Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF022	A. BUILDING _____ B. WING _____	12/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE MANOR INC	830 NORTH MAIN STREET BUFFALO, WY 82834

(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 This State Rules and Regulations is not met as evidenced by: A Life Safety Code survey was conducted at your facility on December 17-18, 2012 by the office of Healthcare Licensing and Surveys, (HLS). The facility was a single story fully sprinkled facility of Type V (111) construction built in 2009. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze branch and an addressable fire alarm system. The facility had a capacity of 26 licensed beds with a census of 23 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, 2006 Edition, unless otherwise noted. This regulation was NOT MET as evidence by: --- A. Based on observation and staff interview, the facility failed to ensure the smoke barrier double	SALF	SALF – A. 1. Effective 02/01/13 the facility will implement a written monitoring tool to verify self-closing doors latch completely during every monthly fire drill. 2. The self-closing doors are scheduled for repair by 02/15/13 by our maintenance staff. 3. The maintenance staff will be adjusting the doors so they close properly. 4. Functional tests, visual inspections and review of written monitoring too will continue to assist in identifying any future issues. 5. In addition to administration inspecting the doors during each fire drill, our maintenance team will be verifying their continuing functionality every 30 days in an attempt to foresee any issues before they arise. SALF – B. 1. Effective 02/01/13 it is the facility will implement a written monitoring	02/15/13 02/01/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 1/17/13

Faxed to w/ Renee Knight, RD, on 1/24/13

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SALF	Continued From page 1 doors were smoke resistant. The findings were: Observation of the smoke barrier double doors on 12/18/12 at 9:02 AM showed the doors were equipped with self-closing devices. Further observation showed the self-closing device on one of the two doors was not able to fully latch the door into the door frame. At the time of the observation the executive director reported the doors were not routinely inspected to ensure the doors were fully latched into the frames. Reference: 32.3.3.6.5 Door-closing devices shall not be required on doors in corridor wall openings other than those serving required exits, smoke barriers, or enclosures of vertical openings and hazardous areas. B. Based on observation and staff interview, the facility failed to ensure hazardous areas were separated from use areas in 1 of 2 smoke compartments. The findings were: Observation of the laundry room on 12/18/12 at 9:46 AM showed the corridor door was equipped with a self-closing device. Further observation showed the corridor door was impeded by a rubber wedge. At the time of the observation the executive director reported she was unaware the corridor doors were prohibited from being held in the open position unless they would close with the activation of the fire alarm system. Reference: 32.3.3.2.2 The areas described in Table 32.3.3.2.2 shall be protected as indicated. Table 32.3.3.2.2 Hazardous Area Protection Central/bulk laundries larger than 100 ft square ... ...1-hour separation/protection	SALF	tool to verify the laundry room door closed at all times. 2. Management has removed the door stop. 3. In addition to the door stop being removed all staff have been informed of the new rules regarding the laundry room door. 4.. Management will maintain weekly checks to see that the door is not propped open and that there is not door stopper in the room to utilize. Administration will be reviewing the written monitoring tool. 5. In addition to managements visual inspection the maintenance department will be responsible for a monthly inspection of the premises, to check the status of the door and any devices present to prop door open. If any devices are found maintenance will remove and notify management. The monitoring tool will be reviewed annually by administration and staff for continued compliance. SALF – C. 1. The facility will insure that all exits shall lead to a public way.	02/15/13

