Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF017	A. BUILDING _____ B. WING _____	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ASSISTED LIVING	950 HOMESTEAD AVENUE RIVERTON, WY 82501

(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		

Life Safety Code survey was conducted at your facility on November 26-27, 2012 by the office of Healthcare Licensing and Surveys, (HLS).

The facility was a single story fully sprinkled building of Type V (111) construction built in 1996 and 1997. The building was equipped with a supervised automatic dry sprinkler system with an anti-freeze loop and an addressable fire alarm system. The facility had a capacity of 49 licensed beds with a census of 37 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 walls were smoke

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M Christensen RN — TITLE: Adm — (X6) DATE: 1-16-13

STATE FORM 6899 FYFD11 If continuation sheet 1 of 12

POC ACCEPTED W/ GERRIT VENNIE, OPERATIONS MANAGER, ON 1/17/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF017	A. BUILDING _____ B. WING _____	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ASSISTED LIVING	950 HOMESTEAD AVENUE RIVERTON, WY 82501

1/17/13

(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 1 resistant in 1 of 4 smoke compartments. The findings were: Observation of the sprinkler riser room on 11/26/12 at 5:08 PM showed a 2 inch by 8 inch gap around the main sprinkler riser pipe. At the time of the observation the manager reported the pipe was modified more than one year ago. He could not explain why the gap was not filled. Reference NFPA 101, 1994 Edition; 22-3.1.3.1 Construction requirements for large facilities shall be as required by this section. Where noted as fully sheathed, the interior shall be covered with a lath and plaster or material providing a 15-minute thermal barrier. B. Based on observation and staff interview, the facility failed to ensure 1 of 3 sets of smoke barrier doors were smoke resistant. The findings were: Observation of the East wing smoke barrier double doors on 11/26/12 at 4:26 PM 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 manger reported the doors were not routinely inspected to ensure they would fully latched into the door frame. Reference NFPA 101, 1994 Edition; 1-7.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained.	SALF	A. Gap Around Sprinkler Riser 1. POC: To plaster hole closed. 2. Improving Process: Management must be more attentive to actions by contract maintenance activities during repairs and modifications to facility and equipments. 3. Procedures for Implementing: Acquire suitable plaster, patching material and tools and plug hole. 4. Completed date: 5. Make note in QAPI guidelines on need to be ultra sensitive while performing scheduled inspection routines required by various regulatory agencies. B. East Wing Barrier Door 1. POC: Engage professional door service to examine and repair latching mechanism. 2. Improving Process: Management must be more critical of latching during tests. Include as item for special attention during fire drills and annual alarm testing 3. Procedure for Implementing: Contacted service agency to perform repair on 12/17/12. 4. Completion date: 5. Include as item for discussion at quarterly QAPI meeting.	12/03/12 12/26/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF017	A. BUILDING _____ B. WING _____	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ASSISTED LIVING	950 HOMESTEAD AVENUE RIVERTON, WY 82501

1/17/13

(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 2 unless the Code exempts such maintenance. C. Based on observation and staff interview, the facility failed to ensure emergency battery lights were operational in 1 of 4 smoke compartments. The findings were: Observation of the west wing electrical room on 11/26/12 at 4:05 PM showed the light would not illuminate when the test button was depressed. At the time of the observation the manger could not explain why the light did not work. Reference NFPA 101, 1994 Edition; 23.3.2.9 Emergency Lighting. Emergency lighting in accordance with Section 5-9 shall be provided ... 5-9.2.1 Emergency illumination shall be provided for a 1 ½ hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 footcandle. 31-1.3.7 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for a minimum of 30 seconds. An annual test shall be conducted for the 1 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 record review and staff interview, the facility failed to ensure 4 of 7 fire alarm system component were properly tested. The findings were: 1. Review of the fire alarm system testing records showed the control panel batteries, alarm	SALF	C. Emergency Light Failure: 1. POC: Lighting unit defunct. Replace with new unit. 2. Improving Process: Records reveal light apparently functioned properly on 11/18/2012. An electro mechanical device, as such, that it might fail after fifteen years is not unlikely. Investigate cost and possibility of need to replace other units. 3. Procedure for implementing: Engaged service provider to obtain and install suitable replacement. 4. Completion date: 5. Present as item of emphasis QAPI quarterly meeting. D. Alarm System Testing: Control Panel Batteries, Alarm Notification Appliances, Heat Detectors: 1. POC: (a.) Incorporate prescribed testing of NAPA72,1993 Edition into appropriate testing and maintenance schedule for batteries (annual & semi-annual), alarm notification appliances (annual) and heat detectors (annual). (b.) As above, Receiver (monthly) 2. Improving Process: Testing schedule, which above cited criteria will replace should preclude recurrence of deficiency.	12/21/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF017	A. BUILDING _____ B. WING _____	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ASSISTED LIVING	950 HOMESTEAD AVENUE RIVERTON, WY 82501

