Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF005	A. BUILDING _____ B. WING _____	10/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CA	1865 SO BEVERLY STREET CASPER, WY 82609

(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 October 15, 2012 by the office of Healthcare Licensing and Surveys, (HLS).

The facility was a two story fully sprinkled building of Type V (111) construction built in 2003. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze loop and an addressable fire alarm system. The facility had a capacity of 42 licensed beds with a census of 31 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, 2000 Edition, unless otherwise noted.

This regulation was NOT MET as evidence by:

A. Based on observation and staff interview, the facility failed to ensure 3 of 4 fire barrier walls

A. Fire Barrier Walls: Double Doors and Walls

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director — (X6) DATE: 11/19/12

STATE FORM 6899 WF8911 If continuation sheet 1 of 12

POC ACCEPTED WITH KENNIE SCHLUGER, DIRECTOR, ON 11/19/12

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SALF	Continued From page 1 were continuous from floor to ceiling. The findings were: 1. Observation of the first floor fire barrier walls on 10/15/12 between 2 PM and 3 PM showed the one of the two double doors on the north and south barriers would not fully latch into the door frame, with three attempts. On 10/15/12 at 2:10 PM the maintenance director could not explain why the doors had not been noticed and repaired during the quarterly inspections. 2. Observation of the second floor north fire barrier wall on 10/15/12 at 5:43 PM showed a ½ inch by 24 inch gap between the fire barrier wall and corridor wall, above the ceiling tile. At the time of the observation the maintenance director reported the gap was caused by the expansion of the building. He could not explain why the gap had not been noticed and repaired during the quarterly inspections. Reference, NFPA 101, 2000 Edition, 32.1.2.1 Where another type of occupancy exists in the same building as a residential board and care occupancy, the requirements of 6.1.14 of this Code shall apply. Exception No. 1: Occupancies that are completely separated from all portions of the building used for a residential board and care facility and its egress system by construction having a fire resistance rating of not less than 2 hours. B. Based on observation and staff interview, the facility failed to ensure hazardous areas were separated from use areas in 2 of 6 smoke compartments. The findings were: Observation on 10/15/12 between 2:30 PM and	SALF	**Policy:** Primrose will inspect fire barrier doors twice a year to ensure proper closing and latching of all fire doors. **Responsible Person:** Maintenance Director and staff completing the fire drills. **Method:** Visual inspection will be completed twice per year as well as during monthly during fire drills. A1: The double doors on the north and south side of Independent Living will be repaired by the Maintenance Director to ensure closure. A2: Fire rated calking/sealant will be used to seal the gap on the second floor north fire barrier wall. **QA/Prevention:** The Maintenance Director and staff will complete a log of inspections every six months. Please see exhibits 1 and 2 for the documentation form that will be utilized. The Executive Director (ED) will inspect the log and ensure all items have been completed and maintained. This log will be stored in the ED's office. **B. Hazardous Area Separation** **Policy:** Primrose will ensure that all hazardous areas are separated from other parts of the building by a smoke partition. This includes laundry rooms.	12/19/12

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SALF	Continued From page 2 4:30 PM showed the corridor door to the first and second floor resident laundry rooms were equipped with self-closing devices. Further observation showed both of the doors were propped open with wedges forced under the doors. On 10/15/12 at 2:39 PM the maintenance director reported he was unaware corridor doors to hazardous areas were only allowed to be held open by devices that released with the activation of the fire alarm system. Reference NFPA 101, 2000 Edition; 32.3.3.2.2 Every hazardous area shall be separated from other parts of the building by a smoke partition in accordance with 8.2.4. Hazardous areas shall include, but shall not be limited to the following: (1) Boiler and heater rooms (2) Laundries (3) Repair shops 32.3.3.6.6 Doors to hazardous areas, vertical openings, exits, and exit passageways shall be self-closing or automatic-closing. C. Based on observation and staff interview, the facility failed to ensure exit discharge pathways did not have abrupt elevation change for 2 of 4 exits. The findings were: Observation of the southeast exit discharge pathway on 10/15/12 at 2:59 PM showed the sidewalk had an elevation change of 1 ½ inch along an expansion line. At the time of the observation the maintenance director reported he was unaware the egress pathway could not have an elevation change that exceeded ¼ inch. Reference, NFPA 101, 2000 Edition, 32.3.2.1; 7.1.6.2 Changes in Elevation. Abrupt changes in elevation of walking surfaces shall not exceed 1/4	SALF	**Responsible Person:** Nursing staff and Management. **Method:** Nursing staff and management will ensure that no door stops are utilized at laundry rooms or other hazardous areas by visual inspection during their daily activities. The door mechanism on the Director of Nursing's door will also be removed. **QA/Prevention:** Door stop devices will be removed and staff will be educated in a staff meeting on 11/12/12 about the necessity of separating hazardous areas. Management will inspect these areas routinely to ensure compliance. **C. Elevation of Exit Pathways** **Policy:** Primrose staff shall ensure the exit discharge pathways do not have abrupt elevations changes. **Responsible Person:** Maintenance Director and Executive Director. **Method:** Primrose will contact a concrete company to bevel/repair/replace sidewalk areas that measure greater than ¼" difference.	12/14/12

