Wyoming Department of Health
Office of Healthcare Licensing and Surveys

RECEIVED
Wyoming Dept of Health
JUN 25 2009
Office of Healthcare Licensing and Surveys

NAME OF FACILITY	FACILITY ADDRESS	DATE OF SURVEY
ABSAROKA ASSISTED LIVING COMMUNITY	2401 COUGAR AVENUE CODY WY 82414	6/8-9/09

SUMMARY OF DEFICIENCY	FACILITY PLAN OF CORRECTION	FACILITY COMPLETION DATE
An annual Health and Life Safety Code survey was conducted at your facility by the Office of Healthcare Licensing and Surveys (OHLS) on 6/8-9/09. The survey revealed the facility was out of compliance with the Rules and Regulations for Program Administration (Chapter 12) and for Licensure (Chapter 4) of Assisted Living Facilities. **Chapter 12, Section 7. Assisted Living Facility (ALF) Core Services.** (b) Resident Assessment and Services. (i) The completion of the ALF 102. (I) the ALF 102 is only valid if completed within forty-five (45) days prior to admission. . **This REGULATION was not met as evidenced by:** Based on record review and staff interview, the facility failed to ensure 2 (#3, #4) of 5 sample resident records were complete. The findings were: Review of resident record #3 revealed the resident was admitted on 12/06/08. The record revealed the ALF 102 was signed on 1/7/09. Review of resident record #4 revealed the resident was admitted 2/01/09. The record documented the ALF 102 was signed 4/16/09. Interview with the facility's administrator on 6/9/09 at 1:48 PM verified the two ALF 102 assessments referred to above were signed and dated by the registered nurse after the resident's move-in date. **Chapter 12. Section 7. Assisted Living Facilities (ALF) Core Services.** (m) Facility Policies and Procedures (i) Management shall develop policies and	Chapter 12, Section 7: ALF Care Services (1)The ALF 102 is valid only if completed within 45 days of admission. 3. The Administrator and/or Resident Care Coordinator will assure that the ALF 102 is completed prior to the move in date through routine review of resident's records upon completion of the move-in process and aptly thereafter. 1. Review of move-ins over last 10 days was conducted to assure compliance. 2. Administrator/Resident Care Coordinator have received regulations and associated company policy to assure understanding.	06/10/09

Valerie Shalosh-Hamm
Administrator's Signature

6/23/09
Date

procedures that are available to residents and staff, including but not limited to: (C Admission, transfer, discharge of residents. **This REGULATION was not met as evidenced by:** Based on review of the facility's policies and procedures and staff interview the facility failed to update their transfer and discharge policy. The findings were: Review of the transfer policy showed "residents/ responsible parties will be given fourteen (14) days written notice of intent to discharge." In addition, review of the current admission contract stated in section 7.6 "Terms of Agreement for Discharge: by Owner with 14 day notice." Chapter 12 of Program Administration of Assisted Living Facilies updated December 12, 2007 states in Section 7, (k) Transfer and Discharge, (i) Residents shall receive a thirty (30) day written notice prior to any facility initiated transfer or discharge. Interview with the facility's administrator on 6/9/09 at 1:48 PM verified the facility's policies and procedure relating to resident transfer and dischargedid not reflect the state requirements. **Chapter 4, Section 10. Life Safety and Electrical Safety** **This REGULATION was not met as evidenced by:** Based on observation and staff interview the facility failed to ensure escutcheon plates and fire sprinkler heads were properly maintained in 2 of 3 smoke compartments. The findings were: Observation on 6/9/09 between 8 AM and 9 AM revealed the following locations had sprinkler heads that lacked escutcheon plates: the bathroom in resident room #12; the closet in resident room #31; resident room #6; the mechanical room next to the dining room. Observation on 6/9/08 between 8 AM and 9 AM	Chapter 12 Section 7: Assisted Living Care Services (m) Facility Policies and Procedures (i) Management shall develop policies and procedures that are available to residents and staff including but not limited to: (c) Admission, transfer, discharge of residents. The Administrator will update all Policies and Procedures to reflect the thirty day notice required for transfer or discharge. Chapter 4 Section 10: Life Safety and Electrical Safety 1. Escutcheon Plates were put in place: #12 Bathroom - #31 Closet - #6 Bedroom Mechanical room next to Dining Room Environmental Director secured all Escutcheon plates with gaps: #10- Resident Room, #13 Bathroom, Closet Bedroom and filled the hole in ceiling #46. 3. Environmental Director unplugged the piggy backed cords in #21. 4. NFPA 101 Life Safety Code, Chapter #31, Attached are copies of the January and February 2009 Battery Operated Emergency Lights Inspection Reports. They were filed in the maintenance Binder. The Environmental Director will insure that the Emergency Lights Inspections will be done monthly. 5. Environmental Director replaced the burnt out bulbs in the Emergency exit signs mounted on the ceiling at the main entrance. 6. The potted flowers that was obstructing the manual fire alarm pull station were removed. Environmental Director will regularly check to insure all pull station and panels are obstruction free. 7. Environmental Director to perform test every 6 months on the Alarm Panel Batteries. 8. The Environmental Director painted the 4 x 3 foot untreated plywood sheathing that was attached to the wall in the mechanical room near the facilities northwest entrance.	6/10/09 6/10/09