1/17/13

(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 3 notification appliance, and heat detectors have not been tested in the past two years. On 11/27/12 at 9 AM the administrator confirmed the aforementioned devices have not been tested in the past two years. She could not explain why the devices had not been tested. 2. Review of the fire alarm system activation records showed the system receiver had not been tested during the months of November 2011 and July 2012. On 11/27/12 at 9 AM the administrator reported the fire system is activated with fire drills, but if a fire drill is not performed each month, the fire alarm system is not activated. Reference NFPA 101; 1994 Edition; 23-2.3.4.1 Fire Alarm Systems, A manual fire alarm system shall be provided in accordance with Section 7-6. 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 72, National Fire Alarm Code. NFPA 72, National Fire Alarm Code, 1993 Edition; Table 7-3.2 Testing Frequencies: 1. Control Equipment-Buildings Not Connected to a Supervising Station a. Functions, quarterly b. Fuses, quarterly c. Interfaced Equipment, quarterly d. Lamps and LED ' s, quarterly e. Primary Power Supply, quarterly f. Transponders, quarterly 6. Batteries-Fire alarm systems d. Sealed Lead-Acid Type 1. Charge Test annually (Replace batteries every 4 years.), 2. Discharge Test (30 minutes), annually 3. Load Voltage Test, semi-annually	SALF	3. Procedure for implementing: Perform prescribed testing and documentation. 4. Completion date: 5. Present as agenda item for familiarization at quarterly QAPI.	12/21/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF017	A. BUILDING _____ B. WING _____	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ASSISTED LIVING	950 HOMESTEAD AVENUE RIVERTON, WY 82501

1/17/13

(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 4 15. Initiating Devices a. Duct Detectors, annually e. Heat Detectors, annually f. Fire Alarm Boxes, annually h. All Smoke Detectors, annually i. Smoke Detectors-Sensitivity, bi-annually 19. Alarm Notification Appliances a. Audible Devices, annually c. Visible Devices, annually 23. Receivers, monthly E. Based on observation and staff interview, the facility failed to ensure sprinklers were provided with escutcheons and failed to ensure sprinkler were unobstructed in 1 of 4 smoke compartments. The findings were: 1. Observation of the kitchen on 11/26/12 at 4:15 PM showed 1 of 3 sprinkler heads was missing an escutcheon ring. At the time of the observation the manager could not explain why the ring had not been noticed and replaced during the quarterly safety inspections. 2. Observation of the sprinkler system on 11/27/12 between 9:30 AM and 10:30 AM showed two sprinkler heads in the attic above the administrator's office were obstructed by wood trusses. The closest truss was 6 inches from and 3 inches below the sprinkler deflector. Further observation showed one sprinkler head in the attic above the kitchen was 8 inches from and 2 inches below the sprinkler deflector. On 11/27/12 at 9:57 AM the manager reported the attic sprinklers were not inspected on an annual basis to ensure sprinkler heads were unobstructed. Reference NFPA 101, 1994 Edition; 22-3.3.5.1 All buildings shall be protected throughout by an approved, automatic sprinkler	SALF	E. Escutcheon: (a.) Missing escutcheon 1. POC: Replace escutcheon. 2. Improving Process: Given we have ongoing problem with falling escutcheons; and given the State Health probably has a plethora of information on securing same, take this occasion to request from them such advice as they may have available. 3. Procedure for Implementing: Locate missing escutcheon and obtain necessary tools and replace escutcheon. 4. Completion date: 5. Report on results of communications with State Dept of health at quarterly QAPI. (b.)Sprinkler Heads in Attic: 1. POC: Inspect and modify sprinklers lines as necessary to meet criteria cited in RP-2012-1109. 2. Improving Process: Should Management, if ever, construct another facility, we must be sensitive to insure contractor is cognizant of how to install sprinklers and monitor such installation closely. 3. Procedure to implement: Engage contractor to perform POC. 4. Completion date: 5. Share information in house at quarterly meeting.	12/13/12 ~~01/12/13~~ 01/22/13