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SALF	Continued From page 2 C. Based on observation and staff interview, the facility failed to ensure 3 of 7 exit discharge pathways led to a public way. The findings were: Observation of the northwest west exit discharge pathway on 12/18/12 at 9:31 AM showed the pathway ended at the lawn without a direct path to a public way. Further observation showed the dining room exit and southwest exit were also not equipped with exit discharge pathways leading to a public way. At the time of the observation the executive director reported she was unaware of the aforementioned requirement. Reference, 32.3.2.7: 7.7.1* Exit Termination. Exits shall terminate directly, at a public way or at an exterior exit discharge, unless otherwise provided in 7.7.1.2 through 7.7.1.4. D. Based on record review and staff interview, the facility failed to ensure emergency battery lights were tested during ~~12 of~~ the past 12 months. The findings were: Review of the emergency battery light testing records showed a monthly 30 second test had not been performed in the past 12 months. Further review showed the annual 90 minute test had not been performed in the past year. On 12/18/12 at 11:15 AM the executive director reported she was unaware of the aforementioned testing requirement. Reference, 32.3.2.9; 7.9.1.3 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted.	SALF	2. The owner of Agape Manor, Inc., the architectural firm, Armstrong Design Studio, and facility maintenance are working toward a permanent solution. 3. The temporary solution will be installed by facility maintenance and overseen by Armstrong Design Studio by 02/15/13. There will be a temporary walkway from the three identified exits to a public way. Drawings from a licensed architect will be submitted to the State of WY Dept of Health for approval. Upon approval of architectural drawings by the WY Dept of Health a permanent pathway will be installed, replacing the temporary system. 4. New architectural and building professionals will be utilized for all future facility improvements. 5. Maintenance will maintain a monthly review of the temporary and permanent exit pathways for any hazardous conditions and ensure pathways are offering safe passage to a public way. SALF – D.	02/15/13

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SALF	Continued From page 3 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted at 30-day intervals for not less than 30 seconds. (2) Functional testing shall be conducted annually for not less than 11/2 hours if the emergency lighting system is battery powered. (3) The emergency lighting equipment shall be fully operational for the duration of the tests by 7.9.3.1.1 (1) and (2). (4) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. E. Based on observation and staff interview, the facility failed to ensure exit signs were illuminated in 1 of 2 smoke compartments. The findings were: Observation of the southwest corridor on 12/18/12 at 9:03 AM showed the exit sign near resident room #106 was not illuminated. Further observation showed the sign was equipped with LED bulbs. At the time of the observation the executive director reported the exit signs were not routinely inspected to ensure they were illuminated. She was unsure when the bulb in the sign stopped working. Reference, 32.3.2.10; 7.10.7.2 Photoluminescent Signs. The face of a photoluminescent sign shall be continually illuminated while the building is occupied ... F. Based on observation and staff interview, the facility failed to ensure a fire watch policy was provided. The findings were:	SALF	1. Effective 02/01/13 the facility will test emergency battery lights on a monthly basis. Each monthly test will consist of a 30-second test and at least once every 12 months a 90 minute test will be performed on each battery light. 2. Prior to 2/15/13 the maintenance department will perform a 90 minute emergency battery light testing, note any necessary repairs, make record of the test and notify administration of any abnormalities. 3. The 30 second tests will be performed by depressing the test button on all emergency lights and verifying illumination on each fixture. The 90 minute test will be performed by shutting off power to the emergency battery lights. A delay of no more than 10 seconds to transfer power to the batteries will be verified. All fixtures will be checked during and at the end of 90 minutes to verify illumination. 4. If staff recognizes an outage in between testing periods management is to be notified immediately and maintenance will be dispatched.	