NAME OF FACILITY	FACILITY ADDRE	DATE OF SURVEY
ABSAROKA ASSISTED LIVING COMMUNITY	**2401 COUGAR AVENUE CODY WY 82414**	**6/8-9/09**
revealed resident belongings were located within 18 inches of the the sprinkler heads in the closets of resident rooms #45 (boxes) and #36 (pillow). Interview with the administrator on 6/9/09 at 9 AM confirmed the above observations. Reference NFPA 101 Life Safety Code, 1994 Edition *"NFPA 101, Chapter 32 Referenced Publications:"* *"NFPA 13, Installation of Sprinkler Systems, 1999 edition."* *"2-2.7.2* Escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly."* *"5-6.5.3* Obstructions that prevent Sprinkler Discharge From Reaching the Hazard. Continuous or noncontinuous obstructions that interrupt the water discharge in a horizontal plane more than 18 in. below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with this section."*	Belongings were removed from upper Closet in #45 #36 4. Environmental Director and Administrator will do monthly checks to insure compliance.	6/10/09
2. Based on observations and staff interview the facility failed to maintain the fully sheathed surfaces of the building in 1 of 3 smoke compartments. The findings were: Observation on 6/9/09 between 8 AM and 9 AM revealed bathroom in resident room #10 had an approximate half-inch gap between the sprinkler escutcheon and the ceiling. Observation on 6/9/09 between 8 AM and 9 AM revealed resident #13's bathroom, closet, and bedroom had sprinkler escutcheons that were not flush with the ceiling surfaces. Observation on 6/9/09 between 8 AM and 9 AM revealed the closet of resident room #46 had a 2 inch circular hole in the ceiling where a sprinkler head had been removed. Interview with the administrator on 6/9/09 at 9 AM confirmed the above observations. Reference NFPA 101 Life Safety Code, 1988 Edition: *"22-3.1.3.1 Construction requirements for large facilities shall be as required by this section.*	2. Environmental Director secured all Escutcheon plates with gaps: #10 Resident Room #13 Bathroom, Closet, Bedroom and filled the hole in ceiling #46	6/11/09

NAME OF FACILITY	FACILITY ADDRESS	DATE OF SURVEY
ABSAROKA ASSISTED LIVING COMMUNITY	2401 COUGAR AVENUE CODY WY 82414	6/8-9/09
Where noted as "fully sheathed," the interior shall be covered with a lath and plaster or material providing a 15-minute thermal barrier." 3. Based upon observation and staff interview, the facility failed to limit the use of flexible electrical cables in accordance with the provisions of NFPA 70. The findings were: Observation on 6/9/09 between 8 AM and 9 AM revealed several electrical appliances (radio, TV) plugged into a black surge protector, which was then plugged into another surge protector (white), which was then plugged into the wall in resident room #21. Interview with the administrator confirmed the two surge protectors were plugged in sequence with each other. Reference NFPA 101 Life Safety Code, 1988 Edition: *"NFPA 101, Chapter 32 Referenced Publications:"* *"NFPA 70, National Electrical Code, 1999 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..."* 4. Based on record review, observation, and staff interview, the facility failed to conduct, collect and record emergency lighting information. The findings were: Record review on 6/9/09 at 8:48 AM revealed no documentation was available to indicate that the thirty second monthly testing of emergency exit lights (battery backup) had been recorded for the months of January, February, and March 2009. Interview with the administrator and maintenance manager on 6/9/09 at 10 AM confirmed this finding. Reference NFPA 101 Life Safety Code, Chapter 31, Operating Features. *"31-1.3.7: A functional test shall be conducted on every required (battery-operated) emergency lighting system at 30-day intervals for a*	3. Environmental Director unplugged the piggy backed cords in #21. Environmental Director will do monthly checks to insure compliance. 4. NFPA 101 Life Safety Code, Chapter 31. Attached are copies of the January and February 2009 Battery Operated Emergency Lights Inspection Reports. The were filed in the Maintenance Binder. The Environmental Director will ensure that the Emergency Lights Inspections will be done monthly.	6/10/09 6/12/09