F. Portable Fire Extinguisher: TO PAGE 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF017	A. BUILDING _____ B. WING _____	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ASSISTED LIVING	950 HOMESTEAD AVENUE RIVERTON, WY 82501

(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 5 system installed in accordance with Section 7-7. Quick response or residential sprinklers shall be provided throughout. Such systems shall initiate the fire alarm system in accordance with Section 7-6. 7-7.1.1 Each automatic sprinkler system required by another section of this Code shall be installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems .... NFPA 13, Standard for the Installation of Sprinkler Systems, 1994 Edition. 2.2.6.2* Escutcheon plates used with a recessed or flush type sprinkler shall be part of a listed sprinkler assembly. 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 foot ... ...0 inch 1 foot to2 feet... ... ...1 inch 2 feet to 2 ½ feet ... ...2 inches 2 ½ feet to 3 feet ... ...,3 inches 3 feet to 3 ¼ feet ... ...4 inches F. Based on observation and staff interview, the facility failed to ensure portable fire were properly tested in 1 of 4 smoke compartments. The findings were: Observation of the kitchen on 11/26/12 at 4:13 AM showed the "K" type portable fire extinguisher was last hydrostatic tested in 2006. At the time of the observation the manager was unaware wet type extinguisher required a 5 year hydrostatic test. He reported that he relied upon the contractor to test the extinguishers as needed.	SALF		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF017	A. BUILDING _____ B. WING _____	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ASSISTED LIVING	950 HOMESTEAD AVENUE RIVERTON, WY 82501

1/17/13

(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 6 Reference NFPA 101, 1994 Edition; 22-3.3.5.3 Portable Fire Extinguishers. Portable fire extinguishers in accordance with 7-7.4.1 shall be provided near hazardous areas. 7-7.4.1 ....Portable fire extinguishers shall be installed in accordance with NFPA 10, Standard for the Installation of Portable Fire Extinguishers. NFPA 10 Standard for the Installation of Portable Fire Extinguishers, 1990 Edition. 4-4.1 Frequency. Fire Extinguishers shall be subjected to maintenance at intervals of not more than 1 year, and the time of hydrostatic test, of when specifically indicated by an inspection. Table 5-2 Hydrostatic Test Intervals for Extinguishers Wet Agent----------5 years G. Based on observation and staff interview, the facility failed to ensure approved ashtrays were provided at the smoking area. The findings were: Observation of the south exit on 11/26/12 at 5:10 PM showed numerous cigarette butts were sitting in a terracotta planting dish on the ground. At the time of the observation the manager reported smoking was prohibited within 50 feet of the building, but one resident still smokes directly outside of the south exit door. He could not explain why the area was not provided with a self-closing type ashtray if the resident would not follow the facility rules. Reference NFPA 101, 1994 Edition; 31-7.4 Smoking. Where smoking is permitted, noncombustible safety-type ashtrays or receptacles shall be provided in convenient locations. H. Based on observation and staff interview, the	SALF	F. Portable Fire Extinguisher: 1. POC: Have extinguisher hydrostatic tested or replaced with up to date device. 2. Improving the Process: Once POC completed annotate monthly extinguisher examination log with due date for next hydrostatic test. 3. Procedure to Implement: Engage contractor to perform POC. 4. Completion date: 12/31/12 5. Include as general information item at QAPI quarterly conference. G. Ashtrays & Smoking: 1. POC: Insure that residents are cognizant of the restrictions on smoking and the consequences for violation thereof. 2. Improving the Process. Be more aggressive in removing non compliant residents. 3. Procedure for Implementing: Implement the POC. 4. Completion date: Resident Transfer 5. Stress the importance of	12/10/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF017	A. BUILDING _____ B. WING _____	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ASSISTED LIVING	950 HOMESTEAD AVENUE RIVERTON, WY 82501

