PRINTED: 10/24/2012
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Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF026	A. BUILDING _____ B. WING _____	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER TRAIL ASSISTED LIVING	2360 REAGAN AVENUE ROCK SPRINGS, WY 82901

(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 A Life Safety Code survey was conducted at your facility on October 9-10, 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 2012. The building was equipped with a supervised automatic wet sprinkler system and an addressable fire alarm system. The facility had a capacity of 62 licensed beds and a total census of 11 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, Health Care with mixed occupancy of New Board and Care, 2006 Edition, unless otherwise noted. The mixed occupancy is required because the facility does not have a 2-hour rated separation wall between the assisted living (Board & Care Occupancy) and memory care (Health Care Occupancy) portions of the building.	SALF		

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys

Owner — TITLE

11/16/12 — (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

POC ACCEPTED W/ TINA GOODELL-WAYZE, ADMINISTRATOR, ON 11/20/12.

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SALF	Continued From page 1 This regulation was NOT MET as evidence by: --- A. Based on observation and staff interview, the facility failed to ensure corridor doors were equipped with latching hardware in 1 of 4 smoke compartments. The findings were: Observation of the Game Room on 10/9/12 at 6:50 PM showed the double corridor doors were not provided with latching hardware. At the time of the observation the maintenance director reported he was unaware the building was designed to Health Care and Board and Care occupancy. He was also unaware Health Care occupancies require latching hardware on all corridor doors. Reference; 18.3.6.3 Corridor Doors 18.3.6.3.5 Doors shall be provided with positive latching hardware. B. Based on observation and staff interview, the facility failed to ensure 2 of 4 smoke barrier walls were smoke resistant. The findings were: Observation on 10/10/12 between 9 AM and 9:30 AM showed the smoke barrier wall near resident room #133 had two unsealed conduit penetrations. Further observation showed the smoke barrier wall near resident room #102 had five unsealed conduit penetrations. The largest gap measured 1 inch by 2 inches. On 10/10/12 at 9:07 AM the maintenance director reported the smoke barrier walls had not been routinely inspected as he assumed the building contractor had sealed all penetrations when the installation was complete.	SALF	A. The facility will ensure that the Game Room doors are equipped with positive latching hardware. a) the facility will retain a qualified workmen to b) install positive latching hardware on both sets of the Game Room doors. c) Facility maintenance staff will inspect the working conditions of the hardware, and d) such inspections of hardware shall occur on a quarterly basis. B. The facility will ensure that all smoke barrier walls are smoke resistant by: a) the facility will retain a qualified workmen to b) seal all unsealed penetrations identified, near resident room #133 and #102 with fire caulk. c) Facility maintenance staff will inspect the identified areas on a quarterly basis. Additionally, all contractors working in the building will be required to sign an agreement stipulating that in the event penetrations are made, all will be resealed to Life Safety and NFPA standards, and d) such inspections of penetrations shall occur on a quarterly basis.	12/21/12 12/21/12

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SALF	Continued From page 2 Reference; 18.3.7 Subdivision of building services 18.3.7.4 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a fire resistance rating of not less than 1-hour ... C. 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 mechanical room #103B on 10/9/12 at 4:29 PM showed three unsealed conduit penetrations. The largest gap was a ½ inch gap. At the time of the observation the maintenance director reported hazardous areas were not routinely inspected as he assumed the building contractor had sealed all penetrations when the installation was complete. Reference; 18.3.2.1 Hazardous areas. Any hazardous areas shall be protected in accordance with Section 8.7, and the areas described in Table 18.3.2.1 shall be protected as indicated. Table 18.3.2.1 Boiler and fuel-fired heater rooms .....1-hour separation/protection D. Based on observation and staff interview, the facility failed to ensure corridors were clear and unobstructed in 2 of 4 smoke compartments. The findings were: Observation on 10/10/12 at 10:55 AM showed the corridors were built 8 feet wide. Further observations showed the junctions near resident room #142, #126 and #108 all had a short chest	SALF	C. The facility will ensure that hazardous areas are separated from use areas in smoke compartments by: a) The facility will retain qualified workmen to b) seal three unsealed conduit penetrations in mechanical room #103B. c) Facility maintenance staff will inspect mechanical rooms, and all contractors entering the building will be required to sign an agreement stipulating that all penetrations will be resealed to facility (and OHLS) standards, and d) such inspections of penetrations shall occur on a quarterly basis. D. The facility will ensure that corridors are clear and unobstructed in corridors to allow a minimum of 6'0" clear. a) The facility staff has been notified, b) all furnishings that conflict with the required clearance of 6'0" have been removed, c) Facility maintenance staff will inspect such corridor areas, and d) such inspections of clearances shall occur on a monthly basis.	12/21/12 12/21/12

