Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF004	A. BUILDING _____ B. WING _____	04/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING COMMUNITY	1930 EAST 12 STREET CASPER, WY 82601

(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
SALF	LIC REGS FOR ASSISTED LIVING FACILITIES	SALF		

A Life Safety Code survey was conducted at your facility on April 25, 2012 by Healthcare Licensing and Surveys, (HLS).

The facility was a three story fully sprinkled building of Type V (111) construction built in 1987. The building was equipped with a supervised automatic wet sprinkler system and an addressable fire alarm system. The facility had a capacity of 116 licensed beds and a total census of 65 residents.

Wyoming Department of Health, Rules and Regulations for Licensure of Assisted Living Facilities Chapter 4
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.

All references are based on the requirements of NFPA 101 Life Safety Code, New Board and Care, 1994 Edition, unless otherwise noted.

This regulation was NOT MET as evidence by:

A. Based on observation and staff interview, the facility failed to ensure ceilings were smoke

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

PoC ACCEPTED W/ MATTHEW GUTTMAN, ED, ON 6/5/12.

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6/5/12

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SALF	Continued From page 1 resistant in 1 of 4 smoke compartments. The findings were: Observation on 4/25/12 between 1 PM and 2 PM showed there was a sprinkler valve in the medical records storeroom and maintenance shop ceilings. Further observation showed the valve was set into an unsealed 6 inch diameter hole. At 1:18 PM the maintenance director reported he was unaware ceiling were required to be continuous to transmit smoke and heat in a potential fire. Reference; 23.2.3.6.1 The separation walls of sleeping rooms shall be capable of resisting fire for at least 20 minutes, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15-minute thermal barrier. Sleeping room doors shall be substantial doors, such as those of 13/4-in. (4.4-cm) thick, solid-bonded wood core construction or other construction of equal or greater stability and fire integrity. Any vision panels shall be of wire glass not exceeding 1296 in.2 (0.84 m2) each in area and installed in approved frames.	SALF	A. 1. The facility will be in compliance with state regulations. 2. The Executive and Maintenance director will be responsible for ensuring this is corrected. 3. The maintenance director will construct a box around the valves in accordance with the preference of the fire marshal by June 15th. 4. The Maintenance director and executive director will review these boxes quarterly in QA inspections. 5. Once completed the facility will contact the fire marshal to approve the smoke resistance.	6/15/2012
	B. Based on observation and staff interview, the facility failed to ensure hazardous areas were separated from use areas in 1 of 4 smoke compartments. The findings were: Observation of the second floor storage room on 4/25/12 at 1:33 PM showed the corridor door was equipped with a self-closing device. Further observation showed the arm to the closure had been removed. At the time of the observation the maintenance director was unsure when or why		B. 1. The facility will be in compliance with state regulations. 2. The maintenance director will reinstall the closing device. 3. The maintenance director will reinstall the closing	5/8/2012

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SALF	Continued From page 2 the arm was removed. He also reported this room was not routinely inspected. Reference; 22-3.5 Operating Features. (See Chapter 31.) 22-2.3.2 Hazardous Areas. Any hazardous area shall be protected in accordance with the following: (a) Any hazardous area that is on the same floor as, and is in or abuts a primary means of escape or a sleeping room, shall be protected by either: 1. An enclosure with a fire resistance rating of at least 1 hour ... 2. Automatic sprinkler protection, in accordance with 22-2.3.5, of the hazardous area and a separation that will resist the passage of smoke between the hazardous area and the sleeping area or primary escape route. Any door in such separation shall be self-closing or automatic-closing in accordance with 5-2.1.8. --- C. Based on record review and staff interview, the facility failed to perform 2 of 2 emergency battery light tests. The findings were: Review of the emergency battery light testing records showed the monthly 30 second test had not been conducted in the past 2 years. Further review showed the annual 90 minute test was last conducted on 8/19/10, more than one year ago. On 4/25/12 at 2:30 PM the maintenance director reported he was unaware of the testing requirement. Reference, 23.3.2.9, 6.9.3; 31-1.3.7 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at	SALF	4. Staff will be re-educated on the need for the self-closures and advised not to remove any. In-service will be on 6/13 5. Automatic closures will be tested on a quarterly basis by QA team, executive director and maintenance director. C. 1. It is the policy of this community to have a back-up electrical lighting system and to test that system in accordance with state regulations. 2. The maintenance director will conduct and log monthly and annually.	5/10/2012