1/17/13

(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 7 facility failed to ensure window curtains were flame retardant in 1 of 4 smoke compartments. The findings were: Observation of resident room #3 on 11/26/12 at 4:53 PM showed flame retardant documentation was not attached to the window curtains. At the time of the observation the manager reported the facility did not spray curtains or loose fabric wall hanging with a flame retardant solution. Reference NFPA 101, 1994 Edition; 31-7.6.1 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. 31-1.4.1 Where required by the applicable provisions of this chapter, draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame retardant as demonstrated by passing both the small- and large-scale tests of NFPA701 ... I. Based on observation and staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 1 of 4 smoke compartments. The findings were: Observation of the electrical system on 11/26/12, between 4:30 PM and 5 PM showed the bedroom lamp, in resident room #23, was plugged into a 3-way electrical adapter. Further observation showed the drier in the east laundry room was plugged into an orange extension cord. The extension cord was plugged into an electrical outlet more than 10 feet away from the drier, which was the closest outlet to the drier. On 11/26/12 at 4:32 PM the manager could not explain why the aforementioned electrical adapter had not been noticed and removed during the	SALF	H. Flame retardant: 1.POC: To assemble inventory of rooms with items requiring application of spray retardant, and so treat such items. Establish and maintain log on location and update as residents move in & out. 2. Improving the Process: Need to include statements in rental agreement to acquaint residents with the requirement for use of fire retardant materials with residency in assisted living accommodations. 3. Housekeeping will be assigned task of implementing POC. 4. Completion date: 5. Report on scope of such materials in use in facility and the impact on the labor force of applying flame retardant, tagging materials and maintaining appropriate records. I. Electrical Wiring: 1. POC: (a.) Remove the three way adapter in Rm #23, substitute power strip if necessary. (b.) Provide permanent electrical outlet for recently acquired clothes washer. 2. Improving Process: Management must be more attentive and responsive during arrival of new resident and equipment.	1/12/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF017	A. BUILDING ______ B. WING ______	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ASSISTED LIVING	950 HOMESTEAD AVENUE RIVERTON, WY 82501

1/17/13

(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 8 quarterly inspections. Reference NFPA 101, 1994 Edition, 22-3.6.1, 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 K-050 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:	SALF	3. Procedure for Implementing: (a.) Insure removal of the 3 way adapter. (b.) Engage electrical contractor to install suitable electrical (110V) outlet. 4. Completion date: (a.) 3 way adapter (b.) Electrical outlet 5. Include comment on nature of deficiency and corrective action at QAP quarterly meeting.	 12/19/12 12/07/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF017	A. BUILDING _____ B. WING _____	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ASSISTED LIVING	950 HOMESTEAD AVENUE RIVERTON, WY 82501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO 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 9 (I) Prompt - maximum of three (3) minutes (II) Slow - between three (3) and thirteen (13) minutes (III) Impractical - more than thirteen (13) minutes (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:	SALF		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF017	A. BUILDING _____ B. WING _____	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ASSISTED LIVING	950 HOMESTEAD AVENUE RIVERTON, WY 82501

1/17/13

(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 10 J. Based on record review, observation and staff interview, the facility failed to ensure fire drills were conducted on each shift during 2 of the past 4 quarters, failed to collect the total time of evacuation for each fire drill and failed to ensure residents fully evacuated the facility during each fire drill. The findings were: 1. Review of the fire drill records showed the second shift occurred between 3 PM and 11 PM and the third shift occurred between 11 PM and 7 AM. Further review showed a fire drill had not been conducted on the third shift during the second quarter of 2012. A fire drill had not been conducted on the second shift during the third quarter of 2012. On 11/27/12 at 9 AM the administrator could not explain why fire drills had not been conducted each shift on a quarterly basis. 2. Review of the fire drill records showed the time of evacuation was not collected for the 12/23/11, 4/29/12, and 6/1/12 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 11/27/12 at 9 AM the administrator reported she was unaware the minutes and seconds were required to be documented for each drill. 3. Observation of the fire drill on 11/27/12 at 9:42 AM showed the residents did not fully evacuate the building. The residents walked to an exit door and stopped. On 11/27/12 at 9:55 AM after the fire alarm system was returned to normal, the administrator reported she was unaware the residents were required to fully evacuate the building with each activation of the fire alarm.	SALF	J. Fire Drills: 1. POC: The Maintenance Director and/or Administrator will conduct fire drills in accordance with Life Safety Codes. 2. Improving Process: the Administrator has developed a Fire Drill Log and Critique to aid in compliance with LSC. The Fire Drill Log has shaded quarters to insure timeliness. The Fire Critique form provides for minutes and seconds recordation of evacuation timing. 3. Procedure for Implementing: Incorporate newly defined criteria into Fire Drill exercises. 4. Completion date: 5.The Maintenance Director and/or Administrator will insure all residents fully evacuate the building at each drill. Compliance will be evaluated quarterly at QAPI meetings.	12/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF017	A. BUILDING _____ B. WING _____	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ASSISTED LIVING	950 HOMESTEAD AVENUE RIVERTON, WY 82501

(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 Reference NFPA 101, 2000 Edition; 32.7.3 Emergency Egress and Relocation Drills. Emergency egress and relocation drills shall be 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		