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SALF	Continued From page 3 of drawers and two upholstered chairs. The furnishings projected 2 ½ feet into the corridor. Observation of the separation wall separating the assisted living and memory care unit on 10/10/12 at 10:05 AM showed the building was not separated by a 2-hour rated fire barrier. This lack of separation required the building to be built and maintained to a mixed Health Care and Board and Care Occupancy. On 10/10/12 at 10:55 AM the maintenance director was unaware the corridors must be maintained clear and unobstructed to the full 8 foot width as the building was built to Health Care standards. Reference; 18.2.3.3* Aisles, corridors, and ramps required for exit access in a hospital or nursing home shall be not less than 8 ft (2440 mm) in clear and unobstructed width ... E. Based on observation and staff interview, the facility failed to ensure the emergency generator annunciator were properly installed and failed to ensure the emergency generator was equipped with a remote emergency stop button. The findings were: 1. Observation of the generator annunciator panel on 10/9/12 at 5:28 PM showed the only panel was located in the mechanical room. The mechanical room is separated from the corridor by an intervening housekeeping closet. At the time of the observation the maintenance director was unaware the annunciator panel was required to be observable by personnel. 2. Observation of the emergency corridor lights showed they were supplied with power from the emergency generator. Observation of the generator on 10/9/12 at 6:15 PM showed it was	SALF	E.1. The facility will ensure the emergency generator annunciator panel is properly installed. a) The facility will retain qualified workmen to b) relocate the annunciator panel to an observable location in the corridor, and install an emergency stop button. c) Facility staff will inspect the annunciator panel to ensure it remains in working condition and observable by staff, and d) such inspections shall occur on a quarterly basis. E.2. The facility will ensure that the emergency generator is equipped with a remote emergency stop button. Prior to such work, the facility will 1) prepare a plan for the work, and 2) submit to OHLS for review and approval. The plan will reference this deficiency letter, section E.1., per the State survey dated 10-10-12: a) The facility will retain qualified workmen to b) install an emergency stop button. c) Facility staff will inspect and test emergency stop button to ensure it remains in working condition, and d) such inspections shall occur on a quarterly basis.	12/21/12

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SALF	Continued From page 4 not equipped with an emergency stop button. At the time of the observation the maintenance director reported he was unaware an emergency stop button was required. Reference, NFPA 101, 2006 Edition, 18.2.9.1, 7.9.2.4, NFPA 110, 2005 Edition; 5.6.5.6 All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.6 Remote Controls and Alarms. A remote, common audible alarm shall be provided as specified in 5.6.5.2 (4) that is powered by the storage battery and located outside of the EPS service room at a work site observable by personnel. F. Based on record review and staff interview, the facility failed to ensure maintenance records were available to review. The findings were: Review of the fire alarm system acceptance and testing records showed there were no records to review onsite. On 10/10/12 at 11:20 AM the maintenance director was unaware the acceptance records and last full year of records must be kept on site at all times for review. Reference, 18.3.4.1, 9.6.1.3, NFPA 72, 2005 Edition; 10.6.1 Permanent Records. After successful completion of acceptance tests approved by the authority having jurisdiction, the requirements of 10.6.1.1 through 10.6.3.1 shall apply. 10.6.1.1 A set of reproducible as-built installation drawings, operation and maintenance manuals, and a written sequence of operation shall be	SALF	F. The facility will ensure that fire alarm system maintenance records (inclusive of all items below) are maintained by the Facility Maintenance staff, being available onsite in the Administrators Office and available to the authority having jurisdiction including: a) a set of reproducible as-built installation drawings, operation and maintenance manuals, and a written sequence of operation for the life of the system in either paper or electronic media. b) Maintenance, inspection and testing records from the initial installation will be available onsite for the life of the system on disk for review by the authority having jurisdiction. c) Facility maintenance staff will maintain records regarding the maintenance, inspection and testing records of the system in notebooks and, d) retain records from the tests until the next test and for 1 year thereafter.	