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SALF	Continued From page 3 30-day intervals for a minimum of 30 seconds. An annual test shall be conducted for the 1 2 hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. D. Based on observation, record review, and staff interview, the facility failed to ensure 1 of 7 fire alarm system tests was performed and failed to provide a current central station certificate. The findings were: 1. Observation of the fire alarm control panel on 4/25/12 at 11:47 AM showed the central station certificate expired on 3/31/2009. At the time of the observation the maintenance director reported he was unaware the certificate expired. 2. Review of the fire alarm system testing records showed the system receiver had not been tested during the months of May, June, July, October and November 2011 as well as January and February of 2012. On 4/25/12 at 2:30 PM the maintenance director reported he was unaware the system was required to be activated and test the receiver on a monthly basis. Reference, 22.3.3.4.1, 7.6.1.4, NFPA 72, 1993Edition; 5-2.2.3.1.1 Fire alarm systems providing services that complies with all the requirements of this code shall be certified by the organization that has listed the central station, and a document attesting to this certification shall be located on or within 36 in. of the fire alarm system control unit or, if no control unit exists, on or within 36 in. of a fire alarm system component.	SALF	3. The maintenance director will conduct monthly 30 second tests and annual 90 min test. 4. The monthly tests will be completed on the same day every month and will be logged both with in the maintenance office and with the administrator. 5. Every test will be double logged with the administrator and maintenance director. Logs will be double checked every quarter by QA team to ensure they are completed. D. a. Central station certificate obtained and posted. 5/10/2012 b. 1. The facility will be in compliance with state regulations. 5/14/2012 2. Maintenance director will be responsible for posting an activation log next to the central station and tracking activation	

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SALF	Continued From page 4 Table 7-3.2 Testing Frequencies. 23. Receivers,.....monthly --- E. Based on observation, record review, and staff interview, the facility failed to ensure adequate sprinkler coverage in 3 of 4 smoke compartments and failed to test 1 of 5 sprinkler components. The findings were: 1. Review of the sprinkler system testing records showed the annual inspection on 6/17/11 documented incomplete sprinkler coverage on all three floors; for example: a. The sprinkler head in resident room #112 living room sprinkler head was 11 feet 6 inches from the far wall. b. The sprinkler head in the first floor chapel sprinkler head was 9 feet 6 inches from far wall. c. The sprinkler head in second floor east corridor sprinkler was 11 feet 5 inches from far wall. d. The sprinkler head in resident room #222 living room sprinkler head was 10 feet 9 inches from far wall. e. The sprinkler head in third floor chapel sprinkler head was 11 feet 10 inches from far wall. f. The sprinkler head in third floor stairwell landing sprinkler head was 12 feet from the far wall. On 4/25/12 at 2:30 PM the maintenance director confirmed these issues have not been corrected. At the same time the administrator reported he was unaware of the incomplete sprinkler coverage. 2. Review of the sprinkler system testing records showed the back flow preventer was last tested on 9/23/10, more than one year ago. On 4/25/12 at 2:30 PM the maintenance director could not	SALF	Times as they occur. Review of the log will be done every quarterly by Executive Director and maintenance director as well as QA team. E. A. 1. It is the policy of this facility to have an appropriate, fully operational fire sprinkler/ suppression system in different areas of the community. 2. The maintenance director will work with our fire sprinkler contractor to correct and replace heads as needed in 112, chapel, 222, theatre, 3rd Stairwell, and 2nd floor corridor. 3. Plans will be submitted by June 22, 2012 Approval will be received by approximately Aug.20th 2012 with the installation completed by Oct. 20th 2012. 4. The sprinkler system will be inspected bi-annually. 5. Inspections logs will be kept in by the maintenance director and the logs will be reviewed quarterly by the maintenance director, Executive Director and QA team	