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SALF	Continued From page 4 Review of the facility policies showed the facility did not have a fire watch policy in the event the fire alarm system or sprinkler systems were impaired. On 12/17/12 at 4 PM the executive director confirmed she was unaware a fire watch policy was required. Reference, 32.3.3.4.1; 9.6.1.6* Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.7.6.1 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. G. Based on observation and staff interview, the facility failed to ensure pull stations were unobstructed, failed to test 4 of 8 fire alarm system components, and failed to ensure the central station certificate was posted. The findings were: 1. Observation of the north exit corridor on 12/18/12 at 8:54 AM showed the pull station near the exit door was obstructed by a large potted plant. At the time of the observation the executive director reported she was unaware pull stations were required to be unobstructed at all times. 2. Review of the fire alarm system testing records	SALF	5. Management will monitor testing records to ensure testing is completed for each 30 day interval. The policy will be reviewed annually by administration and staff for continued compliance. SALF – E. 1. Effective 02/01/13 it is the facility will implement a monitoring tool to check Exit signs for illumination on a monthly basis. The monthly verification will be recorded by maintenance staff. 2. Prior to 2/15/13 the maintenance department will verify proper illumination of all Exit signs, note any necessary repairs, make record of the test and notify administration of any non-working fixtures. 3. The check will be performed by a visual inspection to verify illumination on each fixture. 4. If staff recognizes an outage in between testing periods management is to be notified immediately and maintenance will be dispatched. 5. Management will monitor testing records to ensure testing is completed	02/15/13

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SALF	Continued From page 5 showed the system receiver was not activated during the months of December 2011, March, April, and August 2012. On 12/18/12 at 11:15 AM the executive director reported she was unaware of the aforementioned testing requirement. 3. Review of the fire alarm system testing records showed the last annual fire alarm system was performed on 3/2/12. Further review showed a semi-annual battery load voltage test had not been on the fire alarm control panel since the 3/2/12 test. On 12/18/12 at 11:15 AM the executive director reported she was unaware of the aforementioned testing requirement. 4. Review of the fire alarm system testing records showed the last quarterly supervisory signal device test was performed on 1/24/12. On 12/18/12 at 11:15 AM the executive director reported she was unaware the aforementioned test was a quarterly requirement. 5. Observation of the fire alarm control panel on 12/18/12 at 11:24 AM showed the central station certificate was not posted near the panel. At the time of the observation the executive director reported she was unaware a central station certificate was required and required to be posted with 36 inches of the panel. Reference, 32.3.3.4.1; 9.6.2.6 Each manual fire alarm box on a system shall be accessible, unobstructed, and visible. Reference, 32.3.3.4.1, 9.6.1.3, NFPA 72, 2002 Edition; Table 7-3.2 Testing Frequencies. 6. Batteries-Fire alarm systems d. Sealed Lead-Acid Type 3. Load Voltage Test,.....semi-annually 15. Initiating Devices	SALF	for each 30 day interval. The monitoring tool will be reviewed annually by administration and staff for continued compliance. SALF – F. 1. The facility will be implementing a Fire Watch policy on 02/01/13 in the event the fire alarm system and/or sprinkler systems become impaired. 2. Administration will be responsible for writing and implementing the Fire Watch policy in addition to training staff. 3. Administration will meet with staff on a bi-annual basis to review the Fire Watch policy in addition to training any new staff members in the interim. 4. We will be checking with building construction professionals to gain more information regarding the Fire Watch code requirements. Administration will continue to expand their knowledge of the NFPA fire code. 5. The Fire Watch policy will be reviewed annually by administration and staff for continued compliance.	02/01/13