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SALF	Continued From page 5 provided to the building owner or the owner ' s designated representative. 10.6.1.3 The owner shall be responsible for maintaining these records for the life of the system for examination by any authority having jurisdiction. Paper or electronic media shall be permitted. 10.6.2 Maintenance, Inspection, and Testing Records. 10.6.2.1 Records shall be retained until the next test and for 1 year thereafter. 10.6.2.3 A record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 10.6.2.3: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested, for example, (8) Functional test of detectors (9) Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Other tests as required by equipment manufacturer ' s published instructions (13) Other tests as required by the authority having jurisdiction (14) Signatures of tester and approved authority representative	SALF	The record will include: 1. Date 2. Test Frequency 3. Name of Property 4. Address 5. Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address and telephone number 6. Name, address, and representative of approving agency (ies) 7. Designation of the detector(s) tested, for example, a) functional test of detectors b) functional test of required sequence of operations c) check of all smoke detectors d) loop resistance for all fixed-temperature, line-type heat detectors e) other tests as required by equipment manufacturer's published instructions f) other tests as required by the authority having jurisdiction.	12/21/12

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SALF	Continued From page 6 (15) Disposition of problems identified during test (e.g., owner notified, problem corrected/successfully retested, device abandoned in place) G. Based on observation and staff interview, the facility failed to ensure sprinkler piping was properly installed and failed to ensure there was complete sprinkler coverage in 2 of 4 smoke compartments. The findings were: 1. Observation of the sprinkler system on 10/9/12 between 5 PM and 6:30 PM showed the branch line was exposed CPVC orange piping in the main electrical room #121, the garage and the sprinkler riser room. Further observation showed the pipe was suspended 8 inches below the ceiling. On 10/17/12 at 11 AM the Harvel Blazemaster manufactures installation guide was observed to state "Pendent Sprinklers Light Hazard or Residential Pendent Sprinklers ...The piping shall be mounted directly to the ceiling". On 10/9/12 at 5:26 PM the maintenance director reported he was unaware exposed CPVC pipe was required to be mounted directly to the ceiling. He could not explain why the sprinkler installation company had not followed the manufacturer's recommendations. 2. Observation of the walk-in freezer on 10/10/12 at 10:35 AM showed a sprinkler was not installed inside the freezer. At the time of the observation the maintenance director could not explain why the sprinkler installation company had not installed a sprinkler head in all habitable spaces. Reference, 18.3.5.1, 9.7.1.1, NFPA 13, 2005 Edition; 6.3.6.1 Other types of pipe or tube investigated for suitability in automatic sprinkler installations	SALF	G.1. The facility will ensure that sprinkler piping is properly installed and ensure there is complete coverage in 2 of 4 smoke compartments. a) The facility will retain qualified workmen to b) correct the installation of the exposed CPVC orange piping in the main electrical room #121, the garage and the sprinkler riser room to comply with Blazemaster manufacturer specifications. c) Facility staff will inspect such piping to ensure it remains as specified, and d) such inspections shall occur on a quarterly basis. G.2. The facility will ensure complete sprinkler coverage throughout the facility including the freezer. a) The facility will retain qualified workmen to b) Install a sprinkler head in the freezer area to ensure coverage in accordance with manufacturer specifications. c) Facility staff will inspect such head to ensure it remains as specified, and d) such inspections shall occur on a quarterly basis	12/21/12