6/22/2012 Plan submittal
8/20/2012 Plan Approval
10/20/2012 Installation complete

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SALF	Continued From page 6 at 2:30 PM the maintenance director could not explain why the test had not been performed. Reference, 22.3.3.5.1, 7.7.1.1, NFPA 13, 1994 Edition; Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (Standard Spray Upright/Standard Spray Pendent) Distance from sprinkler to side of obstruction — Maximum allowable distance from deflector above bottom of obstruction Less than 1 ft ... 0 1 ft to less than 1 ft 6 in. ... 2 ½ 1 ft 6 in. to less than 2 ft ... 3 ½ 2 ft to less than 2 ft 6 in. ... 5 ½ 2 ft 6 in. to less than 3 ft ... 7 ½ 3 ft to less than 3 ft 6 in ... 9 ½ 3 ft 6 in. to less than 4 ft ... 12 4 ft to less than 4 ft 6 in. ... 14 Reference, 32.3.3.5.1, 19.7.5, NFPA 25, 1999 Edition; 9-6.2.1 All backflow preventers installed in fire protection system piping shall be tested annually ... F. Based on observation and staff interview, the facility failed to ensure curtains were flame retardant in 1 of 4 smoke compartments. The findings were: Observation on 4/25/12 between 1:30 PM and 2 PM showed the window curtains in resident room #315 and the third floor theater did not have flame retardant documentation attached to them. On 4/25/12 at 1:36 PM the maintenance director reported the curtains had not been sprayed with a	SALF	E. B. 1. It is the policy of this facility to have trained staff or Professionals to ensure the proper operation and maintenance of the system. 2. The maintenance director will contract an outside company to perform the annual test. → BACKFLOW 3. The test will be completed and filed with the city. 4. Logs will be kept by E.D and Maint. Director to ensure the testing is done. 5. The logs will be reviewed on a quarterly basis by the Maintenance director, Executive director and QA team.	5/18/2012

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SALF	Continued From page 6 flame retardant solution. He could not explain why the curtains had not been noticed and sprayed with a flame retardant solution during the quarterly safety inspections. Reference; 22-3.5 Operating Features. (See Chapter 31.) 31-7.5.1 New draperies, curtains and other similar loosely hanging furnishings and decorations in board and care facilities shall be in accordance with the provisions of 31-1.4.1. --- G. Based on observation and staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 3 of 4 smoke compartments. The findings were: Observation of the electrical system on 4/25/12 between 12 PM and 2 PM showed the bed lamp in resident room #117 was plugged into a 3-way adapter. A television set in resident room #210 was plugged into a 3-way adapter. The radio in resident room #216 was plugged into a surge protector which was plugged into a 6-way adapter. The bed lamp in resident room #315 was plugged into a 3-way adapter. The television set in resident room #301 was plugged into a 3-way adapter. At 12:10 PM the maintenance director could not explain why the aforementioned adapters had not been noticed and removed during the monthly electrical inspections. Reference, 22.3.6.1, 7.1.2, NFPA 70, 1993 Edition; 400-8. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a	SALF	F. 1. It is the policy of this facility to practice fire prevention. 2. The maintenance director will be responsible for spraying and tagging curtains. 3. All curtains will be sprayed and tagged and the chemicals sheets will be kept in MSDS. 4. Dates will be kept in logs and online by the executive director and maintenance director to give reminders when the next spray is needed. 5. All new resident rooms will be checked for curtains that would need spraying. Rooms and logs will be reviewed quarterly by the QA team and Maintenance and executive directors.	6/15/2012