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SALF	Continued From page 6 j. Supervisory Signal Devices,.....quarterly k. Waterflow Devices,.....quarterly 23. Receivers,.....monthly 8.2.4.1.2 A document attesting to certification shall be located on or within 1 m (36 in.) of the fire alarm system control unit or, if no control unit exists, on or within 1 m (36 in.) of a fire alarm system component. H. Based on observation and staff interview, the facility failed to ensure sprinklers were unobstructed in 2 of 2 smoke compartments. The findings were: Observation of the sprinkler system on 12/18/12 between 8 AM and 10 AM showed the following sprinkler heads were located above the bottom of obstructions. a. The sprinkler head in the north housekeeping closet was obstructed by ventilation duct work. b. The sprinkler head in the laundry was obstructed by a ceiling mounted light. c. The sprinkler head in the staff lounge was obstructed by a ceiling mounted light. On 12/18/12 at 9:53 AM the executive director reported that the sprinkler system was not inspected annually to ensure heads were not obstructed. Reference, 32.3.3.5.1, 9.7.1.1, NFPA 13, 2002 Edition; 8.6.4.1.1.1 Under unobstructed construction, the distance between the sprinkler deflector and the ceiling shall be a minimum of 1 in. and a maximum of 12 in. throughout the area of coverage of the sprinkler. Table 8.6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (Standard Spray Upright/Standard Spray Pendent)	SALF	SALF – G. 1. Effective 02/01/13 facility Monthly Fire Drill policy has been modified to include: verification that pull stations are unobstructed, and that the system receiver is activated each time. The posting of a central station certificate and expiration date (of applicable) will posted within 36 inches of the fire alarm control panel, and will be verified on the date of each fire drill. The policy will further reflect the requirement to perform a semi-annual battery load voltage test in addition to a quarterly supervisory signal device test. The policy will reflect the requirement to verify the posting of a central station certificate within 36 inches of the fire alarm control panel, and necessity for signing off each month as to its validity. 2. Administration will be responsible for rewriting the Monthly Fire Drill and the record sheets for quarterly and semi-annual aforementioned testing and verifications. Administration and Maintenance will be responsible for implementing policies and recording findings.	02/01/13

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SALF	Continued From page 7 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 I. Based on observation and record review, the facility failed to ensure 1 of 5 sprinkler system components was tested. The findings were: Review of the sprinkler system testing records showed the backflow preventer had not been tested in the past year. On 12/18/12 at 11:15 PM the executive director reported she was unaware of the backflow preventer testing requirement. Reference, NFPA 101, 2006 Edition, 32.3.3.5.1, 9.7.6.2, NFPA 25, 2002 Edition; 12.6.2.1 All backflow preventers installed in fire protection system piping shall be tested annually ... J. Based on observation and staff interview, the facility failed to ensure fire extinguishers were properly mounted and failed to ensure monthly inspections were conducted on 1 of 6 extinguishers. The findings were: Observation the mechanical room on 12/17/12 at 5:30 PM showed the extinguisher was sitting on the ground. Further observation showed there was not a hanger or cabinet to store the	SALF	3. The policy is being modified to include the items not previously addressed on a monthly, quarterly and semi-annual basis. 4. Administration will defer to Fire Code professionals for any additions or changes that need to be incorporated into facility policy. 5. The Fire Alarm Policies and Control Reports will be reviewed annually for quality assurance and compliance by administration. H. 1. The facility policy is that all sprinkler heads meet the required NFPA code. 2. The facility has hired a licensed electrician and fire suppression contractor to assist in meeting NFPA codes. 3. Electrical contractors will be replacing or moving electrical fixtures to meet all NFPA codes by 02/15/13. Fire suppression system contractors will be replacing and/or relocating sprinkler heads that are obstructed.	02/15/13

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SALF	Continued From page 8 extinguisher in. Observation also showed a monthly inspection tag was not provided. At the time of the observation the executive director reported she was unaware this extinguisher was is this location. Reference, 32.3.3.5.6, 9.7.4.1, NFPA 10, 2002 Edition, 1.5.7 Portable fire extinguishers other than wheeled extinguishers shall be installed securely on the hanger, or in the bracket ...approved for such purpose ... 6.2 Inspection. 6.2.1 Frequency. Extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals .... K. Based on observation and staff interview, the facility failed to ensure ashtrays were self-closing in 2 of 2 smoke compartments. The findings were: Observation on 12/18/12 between 8 AM and 9 AM showed the ashtray located near the northeast exit was an open top dish type receptacle. Further observation showed the ashtray at the front entrance had the same design. On 12/18/12 at 8:56 AM the executive director reported she was unaware open top ashtrays were prohibited. Reference; 32.7.4.2 Where smoking is permitted, noncombustible safety-type ashtrays or receptacles shall be provided in convenient locations. L. Based on observation and staff interview, the facility failed to ensure window curtains and decorations were flame retardant in 2 of 2 smoke	SALF	4. All sprinkler heads will be inspected annually by maintenance to insure they are unobstructed. 5. Administration will confer with fire suppression (sprinkler system) contractor during each inspection to help ensure that components of the NFPA code(s) are in compliance. I. 1. The facility will ensure that all (5) sprinkler system components are tested during the required testing periods. 2. A licensed fire suppression system contractor will perform the backflow test prior to 02/15/13. 3. A licensed fire suppression system contractor will perform all required sprinkler system tests during their required periods and provide administration with their report of inspection. 4. Administration will confer with fire suppression (sprinkler system) contractor during each inspection to help ensure that components of the NFPA code(s) are in compliance.	02/15/13