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SALF	Continued From page 7 and listed for this service, including but not limited to CPVC and steel, and differing from that provided in Table 6.3.1.1 or Table 6.3.6.1 shall be permitted where installed in accordance with their listing limitations, including installation instructions. Reference; 18.3.5.1* Buildings containing health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 18.3.5.4. H. Based on observation, record review and staff interview, the facility failed to ensure maintenance records were available for review and failed to provide adequate spare sprinkler heads. The findings were: 1. Observation of the spare sprinkler cabinet on 10/9/12 at 6:10 PM showed the facility did not have the required two spare pendent 212 degree heads to replace the maintenance shop and spa room sprinkler heads. At the time of the observation the maintenance director was unaware of the aforementioned requirement. 2. Review of the sprinkler system testing records showed the facility did not have the acceptance tests to review or any of the quarterly sprinkler tests to review. Further review showed there were no maintenance records for the fire pumps to review. On 10/10/12 at 11:20 AM the maintenance director was unaware the records were required to be available for review, he was also unaware of any maintenance program for any portion of the sprinkler system. Reference, 18.3.5.1, 9.7.5, NFPA 25, 2002 Edition;	SALF	H.1. The facility will ensure that sprinkler system maintenance records and adequate spare sprinkler heads are maintained by the facility maintenance staff, being available onsite and available to the authority having jurisdiction including: a) The facility will correctly purchase and store two spare sprinkler heads for each type of sprinkler head in the building, and b) both 212 degree sprinkler head and spa room sprinkler head will be available for replacement by staff and stored in the maintenance office. c) Facility maintenance staff will monitor inventory of such heads, and d) review such inventory on a monthly basis. H.2. The facility will maintain records regarding the acceptance tests and quarterly sprinkler tests for the maintenance, inspection and testing records of the system. a) The facility will create and maintain such records in notebooks, and b) be stored in and updated periodically. c) Administrator will review and monitor such records, and d) such review shall occur on a monthly basis, and be available to the reviewing authority of jurisdiction. The record will include: 1. Date 2. Test Frequency	

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SALF	Continued From page 8 4.3 Records 4.3.1 Records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. 4.3.2 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. 4.3.4 Original records shall be retained for the life of the system. 4.3.5 Subsequent records shall be retained for a period of 1 year after the next inspection, test, or maintenance required by the standard. 8.5.1 A preventative maintenance program shall be established on all components of the pump assembly in accordance with the manufacturer ' s recommendations. 8.5.3 In the absence of manufacturer ' s recommendations for preventative maintenance Table 8.5.3 shall be used for alternative requirements. I. Based on observation and staff interview, the facility failed to ensure portable fire extinguishers were inspected on a monthly basis in 4 of 4 smoke compartments. The findings were: Observation of the portable fire extinguishers on 10/9/12 between 5 PM and 6:30 PM showed the building was equipped with 12 extinguishers. Further review showed the last annual inspection occurred during January 2012. The extinguishers had not received a monthly safety inspection since the January 2012 annual inspection. On 10/9/12 at 5:01 PM the maintenance director was unaware the extinguisher required a monthly inspection. Reference, 18.3.5.10, 9.7.4.1, NFPA 10, 2002	SALF	3. Name of Property 4. Address 5. Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number. 6. Name, address, and representative of approving agencies. c) Facility maintenance staff shall maintain records in notebooks documenting the maintenance of the fire pump. The record will include: 1. Date 2. Test Frequency 3. Name of Property 4. Address 5. Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number. 6. Name, address, and representative of approving agencies. I. The facility will ensure that all portable fire extinguishers installed throughout the facility are monitored and maintained. a) The facility will maintain record tags at the individual devices, and b) be monitored and inspected by maintenance staff.	12/21/12

