietary policy only stated that "special diets are available." The current rules and regulations however state that "a registered dietician must oversee therapeutic or mechanical altered diets." 3. The facility's policy listing those services which cannot be provided by level I ALF staff listed all services identified in the Program Administration of	indicator will be 100%. The data will be aggregated quarterly and submitted to the Quality Council. Section 7 (m) (i) The facility shall ensure that facility policies and procedures will be updated to contain current information. A) The *Transfer and Discharge-1.4* policy will be updated to reflect a 30-day written notice. A) The *Food Service-6.1* policy will be updated to include that a registered dietician will oversee therapeutic or mechanically altered diets. A) The *Admissions of Residents-1.3* policy will be updated to reflect that "monitoring of acute medical conditions" can not be performed by Level 1 ALF staff.	April 25, 2008.

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ALF (Chapter 12) with the exception of "monitoring of acute medical conditions" which was added to the list with the adoption of the ALF rules and regulations on 12/12/07.

4. Interview with the facility administrator on 2/28/08 at 10:00 AM revealed the current policies and procedures needed to be up dated.

A) All policies will be reviewed and revised to ensure that the policies reflect the current ALF Rules and Regulations adopted on December 12, 2007.

B) All residents have the potential to be affected by policies that are not up-to-date or reflect current regulation.

C) All policies and procedures will be reviewed and revised by the completion date and then annually thereafter.

D) The ALF Policies and Procedures will be reviewed annually in conjunction with the Nursing Administration Procedures to establish a routine time-frame and submitted to the Governing Board for approval at the April board meeting and yearly thereafter.

April 25, 2008