NAME OF FACILITY	FACILITY ADDR.	DATE OF SURVEY
ABSAROKA ASSISTED LIVING COMMUNITY	2401 COUGAR AVENUE CODY WY 82414	6/8-9/09
minimum of thirty seconds. An annual test shall be conducted for the one and one-half hour duration. Equipment shall be fully operational for the duration of the test. Written records of testing shall be kept by the owner for inspection by the authority having jurisdiction." 5. Based on observation and staff interview the facility failed to ensure one emergency exit lights was fully illuminated. The findings were: Observation on 6/8/09 at 4:48 PM revealed the light bulb (one of two) was burned out in the emergency exit sign that was mounted on the ceiling at the main enterance of the facility. Interview with the administrator and maintenance manager on 6/9/09 at 10 AM confirmed the above observation. Reference NFPA 101 Life Safety Code, 1994 Edition *"5-8.1.4 Any required illumination shall be arranged so that the failure of any single unit, such as the burning out of an electric bulb, will not leave any area in darkness."* 6. Based upon observation and staff interview, the facility failed to ensure 1 of 9 manual fire alarm pull station was unobstructed. The findings were: Observation on 6/9/09 between 8 AM and 9 AM revealed the pull station at the northwest facility entrance was obstructed by several potted flower plants. Interview with the administrator on 6/9/09 at 9 AM confirmed the above observations. Reference NFPA 101-Life Safety Code, 1994 Edition *"7-6.2.5. Each manual fire alarm station on a system shall be accessible, unobstructed, visible, and of the same general type."* 7. Based on record review and staff interview, the facility failed to maintain, test, and document the installed fire alarm system in accordance with the provisions of NFPA 72. The findings were:	5. Environmental Director replaced the burnt out bulbs in the Emergency exit signs mounted on the ceiling at the main entrance. 6. The potted flowers that was obstructing the manual fire alarm pull station were removed. Environmental Director will regularly check to insure all pull station and panels are obstruction free.	6/10/09 6/10/09

NAME OF FACILITY	FACILITY ADDR.	DATE OF SURVEY
ABSAROKA ASSISTED LIVING COMMUNITY	**2401 COUGAR AVENUE CODY WY 82414**	**6/8-9/09**
Record review on 6/9/09 at 9 AM showed that the facility was equipped with a Simplex 4010-9101 annunciator panel, one remote annunciator panel, two duct detectors, four heat detectors, nine fire alarm boxes, one-hundred-four smoke detectors, one supervisory signal devices, four waterflow switches and one-hundred-twenty-six alarm notification appliances. Further record review revealed the fire alarm system was inspected on July 24, 2007, then again on July 31, 2008. However, no records were found indicating the alarm panel batteries were ever tested between these two dates. Interview with the administrator on 6/9/09 at 9 AM confirmed a year had elapsed between inspection of the the fire alarm system. Reference NFPA 101 Life Safety Code, 1994 Edition *"NFPA 101, Chapter 32 Referenced Publications:"* *"NFPA 72, National Fire Alarm Code, 1993 edition."* *"Table 7-3.2 Testing Frequencies."* **3. Batteries, Fire Alarm System* *d. sealed lead type, load voltage tested semiannually*	Environmental Director to perform test every 6 months on the Alarm Panel Batteries.	
8. Based upon observation and staff interview the facility failed to provide interior finishing with class A rating in 1 of 2 mechanical rooms. The findings were: Observation on 06/09/09 at 8:30 AM revealed a 4 by 3 foot untreated plywood sheathing attached to the wall in the mechanical room near the facility northeast entrance. Electrical panels were noted to be attached to the plywood. Reference NFPA 101 Life Safety Code, 2000 Edition *"10.2.3.1 Interior wall finish that is required elsewhere in this Code to be Class A, Class B or Class C, shall be classified based on test results from NFPA 255 Standard Method of Test of Surface Burning Characteristics of Building Materials."*	8. The Environmental Director painted the 4 x 3 foot untreated plywood sheathing that was attached to the wall in the mechanical room near the facilities northwest entrance.	6/12/09