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SALF	Continued From page 3 in. (0.6 cm). Changes in elevation exceeding 1/4 in. (0.6 cm), but not exceeding 1/2 in. (1.3 cm), shall be beveled 1 to 2. Changes in elevation exceeding 1/2 in. (1.3 cm) shall be considered a change in level and shall be subject to the requirements of 7.1.7. D. Based on record review and staff interview, the facility failed to ensure 2 of 2 emergency battery light tests were performed. The findings were: Review of the emergency battery light testing records showed the facility did not have a record of the monthly 30 second for August and June 2012. Further review showed the facility did not have a record when the last annual 90 minute test was completed. On 10/15/12 at 5:30 PM the maintenance director could not explain why the aforementioned tests had not been performed. Reference, NFPA 101, 2000 Edition, 19.2.9.1; 7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1-1/2 hours. 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. E. Based on record review and staff interview, the facility failed to ensure 1 of 8 fire alarm system components was tested. The findings were:	SALF	**QA/Prevention:** The Maintenance Director will inspect pathways during the daily/weekly walking-inspections. The Executive Director will be notified of any sidewalk elevation difference of more than ¼ inch. **D. Emergency Lighting Battery Testing** **Policy:** Primrose will ensure periodic testing of the emergency lighting equipment every 30 days and for no less than 30 seconds. An annual test shall also be completed for no less than 1 ½ hours. **Responsible Person:** Maintenance director. **Method:** The Maintenance Director will utilize the log form from OneNote that can be completed on a cell phone and printed for the record to test monthly and annually the emergency lighting. **QA/Prevention:** Monthly and annual testing will be completed and documented. The Executive Director will periodically review the emergency lighting logs, which will be maintained in the ED's office. See exhibit 3. **E. Fire System Testing**	12/14/12

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SALF	Continued From page 4 Review of the fire alarm system testing records showed the last annual inspection occurred on 4/13/12. Further review showed the annunciator panel battery load voltage semi-annual test had not been performed six months prior to the last annual inspection. On 10/15/12 at 5:30 PM the maintenance director reported he was unaware the test was required. Reference NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; Table 7-3.2 Testing Frequencies. 6. Batteries-Fire alarm systems d. Sealed Lead-Acid Type 1. Charge Test,.....annually (Replace batteries every 4 years.) 2. Discharge Test ... ... annually (30 minutes) 3. Load Voltage Test,.....semi-annually F. Based on observation and staff interview, the facility failed to ensure sprinkler heads were unobstructed in 2 of 6 smoke compartments. The findings were: 1. Observation of the first floor nurses' storeroom on 10/15/12 at 2:34 PM showed the sprinkler head was obstructed by the ceiling mounted light. The light was installed 2 inches away and 2 inches below the sprinkler deflector. At the time of the observation the maintenance director reported the heads were inspected annually by an outside contractor. Review of the last inspection reported dated 9/14/12 showed the contractor had noted this head was obstructed. The maintenance director could not explain why this head was not modified. 2. Observation of the sprinkler system on	SALF	**Policy:** Primrose will ensure an annual charge test, annual discharge test, and semi-annual load voltage test are completed and documented. **Responsible Person:** Maintenance Director. **Method:** The fire system annunciator battery, located in the Primrose Store, shall be tested during the fire drill to ensure its charge as per policy. **QA/Prevention:** A master spreadsheet of required testing has been created to ensure documentation and completion of the required testing. This document will be stored in the Executive Director's office and periodically reviewed. See exhibit 4. **F. Sprinkler Head Obstruction** **Policy:** Primrose will ensure sprinkler heads will not be located near objects that obstruct the flow of water from the sprinkler heads. **Responsible Person:** Maintenance Director. **Method:** The light fixture (F1- located in the nurse's store room) will be turned 90 degrees to ensure it no longer blocks the spray of sprinkler head. The light fixtures (F2- which is not located in assisted living but near apartment 101 on IL) located near the sprinkler head shall be moved so	12/14/12