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SALF	Continued From page 9 compartments. The findings were: 1. Observation on 12/18/12 between 9 AM and 11 AM showed the window curtains in the following areas did not have flame retardant documentation attached to them: a. Resident room #110 b. Resident room #116 c. Resident room #205 d. Resident room #207 On 12/18/12 at 9:12 AM the executive director reported she was unaware window curtains and loose hanging fabrics were required to be flame retardant. 2. Observation on 12/18/12 between 9 AM and 10:30 AM showed the following locations had decorations that were not flame retardant: a. Resident room #108 had a live cut pine bough wreath on the corridor door b. Resident room #115 had a live cut pine bough wreath on the corridor door c. Resident room #116 had a live cut Christmas tree d. Resident room #213 had a live cut pine bough wreath on the corridor door On 12/18/12 at 9:09 AM the executive director reported she was unaware live cut trees and boughs were prohibited as they were not flame retardant. Reference; 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	SALF	5. The Fire Suppression/Sprinkler System test policy will be reviewed annually by administration for quality assurance and compliance. J. 1. The facility will ensure that all required fire extinguishers are properly mounted and inspected monthly. 2. Effective 02/01/13 the maintenance department will be responsible for mounting and maintaining inspection records for all fire extinguishers. 3. All extinguishers will be mounted and inspected for compliance with NFPA code. The maintenance department will keep a record of all monthly inspections and report to administration any discrepancies. 4. We will continue to rely upon Fire Code professionals for notification of changes in the code and/or requirements and will incorporate any necessary changes into our policy. Administration will continue to expand their knowledge of the NFPA fire code. 5. The Fire Extinguisher test policy will be reviewed annually by	02/01/13

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SALF	Continued From page 10 demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. M. Based on observation and staff interview, the facility failed to maintain adequate work space in front of electrical equipment and failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 2 of 2 smoke compartments. The findings were: 1. Observation of the main electrical room on 12/17/12 at 5:33 PM showed six card board boxes were stored in front of the main switch gear panel. At the time of the observation the executive director reported she was unaware items were not allowed to be stored in front of the electrical equipment. 2. Observation of the electrical system on 1218/12 between 9 AM and 10 AM showed the following locations had temporary wiring replacing fixed permanent wiring: a. The bed lamp in resident room #106 was plugged into an extension cord b. The television set in resident room #112 was plugged into an extension cord c. The television set in resident room #201 was plugged into a 3-way adapter On 12/18/12 at 9 AM the executive director reported she was unaware electrical adapter were prohibited. She further reported that the electrical system was not routinely inspected. Reference, 32.3.6.1, 9.1.2, NFPA 70, 2002 Edition; 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation	SALF	administration for quality assurance and compliance. K. 1. Where smoking is permitted, the facility will ensure all ashtrays are noncombustible safety-type. 2. Administration is replacing current ashtrays by 02/15/13. 3. Administration is choosing noncombustible safety-type ashtray or receptacle to replace the existing ashtrays. 4. When new equipment is being purchased for the building administration will check to ensure it meets NFPA code. 5. The Smoking area policy and equipment will be reviewed annually by administration for quality assurance and compliance. L. 1. Effective 02/15/13 the facility will implement a Hazardous Conditions monitoring tool to ensure all draperies, curtains and similar loosely hanging furnishings and decorations shall be flame resistant. No live cut wreaths	02/15/13 02/15/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF022	A. BUILDING _____ B. WING _____	12/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE MANOR INC	830 NORTH MAIN STREET BUFFALO, WY 82834