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SALF	Continued From page 9 Edition, 6.2 Inspection. 6.2.1 Frequency. Extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals .... J. Based on record review, observation and staff interview, the facility failed to ensure the kitchen hood fire suppression system was maintained. The findings were: 1. Review of the kitchen hood testing records showed the maintenance director did not have any records to review. On 10/10/12 at 11:20 AM the maintenance director was unaware of a maintenance program. 2. Observation of the kitchen on 10/10/12 at 10:36 AM showed the deep fat fryer was located 10 inches from the gas fired range top. The range top was not provided with a steel baffle to prevent accidental oil splash. The fryer was empty of oil at the time of the survey, but was available for future use. At the time of the observation the maintenance director was unaware of the aforementioned requirement. Reference, 18.2.3.5.1, 9.2.3, NFPA 96, 2004 Edition; 11.2.1 Maintenance of the fire-extinguishing system and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person (s) acceptable to the authority having jurisdiction at least every 6 months. 11.4 The entire exhaust system shall be inspected by a properly trained, qualified, and	SALF	c) The maintenance staff will inspect each device and ensure such inspection is recorded on the tag, and d) such inspection shall occur on a monthly basis. J.1. The facility will ensure that the kitchen hood fire suppression system is inspected and maintained. a) The facility will engage properly trained, qualified and certified person(s) acceptable to the authority, and having jurisdiction b) to inspect and maintain the kitchen fire hood and ensure fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease and oily sludge. c) The facility will have such inspector place stickers on the hood indicating the date of the inspection, and d) such inspections will be at least every six months due to the moderate volume cooking at the facility. Inspection records will be maintained in the administrator's office inclusive of: 1. Date of inspection 2. Test Frequency 3. Name of Property 4. Address 5. Name of person performing inspection, maintenance, tests, or combination	12/21/12

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11/30/12

(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 certified company or person (s) acceptable to the authority having jurisdiction In accordance with Table 11.4 Table 11.4 Exhaust System Inspection Schedule Type or Volume of Cooking Frequency Systems serving high-volume cooking ... ...Quarterly operations such as 24-hour cooking, charbroiling or wok cooking Systems serving moderate-volume cooking ...Semi-annually 11.6.1 Upon inspection, If found to be contaminated with deposits from grease-laden vapors, the entire exhaust system shall be cleaned by a properly trained, qualified, and certified company or person (s) acceptable to the authority having jurisdiction. 11.6.2 Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease and oily sludge. 12.1.2.4 All deep fat fryers shall be installed with at least a 16-in. space between the fryer and surface flames from adjacent cooking equipment. 12.1.2.5 Where a steel or tempered glass baffle plate is installed at a minimum 8 in. In height between the fryer and surface flames of the adjacent appliance the requirement for a 16 inch (406 mm) space shall not apply. K. 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 resident room #11 on 10/9/12 at 5:49 PM showed the television set was plugged into an extension cord. At the time of the observation the maintenance director could not	SALF	thereof, and affiliation, business address, and telephone number, 6. actions taken inclusive of cleaning as described below, and, 7. name, address, and representative of approving agencies. J.2. The facility does not own a deep fat fryer, and apparently the tilt-skillet was mistakenly identified such. No action required. K. The facility will ensure that extension cords are not installed throughout the facility. a) The facility will verify that no extension cords are used in the facility, and b) the residency agreement will further indicate that no extension cords may be used.	12/21/12

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Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF026	A. BUILDING _____ B. WING _____	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER TRAIL ASSISTED LIVING	2360 REAGAN AVENUE ROCK SPRINGS, WY 82901

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SALF	Continued From page 11 explain why the cord had not been noticed and removed during the monthly inspection. Reference, 18.5.1, 9.1.2, NFPA 70, 2005 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 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);	SALF	c) Facility staff will verify the non-use in apartments throughout the building, and d) such review shall be on a monthly basis.	12/21/12