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SALF	Continued From page 7 structure (2) Where run through holes in walls ... (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Wyoming Department of Health Aging Division Rules Program Administration of Assisted Living Facilities Chapter 12 Section 7. Assisted Living Facility (ALF) Core Services. (o) Evacuation Capability, Emergency Procedures, and Fire Safety. (iii) Fire Safety. (E) Fire exit drills shall be conducted in accordance to the Life Safety Code Operating Features sections. The minimum number of drills, as amended, shall be held at least twelve (12) times per year on a monthly basis with a minimum of one drill conducted each quarter on each shift. Fire exit drill records over a two-year period shall be available upon request at the facility. (I) The facility shall be responsible for recording fire exit drills on an evaluation form that include at least the following: (1.) Date of drill; (2.) Time of day; (3.) Type of drill (Practice, Announced, Surprise); (4.) Residents who participated including staff and family members; (5.) Time required (minutes and seconds) to evacuate all residents (including staff) from the occupied areas to a point of assembly as defined in the Life Safety Code; (6.) List of anyone, including staff and family members, who did not evacuate in the required	SALF	G. 1. It is the policy of this facility to practice fire prevention. 2. The maintenance director and housekeeping will be responsible for removing said adaptors in rooms 117, 210, 216, 315, and 301. 3. The maintenance director and housekeeping will be responsible for checking rooms on a monthly basis. 4. An in-service will be done for all staff to ensure that nursing and housekeeping are looking for adaptors and extension cords every visit. In-Service was held on 5/4 5 Monthly checks will be done by housekeeping and maintenance checking for items. Check and reporting will be overseen by the Executive director.	5/9/2012

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	ALF004	A. BUILDING _____ B. WING _____	04/26/2012

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SALF	Continued From page 8 time allowed by the evacuation capability rating of the facility. Evacuation capability rating for each facility shall be listed on the form; (7.) Comments on the factors that contributed to each individual's inability to evacuate successfully and any corrective actions recommended; and (8.) Signature and date of the person completing the form. This regulation was NOT MET as evidenced by: H. Based observation, record review, and staff interview, the facility failed to ensure residents were fully evacuated during fire drills and failed to ensure fire drills were held on 3 of 3 shifts on a quarterly basis. The findings were: 1. Observation of a fire drill on 4/26/12 at 2:32 PM showed the resident from the second and third floor evacuated to the 2-hour rated stairwells, but did not evacuate to the outside of the building. The residents on the first floor evacuated the building and gathered at a point of safety as indicated in the fire evacuation plan. At the time of the observation the manager reported he was unaware the residents were required to fully evacuate the building during fire drills. 2. Review of the fire drill records showed the first shift occurred between 6 AM and 2 PM. The second shift occurred between 2 PM and 10 PM. The third shift occurred between 10 PM and 6 AM. Further review showed fire drills had not been conducted on the first shift during the second and fourth quarters of 2011 and the first quarter of 2012. Fire drills had not been conducted on the second shift during the second and fourth quarters of 2011 and the first quarter	SALF	H. 1. Edgewood vista requires all staff to practice, promote and participate in the safety and emergency procedures as identified in our policy as well as any other approved policies. 2. The administrator and maintenance director will be responsible drills and recording. 3. Fire drills will be executed and documented. Drills will occur the first week of every month, one per shift per quarter. 4. An in-service for all staff to re-educate on the fire drills will be completed and the drills will be double recording by both the maintenance director and administrator. 5. Drill log will be reviewed Quarterly by administrator and maintenance director and QA team.	6/22/12

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SALF	Continued From page 9 of 2012. Fire drills had not been conducted on the third shift during the second, third, and fourth quarters of 2011. On 4/25/12 at 2:30 PM the maintenance director reported he was unaware drills were required to be conducted on each shift during each quarter. Reference; 22-3.5 Operating Features. (See Chapter 31.) 31-7.3 Fire Exit Drills. Fire exits drills shall be conducted at least six times per year on a bi-monthly basis with a minimum of two drills conducted during the night when residents are sleeping. The drills shall be permitted to be announced in advance to the residents. The drills shall involve the actual evacuation of all residents to an assembly point as specified in the emergency plan and shall provide residents with the experience in egressing through all exits and means of escape required by the Code. Exits and means of escape not used in any fire drill shall not be credited in meeting the requirements of this Code for board and care facilities.	SALF	Park Place Assisted Living community will file an informal dispute resolution regarding the complete evacuation of resident from the building. Should the resolution determine that we need to evacuate completely, we will comply with that decision.	