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SALF	Continued From page 5 10/15/12 at 5:37 PM showed three heads in the corridor near resident room #101 were obstructed by ceiling mounted lights. The furthest light was installed 8 inches away and 6 inches below the sprinkler deflector. Reference, NFPA 101, 2000 Edition, 19.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 5-6.4.1.2 Under obstructed construction, the sprinkler deflector shall be located within the horizontal planes of 1 in. to 6 in. below the structural members and a maximum distance of 22 in. below the ceiling/roof deck. Exception No. 2: Where sprinklers are installed in each bay of obstructed construction, deflectors shall be permitted to be a minimum of 1 in and a maximum of 12 in. below the ceiling. 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 G. Based on observation and staff interview, the facility failed to ensure portable fire extinguishers were protected in 2 of 6 smoke compartments and failed to conduct monthly inspections in 1 of 6 smoke compartments. The findings were:	SALF	that there is no obstruction of flow. **QA/Prevention:** Primrose will continue to be diligent in inspecting and observing sprinkler heads placed in inappropriate locations. **G. Portable Fire Extinguishers** **Policy:** Primrose will ensure fire extinguishers are securely installed to the	12/14/12

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SALF	Continued From page 6 1. Observation on 10/15/12 between 2 PM and 4:30 PM showed the portable fire extinguishers in the first floor mechanical room and light bulb storeroom were sitting on the ground. On 10/15/12 at 2:13 PM the maintenance director reported he was aware extinguishers are required to be secured by a hanger or cabinet to prevent damage. He could not explain why the extinguishers were stored on the ground. 2. Observation of the gift shop fire extinguisher on 10/15/12 at 3:54 PM showed a monthly safety inspection had not occurred since May 2012. At the time of the observation the maintenance director could not explain why the extinguisher had not been serviced. Reference NFPA 101, 2000 Edition, 32.3.3.5.5, 9.7.4.1, NFPA 10, 1998 Edition; 1-6.7 Portable fire extinguishers other than wheeled types shall be securely installed on the hanger or in the bracket supplied or placed in cabinets or wall recesses ... 4-3 Inspection. 4-3.1 Frequency. Extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals .... H. Based on observation and staff interview, the facility failed to ensure decorations were flame retardant in 1 of 6 smoke compartments. The findings were: Observation of the second floor south corridor on 10/15/12 at 3:03 PM showed six dried grape vine wreaths were hanging on the wall. Further observation showed flame retardant documentation was not attached to the wreaths. At the time of the observation the maintenance	SALF	wall and monthly and annual inspections are completed. **Responsible Person:** Maintenance Director and Management. **Method:** The Maintenance Director will secure the fire extinguishers to the wall (G1-light bulb room on second floor). A document to help locate all extinguishers has been created. **QA/Prevention:** A new document in OneNote has been created which can be utilized on a cell phone to individually check off each extinguisher examined. This completed document will be stored in the Executive Director's office and be reviewed monthly. See exhibit 5. **H. Fire Retardant Decorations** **Policy:** Primrose will ensure all building decorations follow NFPA 10.3.1 and are flame resistant. **Responsible Person:** Executive Director. **Method:** The Executive Director will remove all decorations that are not flame resistant and replace with items that are flame resistant.	12/14/12