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SALF	Continued From page 12 (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: --- L. Based on policy review, record review and staff interview, the facility failed to ensure the fire policy was appropriate for assisted living facilities, failed to provide a fire watch policy, failed to ensure a fire drills were held on a monthly basis and failed to ensure fire drills were conducted on each shift. The findings were: 1. Review of the resident handbook under fire safety reads as follows, "We recommend that you participate to the extent possible so that you know what to do in the event of a fire. This means that you may have to move from one area of the building to another or exit the building from time to time". Review of the Fire Emergency and Evacuation Plan, section B reads as follows, "The staff member will identify the source of the alarm ...if necessary, begin evacuating and moving	SALF	L.1. The facility will ensure that fire policy is appropriate for assisted living facilities and provide a fire watch policy that remains in effect covering the contingencies that the fire alarm system is out of service or the required automatic sprinkler system is out of service for more than four hours in a 24-hour period. The authority having jurisdiction shall be notified upon each such occurrence. a) The facility will create a fire watch policy, b) prepared by the administrator and staff.	

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SALF	Continued From page 13 residents to the area of safety ...If residents are in immediate danger, residents and staff will evacuate to "safe areas" behind fire doors." Review of section C reads as follows, "Evacuate people in the affected area through fire doors to a "safe area". If the safe area is consumed with smoke or fire, or if directed by fire department personnel, proceed to evacuate residents as directed by fire department personnel. On 10/9/12 at 3:30 PM the administrator reported that she was unsure why these two policies were conflicting. She reported the facility did not have two separate fire policies for assisted living residents and memory care residents. She was unaware assisted living residents had to evacuate the building with every fire alarm activation, even during inclement weather. 2. Review of the facility safety policies showed the facility did not have a fire watch policy. On 10/9/12 at 3:30 PM the administrator reported that she was unaware of such a policy or the steps that need to be taken with the malfunction or impairment of the fire alarm system or sprinkler system. 3. Review of the fire drill records showed a fire drill had not been held during June and August 2012. Further review showed a fire drill had not been held on the night shift occurring between 7 PM and 7 AM during the second and third quarters of 2012. On 10/10/12 at 11:20 AM the maintenance director could not explain why the fire drill had not been held on a monthly basis and on each shift. He was also unaware residents had to fully evacuate the building during each drill in inclement weather. Reference, 18.3.4.1; 9.6.1.6* Where a required fire alarm system is out	SALF	c) the administrator will review the policy, d) on an annual basis. L.2. The facility will ensure that fire policy is appropriate for assisted living facilities and ensure fire drills are held on a monthly basis. a) The facility will schedule fire drills, b) fire drills will be conducted in accordance with the Life Safety Code and the policies are consistent throughout the Resident Handbook. c) Drills will be held at least twelve (12) times per year d) on a monthly basis with a minimum of one drill conducted each quarter on each shift. L.3. The facility will ensure that fire policy is appropriate for assisted living facilities and ensure fire drills are conducted on each shift. a) The facility will conduct fire drills on each shift b) fire drills will be conducted in accordance with the Life Safety Code and the policies are consistent throughout the Resident Handbook. c) Drills will be held at least twelve (12) times per year, and d) on a monthly basis with a minimum of one drill conducted each quarter on each shift.	

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SALF	Continued From page 14 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. Reference, 18.3.5.1; 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.	SALF	Under all fire drills, residents will be instructed to assemble outside the building in designated areas. Fire exit drill records will be maintained by the facility maintenance staff, being available onsite in the administrators office and available to the authority having jurisdiction including: 1. Date of drill 2. Time of day 3. Type of drill (Practice, Announced, and 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 outside the building 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. 7. Evacuation capability rating for the facility shall be listed on the form 8. Comments on the factors that contributed to each individual's inability to evacuate successfully and any corrective actions recommended; and, 9. Signature and date of the person completing the form.	12/21/12