1/24/13

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SALF	Continued From page 11 and maintenance of such equipment ... (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26 (A)(1), (2), and (3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of access to live parts shall not be less than indicated in table 110-26(A)(1) ... Table 110-26(A)(1) . Nominal Voltage To Ground — Minimum Clear Distance (ft) . 0-150 — 3 ft (B) Clear Space. Working space required by this section shall not be used for storage ... 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 Section 7. Assisted Living Facility (ALF) Core Services. (o) Evacuation Capability, Emergency Procedures, and Fire Safety. (iii) Fire Safety.	SALF	and/or trees shall be permitted. If product is not designated as flame resistant it must be sprayed with a NFPA approved fire retardant spray. 2. Housekeeping will be responsible for applying the Fire Retardant spray upon any of the aforementioned fabrics at the time of resident move in. 3. Upon move-in Administration and/or Director of Resident care will inspect fabrics to be hung and note which need to be treated. 4. There will be quarterly inspections of resident rooms in an attempt to identify any hazardous conditions including newly hung fabrics that have not been treated with FRS. 5. The Hazardous Conditions monitoring tool will be reviewed annually by administration for quality assurance and compliance. M. 1. Effective 02/01/13 work space on front of electrical equipment shall be provided and maintained free of any object.	02/15/13

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SALF	Continued From page 12 (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 evidenced by: --- N. Based on record review and staff interview the facility failed to ensure fire drills were conducted on each shift on a quarterly basis and failed to	SALF	Electrical adapters are prohibited in resident rooms. If an electrical adapter is required a power strip with cord must be utilized. 2. Administration will be responsible for checking the workspace in front of all electrical equipment utilizing a Hazardous Conditions monitoring tool. Administration and maintenance will be responsible for inspection resident rooms and replacing any electrical adapters with power strips by 02/15/13. 3. Beginning 02/15/13 a monthly inspection of the maintenance and housekeeping areas will be conducted by Administration. Administration will be looking to verify all areas in front of electrical equipment are free of any objects and that there is a designated area that informs users not to place items within the marked zone. A quarterly inspection of resident rooms for electrical adapters will be conducted beginning 02/15/13. Any electrical adapter will be replaced with a power strip.	

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SALF	Continued From page 13 ensure a minimum of 12 fire drills were conducted annually. The findings were: Review of the fire drill records showed the first shift occurred between 6 AM and 6 PM and the second shift occurred between 6 PM and 6 AM. Record review showed a fire drill had not been conducted during the second shift in the past four quarters. Further review also showed only 8 fire drills had been conducted in the past year. On 12/18/12 at 11:15 AM the executive director could not explain why a fire drill had not been conducted during the second shift over the past year or why 12 drills had not been conducted over the past year.	SALF	4. There will be quarterly inspections of resident rooms to identify any hazardous conditions including newly hung fabrics that have not been treated with FRS and for any non-compliant electrical adapters. We will continue to rely upon the Fire Code professionals for updates and changes in the code and/or requirements and incorporate any necessary changes into our policy. Administration will continue to expand their knowledge of the NFPA fire code. 5. The Hazardous Conditions monitoring tool will be reviewed annually by administration for quality assurance and compliance. N. 1. Effective 02/01/13 facility Monthly Fire Drill policy has been modified to ensure a minimum of 12 fire drills are conducted annually, including one on each shift on a quarterly basis. 2. Administration will be responsible for rewriting the Monthly Fire Drill and the record sheets for quarterly and monthly aforementioned testing and verifications. Administration and Maintenance will be responsible for	02/01/13

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