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SALF	Continued From page 7 director reported he was unaware dry plant based wreaths required flame retardant documentation. Reference NFPA 101, 2000 Edition; 32.7.5.1 New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities shall be in accordance with the provisions of 10.3.1. 10.3.1* Where required by the applicable provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. I. Based on observation and staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 3 of 6 smoke compartments. The findings were: Observation of the electrical system on 10/15/12 between 2 PM and 4 PM showed temporary wiring replaced permanent fixed wiring in the following locations: a. Kitchen convection oven was plugged into an extension cord b. Resident room #133 television set was plugged into an extension cord c. Resident room #228 telephone was plugged into an extension cord d. Beauty shop curling iron was plugged into a surge protector which was plugged into an extension cord On 10/15/12 at 2:23 PM the maintenance director reported the electrical system was not routinely inspected to ensure electrical adapters were prohibited Reference NFPA 101, 1994 Edition, 22-3.6.1,	SALF	**QA/Prevention:** The Executive Director will ensure no other decorations that may be a fire hazard be placed in the building. **I. Temporary Electrical Wiring** **Policy:** Primrose will ensure no temporary electrical wiring is utilized in the facility. **Responsible Person:** All staff. **Method:** An electrician has been contacted to provide an outlet for the new oven (IA) and salon (ID). Surge protectors will be provided for residents that were using extension cords (IB and IC). **Prevention:** Nursing and housekeeping staff will monitor apartments on a continual basis for use of extension cords. Surge protectors will be stocked to correct these issues immediately.	12/14/12 12/14/12

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SALF	Continued From page 8 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 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 Effective December 12, 2007 Section 7. Assisted Living Facility (ALF) Core Services. (o) Evacuation Capability, Emergency Procedures, and Fire Safety. (i) Evacuation Capability. (A) The evacuation capability rating for the group of residents, as defined by the Life Safety Code, in accordance with licensure rules, shall meet prompt or slow for facilities with nine (9) or more residents, and the rating shall meet prompt for facilities of eight (8) or fewer residents. The facility shall be responsible for maintaining evacuation capability ratings by timed fire exit drills. (I) Exception shall be a facility where the construction meets the impractical evacuation capability rating. (B) Evacuation Capability Ratings: (I) Prompt - maximum of three (3) minutes (II) Slow - between three (3) and thirteen (13) minutes (III) Impractical - more than thirteen (13) minutes	SALF		

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SALF	Continued From page 9 (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 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 evidence by: --- J. Based on record review and staff interview, the facility failed to ensure fire drills were conducted	SALF	**J. Fire Drills**	

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SALF	Continued From page 10 on each shift during 1 of the past 4 quarters, failed to collect the total time of evacuation for each fire drill and failed to ensure fire drills were performed in less than 13 minutes. The findings were: 1. Review of the fire drill records showed the first shift occurred between 6 AM and 2 PM. Further review showed a fire drill had not been conducted on the first shift during the fourth quarter of 2011. On 10/15/12 at 5:30 PM the maintenance director could not explain why the fire drill had not been conducted. 2. Review of the fire drill records showed the time of evacuation was not collected for the 6/27/12 and 8/30/12 drills. Further review showed the facility was not collecting the minutes and seconds on any of the drills, they were only collecting the minutes. On 10/15/12 at 5:30 PM the maintenance director reported he was unaware the minutes and seconds were required to be documented for each drill. 3. Review of the fire drill records showed the third shift occurred between 10 PM and 6 AM. Further review showed the drill conducted on 10/18/11 took 13 minutes to evacuate and the drill conducted on 1/25/12 took 18 minutes to evacuate. On 10/15/12 at 5:30 PM the maintenance director reported no additional education or practices were held to ensure the residents could fully evacuate the smoke compartment in less than 13 minutes. He was unable to confirm the drill on 10/18/11, took no more than 13:00 minutes. Reference NFPA 101, 2000 Edition; 32.7.3 Emergency Egress and Relocation Drills. Emergency egress and relocation drills shall be	SALF	**Policy:** Primrose will ensure fire drills are conducted on each shift of each quarter and properly documented. **Responsible Person:** Director of Nursing and Executive Director. **Method:** Primrose has developed a new fire drill report form to better clarify the areas they were deficient in with regards to documentation. **QA/Prevention:** Staff will be educated in the specific areas that need completed on the drill document form. Forms will be kept and reviewed in the Director of Nursing's office. See exhibit 6.	12/14/12

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	ALF005	A. BUILDING _____ B. WING _____	10/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CA	1865 SO BEVERLY STREET CASPER, WY 82609

(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	Continued From page 11 conducted not less than six times per year on a bimonthly basis, with not less than 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 experience in egressing through all exits and means of escape required by the Code. Exits and means of escape not used in any drill shall not be credited in meeting the requirements of this Code for board and care facilities.	SALF		